Country Operational Plan

COP 2019

Strategic Direction Summary

April 5, 2019

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1.0 Goal Statement

PEPFAR Lesotho's Country Operational Plan (COP) 2019 is built upon the strategic priorities and national expansion of our COP18 approach. The goal is to achieve UNAIDS 90-90-90 targets in all age and sex bands and national 95-95-95 targets. Achieving this 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 recently updated 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 81/92/88, with 81% of PLHIV knowing their status, 92% 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.

To get the last mile towards epidemic control, in COP19 the PEPFAR Lesotho program will expand index testing and self-testing with fidelity, ensuring that all HIV-positive Basotho know their status and have access to treatment. COP19 investments will achieve 90% antiretroviral therapy (ART) coverage across all ten districts in Lesotho and saturation across all age groups and sexes. Recency testing will be rolled out nationally and integrated within testing modalities to inform targeting and hotspots mapping for new HIV infections. Real-time epidemiological data analysis for recent infection results, index testing, and partner notification services can identify clusters of recent infection to be prioritized for targeted prevention interventions. Furthermore, PEPFAR Lesotho is going to optimize site-level data and roll out e-registers nationally across all 10 districts. This will ensure a viable unique identifier system, enabling a system of case-based surveillance to prevent, detect, and intervene on the epidemic.

In COP19, populations to be prioritized include adolescents/young adults and males as they currently have the lowest ART coverage rates. Efforts to reach these populations include establishment of additional men's clinics and adolescent corners in high-volume sites. Preliminary data indicate that men's clinics and adolescent corners have been successful in attracting greater numbers of PLHIV in these two groups. At these sites, we have been able to achieve high HIV testing services (HTS) yield, linkage to treatment, and retention.

Optimizing antiretroviral regimens can increase access to treatment and improve treatment outcomes through impact on treatment adherence, viral suppression, and quality of life of PLHIV. The MOH has shown commitment and political will to transition the majority of PLHIV in Lesotho from nevirapine and TLE regimens to TLD. Beginning November 2018, the MOH has led the revision of the ART treatment and prevention guidelines, in line with the WHO recommendations, and revised the adult and pediatric first-line treatment regimens. In order to ensure that the ARV Optimization and TLD transition occurs, the MOH has committed to phase-out of both pediatric and adult nevirapine regimens by June 2019 and October 2019, respectively. Both GF and MOH have

provided resources to fund ARV supply plans that align with the new optimized regimens for pediatrics, adolescents, and adults in their FY 2019 to 2020 budgets.

PEPFAR Lesotho has worked with a wide range of stakeholders in developing COP19. 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) is the norm. Through the biannual health summits and quarterly PEPFAR Oversight and Accountability Review Team (POART) meetings, the PEPFAR Lesotho program works alongside the Government of Lesotho and all stakeholders 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 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.[1] The country is divided into ten districts. Lesotho is classified as a lower middle-income country with a Human Development Index of 0.497 and a Gross National Income (GNI) per capita of $1,210.00.[2] Sixty-six percent of the population lives in rural areas.[3]

Lesotho completed a national census in 2016, and these updated numbers have been incorporated into our population-level estimates in the UNAIDS Spectrum model along with the Lesotho Population Based HIV/AIDS Impact Assessment (LePHIA) district prevalence, ARV-corrected incidence and country 2018 program data. This model forms the basis for PEPFAR planning. Prevalence among men and women 15-59 is 25.6%. LePHIA results showed that women have a higher HIV prevalence than men at all ages, with the exception of 55-59 years.

Beginning in COP18, all ten districts of Lesotho became "scale-up saturation" districts. PEPFAR Lesotho is supporting 207 health facilities across the ten districts in COP19 with Prevention of Mother-to-Child Transmission (PMTCT), HIV testing, and HIV care and treatment. Voluntary medical male circumcision (VMMC) services will be synergized between PEPFAR Lesotho and The Global Fund to Fight AIDS, Tuberculosis and Malaria (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 Maputsoe, Leribe, urban centers that border South Africa, where female sex workers (FSW) and men who have sex with men (MSM) are concentrated.

Lesotho continues to be ranked second highest in the world for 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 1.1% in 2018.[4] Lesotho was the first country in Africa to implement Test and Start in June 2016. In 2017, Lesotho adopted multi-month dispensing (MMD) for stable patients. During COP19, Lesotho will continue to scale up index testing, HIV self-testing (HIVST), Pre-Exposure Prophylaxis (PrEP), TB preventive therapy (TPT) and differentiated models of care with a transition to TLD beginning in August 2019. In COP19 Lesotho will scale up the e-register program enabling a unique idenitifier for all people living with HIV allowing case monitoring from the time the person tests for HIV.

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

[1] Lesotho Census, 2016
[2] http://hdr.undp.org/en/data
[3] http://data.worldbank.org/country/lesotho
[4] LePHIA, ARV-corrected incidence, Dec 2018

urgently needs to be addressed to reach the 90-90-90 goals in this population. Frequent changes in key personnel at the Ministry of Health (MOH) and ongoing political issues threaten the success of Lesotho's national HIV program. The Government of Lesotho's (GOL) revised National Strategic Plan for HIV and AIDS (NSP) 2018-2023 endeavors to halve new infections and AIDS-related deaths by 2023 and eliminate mother to child transmission of HIV (MTCT), by focusing on two core programs and eight program results:

1. Expanded Access to Treatment and Combination Prevention
    a. 95% of people aged 15 and over have accessed combination prevention;
    b. MTCT eliminated and 95% of children living with HIV on treatment;
    c. Test and treat cascade fast tracked to attain 95-95-95 targets.

2. Social and Structural Enablers
    a. Gender and human rights related barriers removed
    b. 75% of People Living with HIV/AIDS (PLHIV) at risk of and affected by HIV, benefit from HIV-sensitive social protection
    c. At least 40% of the HIV/TB response is community-led and sustainable
    d. Health system is people-centred and sustainably integrates HIV, TB and other infections
    e. Increased efficiencies and financial investments from less than 70% to 90% of the NSP budge

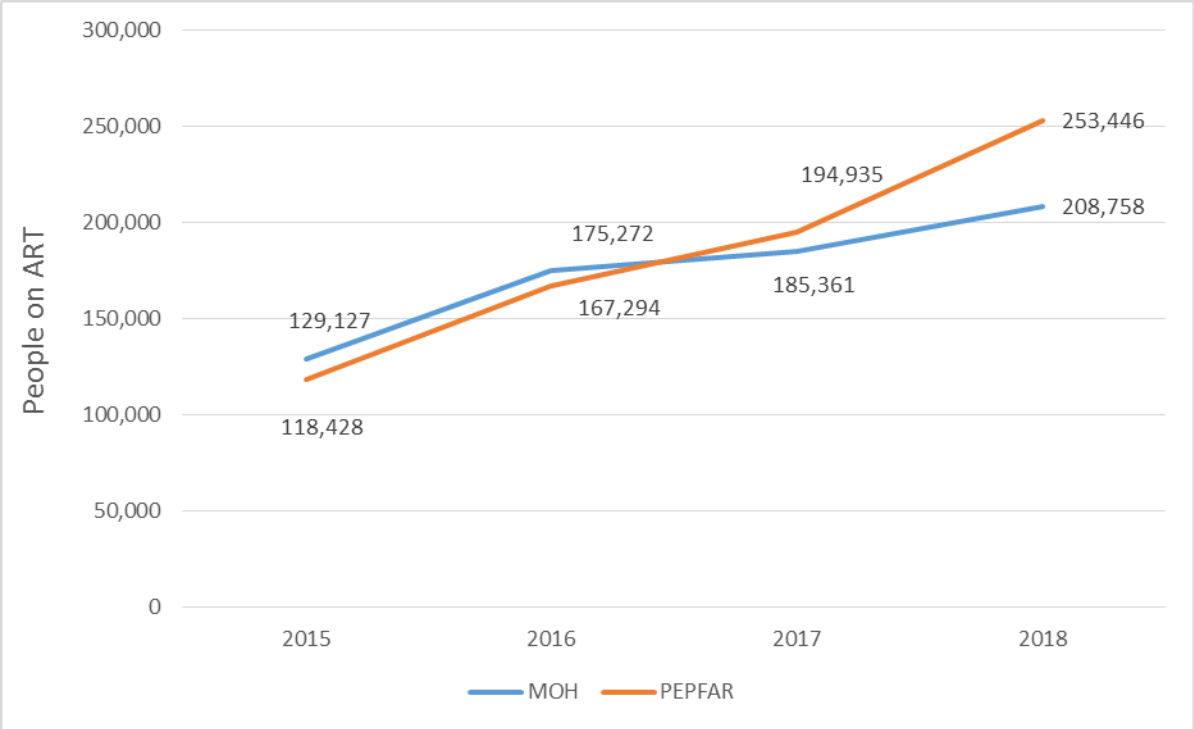
Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	2,007,201	100	318,819	15.9	318,625	15.9	204,092	10.2	205,041	10.2	502,157	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)	5178		431		440		273		191		2064		1778		2018, Spectrum
# PLHIV	328,577		7447		7442		20,342		8983		165,424		118,939		2017, LePHIA (0-59)
Incidence Rate (Yr)		1.10	---	---	---	---		1.49		0.13		1.22		1.00	2017, LePHIA (25+ is 15-59)
New Infections (Yr)	10,834														2018, Spectrum
Annual births	37,550	---													2016, BOS
% 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	12,388	---													2018, Spectrum
Orphans (maternal, paternal, double)	210,712		70,015		70,015		35,341		35,341		--		--		2018, Spectrum (15-24=15-17)
Notified TB cases (Yr)	7271														2018, Global TB Report
% of TB cases that are HIV infected		70%	---	---	---	---	---	---	---	---	---	---	---	---	2018, Global TB Report
% of Males Circumcised	177,411				80,094	45			67,206	38			30,111	17	2018, Project SOAR
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	4,947	---													2017, in-country estimate (15+)

Prevalence (Taxi Drivers)															
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	2,007,191	25.61^	328,577	313,221	253,446	81%	93%	862,998	31,873	28,707
Population <15 years	637,444	2.1	14,889	14,007	11,625	83%	87%	170,953	766	723
Men 15-24 years	205,041	3.4	8983	8598	4815	56%	78%	77,220	1103	777
Men 25+ years	393,638	20.8	118,939	107,381	85,905	80%	93%	162,961	10,520	9639
Women 15-24 years	204,092	11.1	20,342	21,237	10,831	51%	89%	171,864	5553	4548
Women 25+ years	395,189	30.4	165,424	159,398	140,270	88%	95%	280,000	13,814	13,020
MSM	10,845	33.3	3,611	---	---	---	---	1170	44	
FSW	5,986	71.9	4,304	---	---	---	---	918	121	
PWID	No data	---	---	---	---	---	---	---	---	---
Priority Pop (Prisoners)								1594	124	

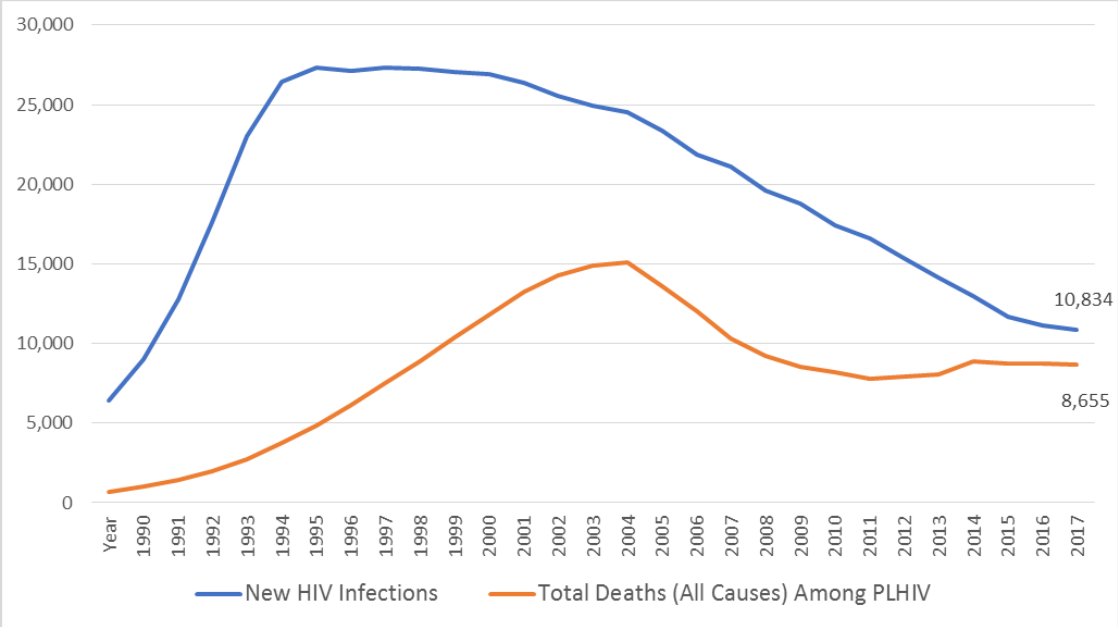
*2016 Census (2019 population estimate is not available)
**LePHIA, 2017
†Spectrum 2018
‡Program data, Qtr1 2019
^15-59 year prevalence

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment*



*MOH 2018 program data from DHIS2; PEPFAR data from 2018 Spectrum

Figure 2.1.4 Trend of New Infections and All-Cause Mortality among PLHIV*



*Spectrum Estimates for the period of 1990 to 2018.

2.2 Investment Profile

In Lesotho, the GOL, GF, and the United States Government (USG) through PEPFAR primarily fund the HIV response. Over the past few years, PEPFAR Lesotho's budget has significantly increased from $34 million in COP15 to $85 million in COP19. PEFPAR's percentage of the national HIV response has therefore increased. GF grant expenditure was lower in 2018 as the GF grants transitioned to the new three-year grant 2018-2021. Historic expenditure for the two year grant from 2016-2018 was just under 80%. 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 $94,402,232. PEPFAR's contribution to the national response has increased to 67% of the HIV funding. The largest cost categories are those directly associated with achieving 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]
Care, treatment and support	$20,253,668	70%	28%		2%
PMTCT	$1,591,312	62%	38%		0%
HTS	$12,816,652	85%	14%		0%
VMMC	$5,771,963	97%	3%		0%
Priority population prevention	$4,575,746	68%	32%		0%
Key population prevention	$1,117,899	65%	35%		0%
OVC	$2,164,324	100%	0%		0%
Laboratory	$5,940,775	72%	27%		1%
SI, Surveys and Surveillance	$1,650,508	58%	35%		10%
HSS	$4,539,058	66%	33%		2%
Total	**$94,402,232**	**67%**	**15%**	**18%**	**1%**

[1]PEPFAR Expenditure Reporting 2018
[2]Global Fund: Self Reported Expenditure Analysis 2018
[3]Ministry of Health planned total HIV budget for FY2019
[4]Other: CHAI and SolidarMed self-reported expenditures 2018

Table 2.2.2 shows that GOL procures the majority of 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. GF continues to procure ARVs, test kits, condoms, reagents, and other commodities. It is worth noting that the Global Fund contributions in this table are low because year 1 of the new grant is a special case where the GF grant is covering very few commodities compared with year 2 and year 3.

Table 2.2.2 Annual Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR[1]	% GF[2]	% Gov. of Lesotho[3]	% Other[4]
ARVs	$ 23,416,988	0%	5%	95%	0%
Rapid test kits	$ 1,298,018	36%	64%	0%	0.4%
Other drugs	$ 272,634	0%	100%	0%	0%
Lab reagents	$ 1,637,390	58%	39%	0%	4%
Condoms	$ 184,258	11%	89%	0%	0%
Viral Load commodities	$ 6,542,142	97%	3%	0%	0.1%
VMMC kits	$ 506,348	94%	6%	0%	0%
MAT	$ -	0%	0%	0%	0%
Other commodities	$ 25,157	0%	100%	0%	10%
Total	**$ 33,918,935**	**24%**	**10%**	**65%**	**0.2%**

[1]PEPFAR: Condoms from Expenditure Reporting 2018, all other costs from COP18 Budget

[2]Global Fund: self reported Expenditure Analysis. Note: year 1 of the new grant did not include any ARV funding – all funding was in years 2 and 3.

[3]Ministry of Health self-reported ARVs only

[4] Other: SolidarMed self-reported expenditure

As Table 2.2.3 shows, the only bi-lateral USG non-PEPFAR funding in Lesotho is for Peace Corps and MCC. Lesotho does benefit from small amounts of regional funding through the USAID regional office in Pretoria.

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	$1,575,000	$1,575,000	1	$930,112	FY19 funding for Peace Corps Lesotho. FY20 is expected to be similar.
MCC	$5,780,000	$0	0	$0	$5,780,000 was announced in February 2019 to conduct feasibility studies in Lesotho. The funding for the full MCC second compact is still undetermined.
Total	**$7,355,000**	**$1,575,000**	**1**	**$930,112**	

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	$1,137,155	$0	$1,137,155	2	$0	Cervical cancer screening for HIV positive women over 25
FBO Initiative Funding	$7,300,000	$0	$7,300,000	3	$0	FBO Initiative funding for CDC and USAID.
DREAMS Innovation Fund						
KPIF						
Total	$8,437,155	$0	$8,437,155		**$0**	

2.3 National Sustainability Profile Update

PEPFAR Lesotho completed a Sustainability Index Dashboard (SID) in December 2017 to assist with identifying areas of weakness that are critical to the HIV and AIDS response and the attainment of epidemic control in Lesotho. 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).

While "planning and coordination" scored "sustainable" under SID, there are still areas for which PEPFAR can invest in, particularly in the provision of technical assistance to the MOH for HIV program coordination and policy and guidelines development. As such, these investments will continue in COP19, especially for technical assistance in TLD transition, pediatric ART optimization, and update of National ART guidelines.

The elements that scored "emerging sustainability" (yellow) included private sector engagement, public access to information, service delivery, human resources for health (HRH), 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.

PEPFAR Lesotho has been focusing above-site investments in commodity security and supply chain; epidemiological and health data; performance data; and laboratory systems due to sustainability vulnerabilities in these areas. In COP19, PEPFAR Lesotho will continue to support the MOH to strengthen these specific elements, as these are critical to helping Lesotho reach epidemic control. For example, Lesotho has experienced consistent laboratory stock-out challenges, leading to poor viral load (VL) coverage. PEPFAR Lesotho will continue to provide technical support and capacity building to the MOH through the Supply Chain Management Directorate (SCMD), 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 and laboratory commodities. Optimization of information systems such as e-registers and DHIS2 at the health facility level will ensure timely, complete, and accurate data management to inform programmatic planning by the host country. National rollout of electronic registers (e-registers) will ensure a viable unique identifier system that will allow patients to be tracked across health facilities and allow for the sustainable measurement of the cascade of HIV services. Furthermore, this will enable a system of case-based surveillance to prevent, detect, and intervene on the epidemic, especially once Lesotho reaches epidemic control. Laboratory services, which are vital to HIV service delivery, will be supported in COP19 through: 1) strengthening local referral networks through tiered lab services (national, district, and site levels); 2) strengthening laboratory information systems (LIS); 3) improving laboratory quality systems and; 4) supporting the development of lab policies, strategic plans, and guidelines. This will ensure improved VL coverage of 90% by the end of COP18 and 100% by the end of COP19 (refer to Section

6.0 for more details). The second Lesotho Population-based HIV Impact Assessment (LePHIA) will help clarify the programmatic gains made in the past three years and show where Lesotho is with regards to the UNAIDS 90-90-90 goals.

PEPFAR Lesotho is currently investing in all the areas that it can to sustain epidemic control once it is reached. Planning and coordination will need to be refined as Lesotho transitions from a donor-centered environment to one that is host country-led. Once the systems for laboratory, supply chain, and health information are established and optimized, knowledge and skills transfer through our current implementing partners should enable the host country to assume operations. For full ownership, however, the host country will need to continually invest resources in the maintenance of these systems, including procurement of essential commodities. It should also be mentioned that political instability, extensive corruption, and limited technical capacity are challenges that cannot be fully addressed by the PEPFAR Lesotho program, but can seriously affect the sustainability of its response.

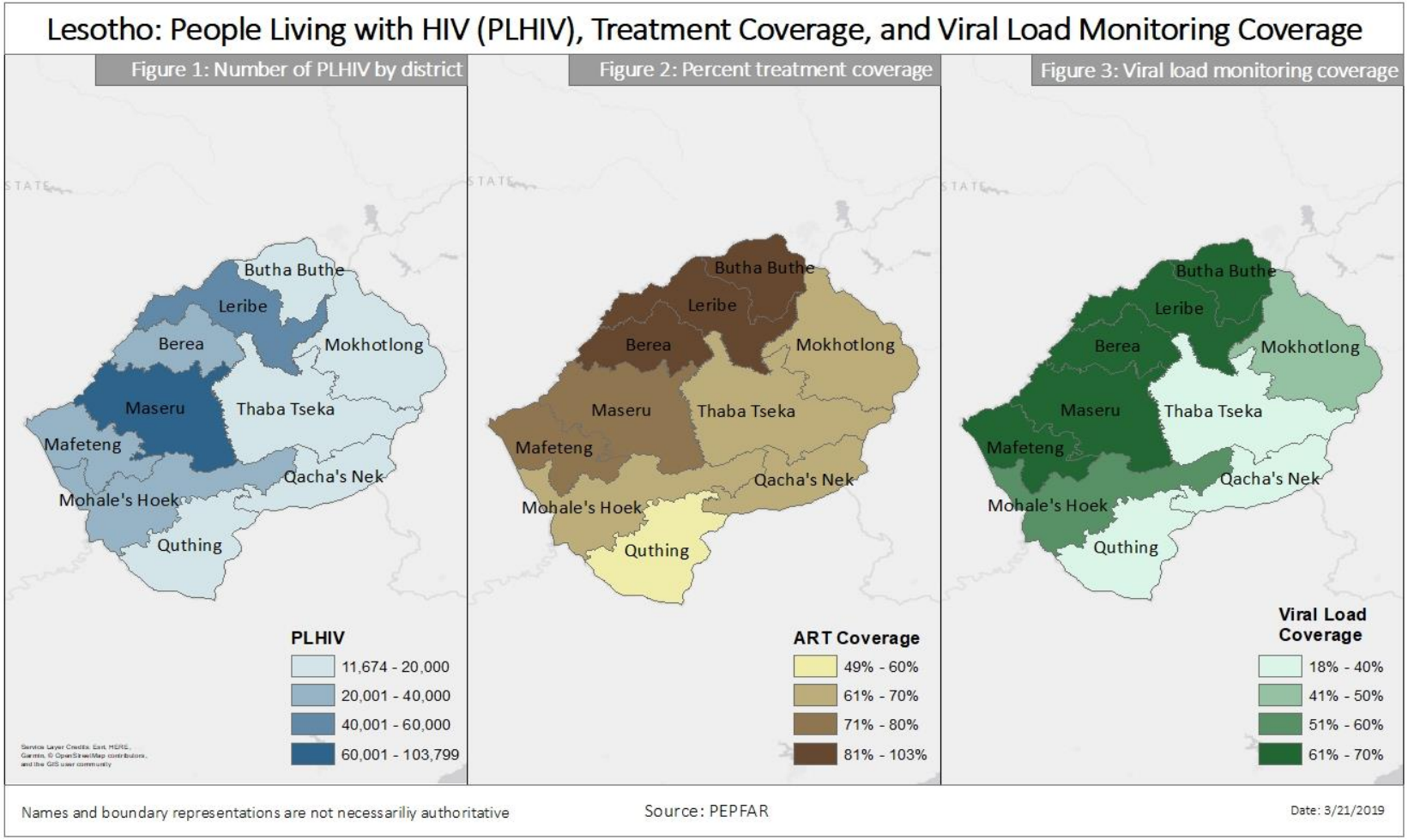
PEPFAR and GF have synergized resources in Lesotho to address gaps in sustainable epidemic control. GF invests directly into the Ministry of Finance as a prime partner and the MOH as a sub-recipient. Therefore, it has been able to build capacity from within the finance and health sectors, addressing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

PEPFAR Lesotho will increasingly work with and implement activities through indigenous partners, including faith communities and faith-based organizations (FBOs), to build local capacity, increase program sustainability, and ensure sustainable epidemic control. For COP19, PEPFAR Lesotho can show clear evidence of agency progress toward local, indigenous partner prime funding. For USAID, current transition milestones are set at 30% for COP19, reaching 48% of their portfolio to be implemented by indigenous entities, by COP22. USAID has established three mechanisms limited to indigenous or regional partners that are to be determined in COP19. CDC will offer preference points to indigenous organizations in future notice of funding opportunities. Furthermore, they will incorporate health system strengthening activities for the MOH in all new awards to develop local capacity.

2.4 Alignment of PEPFAR investments geographically to disease burden

According to LePHIA, 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. As Lesotho was approaching epidemic control, PEPFAR expanded to 45 sites in the five highland (formerly "sustained") districts, leading to 99% coverage of PLHIV on ART. 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 expansion of facility-based PrEP and men's clinics, in order to reach national 95-95-95 targets and epidemic control in Lesotho. In COP19, PEPFAR will remain in these 207 sites.


Lesotho: People Living with HIV (PLHIV), Treatment Coverage, and Viral Load Monitoring Coverage
Figure 1: Number of PLHIV by district
Figure 2: Percent treatment coverage
Figure 3: Viral load monitoring coverage
Butha Buthe
Leribe
Berea
Mokhotlong
Maseru
Thaba Tseka
Mafeteng
Qacha's Nek
Mohale's Hoek
Quthing
PLHIV
11,674 - 20,000
20,001 - 40,000
40,001 - 60,000
60,001 - 103,799
ART Coverage
49% - 60%
61% - 70%
71% - 80%
81% - 103%
Viral Load Coverage
18% - 40%
41% - 50%
51% - 60%
61% - 70%
Names and boundary representations are not necessariliy authoritative
Source: PEPFAR
Date: 3/21/2019

2.5 Stakeholder Engagement

COP19 development included various stakeholders from the MOH, Ministry of Social Development, civil society organizations (CSOs), GF, National AIDS Commission (NAC), United Nations Agencies, faith-based organizations, PEPFAR implementing partners, and other select local non-government organizations in three successive in-country planning meetings from 29th to 31st January. 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), SkillShare Lesotho, Care for Basotho, and Phelisanang Bophelong (PB). FBOs that participated included Christian Health Association of Lesotho, Lesotho Inter-Religious AIDS Consortium (LIRAC), World Vision, and Christian Council of Lesotho. Prior to these meetings, COP19 guidance, along with critical data and materials (POART FY18 Q4 presentation slides and web links to PEPFAR Solutions Platform, COP18 SDS and Q4 results via Spotlight) 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. These stakeholder strategic planning meetings were well-attended and well-engaged. Stakeholders expressed general agreement with many of the COP19 minimum program requirements, particularly: 1) enhanced case-finding through index testing and partner notification services; 2) TLD transition; 3) increased funding to indigenous partners; and 4) establishment of functional unique patient identifiers.

Representatives from the MOH, CSOs (Sentebale and LENEPWHA), GF, WHO, UNAIDS, and global implementing partners (Jhpiego, EGPAF, PSI, ICAP, and CRS) participated in the five-day, in-person planning meeting in Johannesburg from 11th to 15th March. Stakeholders contributed to effective discussion and agreed on the collaborative objectives and strategic priorities for COP19. Implementing partners involved with testing services agreed to enhanced case-finding through the scale-up of index testing and partner notification services. GF contributed to important discussions surrounding commodities security of HIVST kits and assisted with the fast-track ordering of these commodities at the meeting. MOH representatives committed to specific strategic directives and issued a memo to district health management teams and health providers to help launch many of the PEPFAR Lesotho COP19 priorities. These strategic directives included: 1) rapid scale-up of index testing, partner notification and self-testing; 2) MMD of ARVs; 3) phase-out of NVP-containing regimens and transition to TLD; 4) TPT commodities security; 5) routine screening of cervical cancer and; 6) scale-up of VL and TB GeneXpert patient monitoring and coverage.

The wider in-country stakeholders and implementing partners were briefed on outcomes from the Johannesburg In-Person Planning Meeting on 26th March 2019. Implementing partners expressed their appreciation for their inclusion in these meetings and cited this as an example of the increasing transparency of the PEPFAR COP process. The MOH reiterated their commitments made in Johannesburg and expressed continued collaboration with PEPFAR in implementation of the COP19 strategy. The draft COP19 strategic direction summary was distributed to all stakeholders prior to submission on 5th April 2019.

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 additional sites in the lowland districts. Altogether PEPFAR Lesotho supported 161 treatment sites. In COP18, PEPFAR Lesotho provided additional direct service delivery (DSD) support for public and private facilities in the five highland districts. All districts were considered "scale-up saturation" in COP18. A total of 207 treatment sites were supported with nearly all facilities having a minimum of 200 PLHIV on treatment. Supported sites accounted for 99% of persons currently on treatment in Lesotho. The number of supported sites will remain unchanged in COP19.

As of quarter 1 in COP18, PEPFAR Lesotho had not reached attained status for ART for any of the ten districts. However, results of the LePHIA show good progress towards the UNAIDS 90-90-90 goals with national coverage of 81% of PLHIV being diagnosed, 92% of those who know their status on treatment, and 88% of those on treatment virally suppressed. Unfortunately, program data currently available shows substantially lower results. This makes it difficult to accurately measure Lesotho's progress. The LePHIA is to be repeated beginning in late 2019, which again should provide an accurate measure of our progress. In COP19, populations to be prioritized include adolescents/young adults and males as they currently have the lowest ART coverage rates. The goal in COP19 is to achieve at least 90% treatment coverage in all age and sex bands and 95% treatment coverage overall for the national population of PLHIV.

Efforts to reach these priority populations (adolescents/young adults and males) include establishment of additional 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. At these sites, we have been able to achieve high HIV testing services (HTS) yield, linkage to treatment, and retention.

In COP18, PEPFAR is providing VMMC in the five lowland districts, with a target population of 10-29 year olds. Overall coverage as of COP18 Q1 was 57% for males 10-29 years of age, ranging from 37% in Mohale's Hoek to 69% in Maseru. Efforts in COP19 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 five highland districts of Lesotho. The COP19 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 COP19	# Current on ART (FY18)	# of SNU COP18 (FY19)	# of SNU COP19 (FY20)
Attained	N/A	N/A	N/A	N/A
Scale-up Saturation	328,577/100%	253,446	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 ensuring viral suppression

4.1.1. Adult Women 15+ years

HIV disease burden in Lesotho is higher among women, who have a prevalence of 30.4% in those aged 15-59 years compared to 20.8% in their male counterparts.[5] The Government of Lesotho (GOL) adopted the UNAIDS fast-track goals for HIV epidemic control and 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.[6] Program results show high uptake of facility-based HTS with >90% of adult women who present at health facilities (outpatient, inpatient, maternal child health (MCH), adolescent corners) know their HIV status. Adult women account for 59.6% (151,101/253,446) of patients currently on treatment.[7] The PEPFAR/Lesotho program results show high viral suppression rates among adult women – 95% across all age groups and 93% among pregnant and breastfeeding women.[8]

Although SPECTRUM 2019 estimates indicate treatment coverage in adult women at 81%, they still account for 46% (34,665/75,131) of the total unmet need for treatment among all PLHIV in Lesotho. The highest unmet need for treatment for women is among adolescent girls 15-19 years at 51%, young women 20-24 years at 45%, and women 25-29 years at 30%.[9] Community viral suppression rates among women aged 15-59 years are still below the UNAIDS goal at 70.5%.[10] Programming gaps are aligned to the clinical care cascade and include: 1) sub-optimal coverage of index testing and partner notification services; 2) inadequate coverage of HIVST; 3) low Provider Initiated HIV Testing and Counseling (PITC) yield; 4) sub-optimal HTS to treatment linkages for adolescent girls; 5) low retention rates and; 6) sub-optimal coverage of differentiated care.

The COP19 strategic goals for adult women aged 15+ years include: 1) improving HIV case identification to 95% in women living with HIV; 2) increasing treatment coverage to 95% among adult women who know their HIV status; 3) strengthening retention rates to 95% for new and those already on treatment and; 4) attaining viral suppression rates of 95% among those on treatment. The program will utilize the strong national policy framework that is aligned to WHO standards for HTS, HIVST, index testing and partner notification, test and treat, ART Optimization using more efficacious regimens, MMD, and routine monitoring of treatment using VL testing.

[5] LePHIA, 2017
[6] LePHIA, 2017
[7] UNAIDS SPECTRUM, 2019
[8] APR, 2018
[9] SPECTRUM, 2019
[10] LePHIA, 2017

COP19 strategic priorities for case identification of undiagnosed adult women will focus on expanding HTS modalities that result in high yield (i.e. 10% PITC and 20% in index testing) and the generation of a high volume of newly diagnosed HIV-positive women. The main HTS modalities that will be utilized in COP19 to identify the missing adult women include optimized PITC, index testing, partner notification, community mobile testing, and HIVST services. 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, including outpatient department, MCH clinic, TB Clinic, and inpatient wards. Facility and community index testing and partner notification services will be scaled-up in all PEPFAR-supported districts based on national guidelines. The index testing and partner notification modality will contribute at least 50% of the total newly diagnosed positives in districts that have >70% ART treatment coverage. Assisted partner notification methods, such as face-to-face communication, phone calls, text messages, and WhatsApp-based video messaging will be supported. PEPFAR Lesotho will ensure that the different options of notifying partners of adult women (e.g. client referrals, provider referrals, contract referral) will be available at supported sites.

At the community level, PEPFAR will scale up targeted mobile testing so as to identify underserved adolescent girls and young women (AGYW), women aged 50+ years, FSWs, and undiagnosed women in hard-to-reach areas. HIVST will be used to complement all other testing approaches for adult women at facility and community levels targeting sub-populations with the highest unmet need for treatment. HIVST services will be scaled up targeting FSWs and women in the corporate sector, tertiary institutions, and prisons who have limited access to the routine facility or community service delivery points either due to competing priorities at work, schools, or institutional settings. In addition, HIVST will be rolled out in the health facilities (especially adolescent corners) and for those who decline PITC services. Demand creation for HTS services will be scaled up through village health workers and community focal persons. At district level, PEPFAR will continue supporting PITC officers who provide a multitude of activities to ensure quality testing services and correct targeting for those at greatest risk and need. These include: 1) mentorship, support supervision, and on-site training of lay counselors and professional counselors; 2) monitoring site-level PITC coverage rates and use of the risk assessment tool; 3) site-level performance monitoring on HTS yield, case identification, and linkage; 4) quality assurance and external quality control and; 5) collaborative quality improvement approaches to address site-level HTS cascade gaps.

PEPFAR Lesotho will continue to attain high HTS-to-treatment linkages that are >95% in the supported sites. Same-day and rapid ART initiation for adult women will be scaled up through active escort of patients within health facilities, strengthening facility-community tracking of newly diagnosed and linkage to treatment, and expansion of the community ART initiative targeting community councils 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 ongoing ART, antenatal care (ANC), and mother-infant pair support. The

mobile health (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 COP19, PEPFAR Lesotho will continue to increase access to treatment services for underserved WLHIV. The program will build on the successes of the adolescent corners to expand the number of sites providing adolescent-friendly health services. The adolescent-friendly service package is an integrated prevention, care, and treatment package of interventions provided by health care workers who have been trained in providing age-appropriate adolescent-sensitive services. These services offered in flexible working hours (including weekends) are layered with the OVC/DREAMS program and foster retention support using Youth Ambassadors. PEPFAR Lesotho will continue to leverage MOH and GF resources to provide mobile clinical services for factory workers, patients in high transit areas, and cross-border clinics. Treatment services for FSWs and women in prison settings, tertiary institutions, and corporate and public sector institutions will be expanded.

The PEPFAR Lesotho program will continue to provide technical and DSD support for ART optimization for adult women. The program will support the MOH in updating national policies to align with WHO guidelines on the provision of more efficacious regimens for adult women, including provision of TLD as the preferred first-line regimen for post-menopausal women, TLD for women of reproductive potential who provide informed consent, and TLE400 for women of reproductive potential. PEPFAR will provide training at district and site level on new policy changes, and will support facilities to ensure they have adequate commodities based on client volume for this optimization.

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 opportunistic infections; 4) screening and management of TB, including TPT; 5) screening and management of sexually transmitted infections (STIs); 6) screening and management of cryptococcal meningitis, including secondary prophylaxis; 7) nutrition assessment counselling and support (NACS); 8) voluntary family planning services based on informed choice; 9) screening and treatment of cervical cancer; 10) condom provision for their sexual partners; and 11) 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. MMD will be expanded to 95% of sites as a strategy to extend clinic visits to at least three months. Fast tracking of pharmacy refills and community ART groups (CAGs) will be expanded to all PEPFAR–supported districts. 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). Pharmacy technicians will streamline site-level commodity forecasting and ordering that is

matched to the differentiated models of care. At policy level, PEPFAR will continue advocating to the MOH for six-month refills for Basotho working in the Republic of South Africa.

Focal persons and records assistants will utilize the mHealth application to provide SMS reminders on clinic appointments for both newly enrolled and existing clients 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 e-registers that will have unique identifiers for 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.[11] In order to scale up VL uptake, ART refill appointments will be aligned to the laboratory sample transport days, Early Infant Diagnosis/Point-of-Care (EID/POC) platforms will be utilized to provide VL testing for pregnant and breastfeeding women, and dried blood spot (DBS) VL monitoring will be scaled up, especially 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. Adult 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 e-register at all supported sites. Site, district, and partner-level performance reviews will include: 1) weekly reporting on selected clinical cascade indicators (initially, HIV case identification, treatment Net_New retention trends, community tracking interventions, VL coverage, and TB prevention therapy services); 2) monthly performance reviews; 3) enhanced site-level performance analysis across the clinical cascade by age and gender; 4) site-level visits for programmatic monitoring and; 5) supporting inter-partner collaboration to improve linkages, retention, and service uptake.

4.1.2 Adult Men 15+ Years

The LePHIA provided an important snapshot of the state of the HIV epidemic in Lesotho. Based on self-report and ARV detection data from the LePHIA, it is estimated that 76.6% of HIV-positive males in Lesotho aged 15-59 years know their HIV status, 91.6% of males who know their status are receiving ART, and 87.7% of males on treatment are virally suppressed. Once males are aware of their status, they achieve the same progress towards ART coverage and VL suppression as females. The major gap is in reaching and diagnosing men living with HIV; particularly men aged 15-34 years. There is high incidence in males >25 years, 1.4% in males 25-34 years and 2.7% in males 35-49 years. The lowest coverage of ART among those who are aware of their status are males 15-24 years. Approximately two years after the LePHIA, programmatic data still shows persistent gaps in

[11] APR, 2018

achievement of 95-95-95 targets for young and middle-aged men; men 15-34 years represent approximately 41% of the unmet need among all adult males 15+.

COP18 initiatives targeting men 15+ such as men's clinics, index testing with partner notification, and assisted self-testing have shown promise in addressing the gaps identified above. However, this will need to be rapidly scaled-up during COP18/COP19. During COP19, PEPFAR Lesotho has prioritized implementation of differentiated HTS for adult males based on age groups and location (rural vs. urban) to improve testing coverage yield and linkage to treatment.

In COP19, PEPFAR Lesotho will address identified barriers that prevent male HIV diagnosis and linkage into treatment.

Index testing/partner notification services have already demonstrated yield >20% among adult males during COP18 implementation, but index testing at FY19Q1 accounted for only 6% of overall PEPFAR Lesotho program testing. For the next 18 months (COP18/19 period), index testing must account for 40% of the newly diagnosed men 15+, and the yield sustained above 20% for both community and facility index testing channels. Achieving scale and maintaining efficient index testing will be the primary strategy in identifying undiagnosed males. This will be strengthened through the use of the currently approved MOH HTS tools that include a risk assessment/retesting protocol and prioritizing testing of sexual partners of newly diagnosed individuals. In addition, recency testing (see section 4.3.1) and real-time mapping for transmission networks will be integrated with index testing and partner notification services to further improve efficiency and increase yield.

The facility-based men's clinics have demonstrated higher testing yield (>12%) compared to general outpatient department (OPD) testing for adult males. Men's clinics have also identified a significant number of adult males that were aware of their HIV status, but not enrolled on ART. This strategy is particularly valuable because it addresses specific needs of men, such as client-friendly and gender-appropriate health services for Basotho young and middle-aged men, thus ensuring an effective HIV response. The service package includes HIV prevention counselling, condom provision, referral for VMMC, Post-Exposure Prophylaxis (PEP), PrEP, ART initiation, ART refills, adherence counselling, VL monitoring, TB services (screening, diagnosis, treatment and follow up), STI screening and treatment, and multi-disease screening. During COP18 implementation, Lesotho aims to establish 35 men's clinics across the country (17 are currently active). Due to space constraints and limited number of male health care workers, COP19 will focus on scaling up various models of male-friendly services to ensure 100% coverage of all facilities. This will include implementation of the men's service package through strengthening health delivery approaches that attract adult men (e.g. expanded hours) and training all service providers on male friendly service provision without requiring dedicated space or male specific staff.

To further strengthen facility-based approaches to identify undiagnosed adult men, the PEPFAR Lesotho program will focus on scaling up targeted, risk-based testing and ensuring that yield is above 10%. This will include risk-based assessment and testing for men presenting at OPD,

emergency wards, and inpatient wards and ensuring that 100% of presumptive TB cases have a documented HIV status. The PEPFAR Lesotho program will continue to track weekly HIV testing data and treatment enrollment rates to ensure that each individual site is conducting facility-based testing more strategically to identify undiagnosed HIV positive males. To ensure the facility-based-channel remains efficient, the PEPFAR Lesotho program will also utilize SIMS assessments to assess linkage between services like sexual reproductive health, VMMC, PrEP and TB.

Community-based testing targeting high transit areas for young and middle aged men in Lesotho (taxi ranks, border crossing) linked with the community ART initiative remains a key strategy to identify and immediately link men aged 25-34. PEPFAR Lesotho program data show that integration of assisted HIVST into community mobile testing increased uptake among men 15-34, increased yield, and improved efficiency in this testing channel. The focus in COP19 is to prioritize community testing with integrated assisted HIVST to identify undiagnosed adult males focusing in districts with the highest unmet need. For the next 18 months, the real time tracking of HIV positives identified by geography will ensure that the roving community ART initiation teams are always paired with the testing teams to maximize linkage of newly identified HIV positive men. The CommCare mHealth application will be updated to track linkages from community testing and community ART initiation to the facility of the patient's choice.

HIV testing and case-finding among MSM through the enhanced peer outreach approach (EPOA) in Maseru and Leribe district has been shown to be an effective method, especially among MSM aged 25 and above. During COP19, this approach will be prioritized and scaled up. This will be linked with the KP program to ensure that the right MSM sexual networks are being targeted. In addition, the PEPFAR Lesotho program will strengthen the FSW testing program in the two districts to identify the clients of FSW through partner notification services and HIVST distribution through FSW networks. The PEPFAR program will ensure that implementing partners leverage other MOH/GF initiatives, such as border clinics, to diagnose adult males that may have been missed through other approaches.

Examples of differentiated HTS for adult males: focus on districts with low adult male ART coverage to be implemented in COP18/19		
15-24	**25-34**	**35+**

• Use HTS screening tool at OPD and adolescent corners to identify young men at risk • VMMC Platform - demand creation for HTS, PrEP and other prevention services • Index testing and recency testing for newly identified positives	• Index testing/partner notification and recency • Men's clinics /male friendly services with empowered HCW on male related issues • Mobile testing linked to community same day ART initiation and male targeted HTS services • Sexual network testing and EPOA	• Index testing/partner notification and recency • Targeted PITC • Men's clinics /male friendly services with empowered HCW on male related issues • Community same day ART initiation linked with male targeted HTS services • Sexual networks testing and EPOA

PEPFAR Lesotho will monitor weekly trends of service uptake by tracking MER indicators HTS_TST, HTS_TST_POS, HTS_SELF, HTS_RECENT and TX_NEW by age group, site, and district to ensure implementing partners stay on course with real-time interventions to address gaps. This is done to ensure that the testing approaches to identify adult males are implemented with fidelity and scale and are efficient.

PEPFAR Lesotho's main treatment priorities are to increase treatment initiation among 25-34 year-old men, and increase retention, VL coverage, and VL suppression among 15-34 year-old men. The implementation of care and treatment services for males aged 15+ has progressed from COP16 to date. During COP19, PEPFAR Lesotho will ensure that care and treatment are differentiated to remain more responsive and acceptable to the needs of adult males based on their age, place (rural or urban), and timing. The men's clinics are not only key for HIV testing uptake, but also for retention, thus achieving better VL suppression.

The men's clinics treatment cascade will continue to be analyzed on a monthly basis to ensure that they are attracting HIV-infected men 15-34 years who are likely to know their HIV status, but who have not initiated treatment. The aim is to ensure that peer psychosocial support available at the men's clinics and facilities with male friendly services enables younger men to link early and be retained on treatment.

Same-day ART initiation at both facility and community (through the community ART initiative) data will be tracked weekly to ensure that this approach is scaled at all testing points to increase linkage to treatment and viral suppression among adult males. During COP19, the provision of one-month starter packs will be piloted upon discussion with the TB/HIV technical working group and approval by MOH for specific adult males, such as migrant workers who may not be able to link within two weeks of HIV diagnosis. Results from Lesotho's CASCADE study implemented by SolidarMed showed that readiness to start ART on same day was 98%, and patients who were given one-month ART starter packs had higher linkage rates. PEPFAR Lesotho will continue to support linkage navigators to ensure that same-day ART initiation is being implemented with fidelity at both facility and community ART initiation points.

Lesotho is transitioning to Dolutegravir (DTG)-containing regimens as the preferred first-line regimen due to its superior efficacy, more rapid VL suppression, improved tolerability, and higher threshold for resistance compared to the current Lesotho first-line regimens. All adult men are eligible for the fixed dose tenofovir disoproxil fumarate/lamivudine/DTG (TLD) regimen. In collaboration with the MOH and GF, in the next 18 months, PEPFAR Lesotho will support activities to fast track the rapid transition to TLD-based regimens for adult males and other eligible populations based on the national ART guidelines. TLD uptake will be monitored monthly with the TLD transition tool by facility and eligible subpopulations.

PEPFAR Lesotho will continue to analyze its HRH resources to ensure that they are utilized to strengthen service delivery for HIV-infected men. This will include implementation of expanded clinic hours (early morning, evenings, and weekends) to accommodate adult males. This approach will include fast-tracking for ART refills at these facilities.

PEPFAR Lesotho will support the scale-up of the advanced disease package described in the revised Lesotho ART guidelines, which was based on lessons learned from implementation and evaluation of the differentiated HIV care and treatment for people with advanced disease project in Motebang and Berea government hospitals. This includes a package of care for people presenting with advanced HIV disease defined by CD4 count <200 cells/mm3 or WHO clinical stage three or four. The package includes key evidence-based interventions to reduce morbidity and mortality among this clinically unstable population. It includes the following minimum interventions: (1) rapid initiation of antiretroviral therapy (ART) once the risk of immune reconstitution inflammatory syndrome (IRIS) is assessed; (2) co-trimoxazole prophylaxis; (3) screening for active TB disease and prompt initiation of anti-TB treatment or isoniazid preventive therapy (IPT) as indicated; (4) systematic screening for cryptococcal disease; and (5) intensive follow-up. Adult men are at increased risk of presenting with advanced HIV disease leading to high morbidity and mortality. The COP19 focus will be training of all clinicians to identify advanced HIV disease, address health system challenges affecting implementation of the package at all facilities (e.g. stock out of key commodities for package of care for advanced HIV disease and knowledge gaps among clinicians).

Scale-up of TB preventive therapy (TPT) is a priority for PEPFAR Lesotho in the next 18 months. Adult men are at an increased risk of developing HIV-associated TB and men aged 15-34 have the lowest TB treatment coverage based on the 2018 global TB report. As described in section 4.3.1, TPT will be scaled up to reduce incident TB among adult males and reduce mortality associated with TB.

During COP19, PEPFAR Lesotho will support activities to maximize retention and optimize care among adult males. To reach epidemic control among males, retention will be enhanced with differentiated service delivery that decreases the number of clinic visits for stable adult males. Differentiated service models implemented in COP17/18 that need to be scaled up include CAGS, MMD, and integrated outreaches. PEPFAR Lesotho will advocate for procurement of TLD-180 day packs to enable patients to receive a 6-month ARV supply. On a monthly basis, PEPFAR Lesotho will track enrollment into CAGs by site and by district.

The scale-up of community ART delivery as a differentiated care model is a collaborative effort with the MOH. PEPFAR Lesotho will continue to track the establishment and functionality of the health posts across the country and support activities for the integration of community ART initiation and refills at these health posts. This approach will be beneficial to adult males who are in rural areas and face constraints in obtaining medication refills.

SIMS assessments, recent national DQA, and utilization of the TX_NET_NEW tool have identified undocumented transfer ins and outs, undocumented re-engagement into care, and weaknesses in patient monitoring to be critical gaps affecting retention for adult males. PEPFAR Lesotho is now utilizing the TX_NET_NEW Site Level Dashboard to monitor performance trends for retention by site and subpopulation. In addition, PEPFAR Lesotho is scaling up electronic ART registers to enhance retention data analysis by site and sub-populations. In the next 18 months, PEPFAR Lesotho will support the utilization of the ART e-registers to rapidly identify missed appointments and males with high VL. PEPFAR Lesotho will continue to support the tracking and tracing of adult males to bring them back to care. The performance of the community partner responsible for tracing patients will be monitored every month to ensure that all patient losses have a documented outcome (dead, lost to follow up, returned to care, etc.). Other PEPFAR supported interventions to enhance retention include utilization of the CommCare mHealth application and reminder SMS messages sent to patients.

PEPFAR-supported clinical and laboratory partners, in collaboration with MOH, will implement the VL-clinical interface to rapidly address programmatic gaps identified among adult males. The VL–clinical interface supports creation of electronic dashboards for VL data management. This will provide a harmonized, comprehensive approach that can maximize efficiencies and strengthen health systems for effective VL scale-up. Program data show low VL coverage among 15-34 year olds and low VL suppression among younger men aged 15-24. At site level, the clinical implementing partner will ensure completion of VL registers, expedite tracking of unsuppressed males, provide enhanced adherence counseling, and ensure that male ART patients who require a switch to second-line treatment are smoothly transitioned. The clinical partner will ensure that facilities with e-registers capture VL data to identify in real time and address unsuppressed VLs through enhanced adherence sessions and switch to second-line regimens where applicable.

In the next 18 months, PEPFAR Lesotho will continue to pursue strategic partnerships with FBOs, the private sector, and civil society to leverage resources that may be available to address current gaps in the 95-95-95 cascade for adult males.

4.1.3 Children <15 Years

PEPFAR Lesotho's COP19 strategic goal is to attain 95% treatment coverage and 95% viral suppression for all children living with HIV. PEPFAR will continue to support case identification, which begins with MNCH for pregnant and lactating women and rapid ART initiation for HIV-positive women. ART uptake in MNCH remains high at 99%. HIV exposed infants (HEI) will be

followed to the end of breast feeding. Children will be assessed for risk and tested for HIV at all entry points, including outpatient departments, pediatric inpatient wards, and TB clinics. Index testing of biological children of HIV-infected parents will be scaled up with fidelity. Due to the effectiveness of the Lesotho PMTCT program, most HEI have good outcomes, as indicated by program data (MTCT rate of 1.6% at <2 months and 2.2% at 2 to 12 months). HIV testing yield remains low for children at 0.9%.

During COP19, PEPFAR Lesotho will continue to support the MOH in the adoption of new ART guidelines as recommended by the WHO. The priority is to transition clinically stable children and adolescents to optimal ART regimens so as to enhance adherence and retention, as well as improve treatment outcomes. The HIV and TB technical working group (TWG) recommended that as the county transitions to DTG, priority will be given to those children who are on nevirapine-based regimens. PEPFAR provides technical support on the use of more efficacious pediatric treatment regimens, including LPV/r pellets for younger children as a more palatable pediatric formulation. Adolescent friendly health care services will be rolled out to more high volume health facilities in COP19.

Retention initiatives targeting children and adolescents such Ariel and teen clubs will be scaled up. Parents and care givers will be given psychosocial support and skills to support and care for children and adolescents living with HIV. FBOs will be actively engaged in demand creation for HIV testing for children and younger men, and support adherence and retention in care. All children living with HIV will be routinely monitored for viral suppression, and PEPFAR will conduct on-site trainings and mentorship to health care providers on pediatric enhanced adherence counseling, which is critical for the management of unsuppressed children living with HIV. PEPFAR Lesotho will continue to strengthen tracking of children who miss any of their clinic appointments so as to bring them back into care. The mHealth application, e-registers, and the use of unique identifiers will be helpful in accounting for losses in the clinical care cascade and tracking adolescents who age out to the adult treatment program.

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 22.8%.[12]

LePHIA results show significant improvements in the national PMTCT response showing that 97.1% of pregnant women have attended at least one ANC visit, 95.6% of women (aged 15-49 years) who gave birth 12 months prior to the LePHIA survey knew their HIV status, 98.5% of HIV-positive pregnant women received ARVs for PMTCT, and 2.8% mother-to-child transmission rate among

[12] HIV Sentinel Surveillance, 2018

HIV exposed infants. The 2014 DHS found that 77.8% of women attended at least four ANC visits and 76.5% of births occur at health facilities.[13]

This performance trend mirrored by PEPFAR program data shows high uptake of PMTCT services within health facilities. APR2018 results show 99% of pregnant women who attended their first ANC visit in the PEPFAR-supported sites knew 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 HEI aged <2 months of age is 1.7%.[14]

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 66% of positive pregnant women have a known HIV positive status and 74% of these pregnant women were already on ART for their own health. The uptake of EID has continued to increase with 94% of HEI receiving EID services by two months of age (FY19Q1).

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 births per woman 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. 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. 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 COP19, PEPFAR Lesotho will continue to support the national PMTCT elimination goal of attaining <5% MTCT rate in all the ten districts of Lesotho. The COP19 strategic goals are to achieve 95% coverage of HTS, 95% treatment coverage for HIV-infected pregnant and lactating women identified, 95% uptake of EID services at two months of age, 95% retention of mother-infant pairs, and 95% viral suppression rates.

The PEPFAR Lesotho program will consolidate the gains made in the existing sites through direct service delivery and will expand integrated service delivery for adolescents living with HIV focusing

[13] LDHS, 2014
[14] APR, 2018

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 COP19, 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 ANC 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 MMD 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 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 COP19, 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 >95% at less than two months of age. PEPFAR Lesotho will expand the use of the EID/POC platform to increase early EID uptake within 2 months and provide VL testing for pregnant and breastfeeding women. 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, leveraging 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 also continue to advocate with the MOH to triangulate these data sources with national census and program data to determine the true denominator for PMTCT.

4.2 Prevention

4.2.1 HIV prevention for AGYW and children

In response to the high numbers of orphans and vulnerable children (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 for these children. Although this is fully developed, not all of the policies and strategies have yet been fully implemented. The National Strategic Plan on Vulnerable Children April 2012 - March 2017 (extended to 2018, and currently being revised) is the core guiding document for Lesotho's response to vulnerable children, and is coordinated by the National OVC Coordinating Committee (NOCC). Through this, the Ministry of Social Development developed a standardized, HIV-sensitive case management system. The tools 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) and violence against children (VAC). The OVC program will continue implementation using the existing national frameworks.

The OVC program is geographically aligned and implemented within the ten PEPFAR Lesotho supported districts where OVC burden is also high. In COP19, the OVC program will transition to a local partner, as per PEPFAR's global shift to transition to indigenous partnerships and the focus

on sustainable approaches. This program will continue to deliver child-focused, family-centered interventions to prevent VAC, 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 OVC 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 HIV-positive OVC. The new OVC/DREAMS implementing partner will coordinate with other clinical partners to facilitate targeting and referrals for HTS and treatment. Both OVC and DREAMS programming substantially overlap; OVCs needing DREAMS services will be referred for such services, which help 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 other social welfare services as necessary.

AGYW ages 15-24 years account for over 25% of new HIV infections in Lesotho.[15] 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 dropout, stigmatization, and engagement in age-disparate and/or transactional sexual relationships. There are various ministries, policy documents, and interventions that work 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.[16] There are also reports indicating high levels of sexual violence and exploitation against children in their communities, usually by someone known to the child.[17] 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.[18] Despite such high levels of GBV, the majority of victims do not report these incidents to police, seek medical attention, or legal recourse.[ibid.]

For COP19, the DREAMS initiative will continue its implementation in the two priority districts of Maseru and Berea in order to reach 90% saturation. Although there will be no geographical

[15] UNAIDS Country factsheets Lesotho 2016 http://www.unaids.org/en/regionscountries/countries/lesotho
[16] Gender Links. The Gender-Based Violence Indicators Study Lesotho - 2014
[17] 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
[18] LDHS, 2014

expansion of DREAMS, the GF is implementing DREAMS-like activities in the other 8 districts. Through GF catalytic funding, PACT will implement programming for AGYW and youth focused on behavior change messaging, increasing comprehensive HIV knowledge, reducing the overall numbers of 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 ages 18-24 in Maseru and Berea. Comprehensive layering of DREAMS services will be expanded to all AGYWs who missed some of the services as a way to ensure that all AGYWs of different age bands were reached with all primary and secondary services. This will enhance effective layering of the DREAMS activities to all AGYWs who are DREAMS beneficiaries. All of the DREAMS IPs will use the CommCare mHealth application to support the layering for AGWYs. CommCare is a cell phone-based application that will support tracking AGYWs for all services that they receive. The CommCare application will also help with the reporting of the new indicator, AGYW_PREV. In COP19, 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, PCVs 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. For example, 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 efforts to prevent early sexual debut and supporting healthy choices. Fifteen to 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 comprehensive assessments done by caseworkers. There may be overlap between the AGYW and OVC programs as some AGYWs 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 will contribute to HTS targets, as well as the identification of HIV-positive children and AGYW. Lesotho is one of the countries where recency 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 partners. 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 Key Populations (KP)

In Lesotho, HIV-related policies and legal frameworks do not specifically address groups at high risk, such as KP. Although these KP exist in Lesotho, epidemiological data on them are either unavailable or remain incomplete.[19] According to the preliminary results of the Biological Behavioral Surveillance Study (IBBS) February 2019, FSW and MSM in Lesotho have an increased burden of HIV, as compared to other adults of reproductive age. Fifty–six to 69% of FSW and 80 to 90% of MSM reported having tested for HIV in the previous 12 months. MSM prevalence ranged from 9.1% in Mafeteng to 34.4% in Leribe, while FSW prevalence varied from 38.6% in Butha Buthe to 56.8% in Leribe.

During the FY19 Q1, a total of 1,048, (25%) of the annual target of 4,131 MSM and 708 (29%) of the annual target of 2,468 FSWs were reached with a minimum package of interventions. These interventions included correct and consistent condom usage, benefits of accessing HTS and encouraging them to test, information on STIs, and advantages of accessing HIV care and treatment. For HIV testing the positivity yield was 8% for MSM and 18% for FSW, and all 100% of those found positive were initiated on treatment, while all those negative were referred for PrEP. Intensive partner management was implemented with the IP of this program, and results were vastly improved. The IP embarked on a new case finding strategy, EPOA, which has greatly facilitated finding MSM, especially the older ones who had never come for services. This approach is yielding good results and the country will continue to use this approach in other community councils. In COP19, LINKAGES will build from its strong foundation and seek to build the capacity of local KP organizations.

[19] UNAIDS, 2012

PEPFAR Lesotho will target MSM and FSWs to reduce HIV transmission, ensure that KPs living with HIV have a high quality of life, and work towards UNAIDS 90-90-90 targets in this population. The KP cascade 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 immediately 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, HIVST, and methods to reach and engage KPs online), and adaptation of state-of-the-art data use and tracking systems.

The KP partner will continue to provide leadership and support to 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 in order to work effectively to reach target populations and implement programming. For example, the partner working with KPs in Maseru and Leribe sub-grants to Care for Basotho, Phelisanang Bophelong and MATRIX to provide peer-to-peer prevention and outreach work with FSW and MSM and link them to testing and treatment.

The National AIDS Commission (NAC) has the national mandate to coordinate HIV prevention, but they have not been able to coordinate activities to align partners. They have held one KP Prevention TWG meeting without sustaining use of 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. LINKAGES will also second a KP Advisor to MOH. All partners implementing KP activities are providing a monthly update on their progress and highlight implementation challenges in order to better address issues as they occur to ensure improved performance.

4.2.3 FBO and Communities of Faith Engagement

In COP19, PEPFAR Lesotho will embark on effectively engaging faith communities, including FBOs as these are essential partners in the fight against HIV/AIDS and TB.

FBOs have significant influence within their communities, and as they are often the first point of contact for people in need, they are promising delivery points for key messaging. Their moral

authority typically gives them credibility other institutions may lack, and they often have extensive networks and structures enabling them to access hard-to-reach populations.

HIV testing and treatment coverage has dramatically improved in Lesotho in recent years, but significant barriers to HIV prevention remain. These include stigma and discrimination, GBV, and poverty. In Lesotho, the faith sector has been involved in the HIV response since the advent of the epidemic, ranging from prevention, care and treatment, to impact mitigation. In 2007, faith leaders signed a *Statement of Commitment by Lesotho's Church Leaders on AIDS*. Following this, several documents were developed for use by church leaders to address HIV and AIDS in their various congregations. These included among others, the *Sunday Pack* (which will be updated with new clinical care guidelines, PrEP and VMMC), an educational toolkit that provided standard sermon guidelines and other material, but was not widely used or disseminated. In addition, a national framework has been developed in 2018, with support from UNAIDS, entitled *Lesotho Faith Sector Implementation Framework on HIV and AIDS,* which must now be operationalized.

As per the COP19 planning level letter, PEPFAR Lesotho will expand CRS/4Children to expand programming to fully engage FBOs and related structures, both Catholic and non-Catholic. Such structures will be strengthened to support HIV interventions, enabling them to: 1) ensure all communities of faith are aware of the most up-to-date strategies for epidemic control as a means of contributing to the 95-95-95 goals and reducing stigma and discrimination and 2) support children, adolescents and adults at risk of and/or directly impacted by HIV and TB including AGYW and adolescent boys and young men (ABYM). Additional FBO funds will be used to buy into a regional capacity building mechanism that will manage sub-grants to FBOs and provide technical and organizational capacity building to these FBOs. CDC will utilize their FBO funds to strengthen community-based mechanisms to work on comprehensive HIV education messaging with AGYW and for case finding.

Numerous HIV prevention and empowerment initiatives already target AGYW and are beginning to show results. However, an unintended consequence of this is that boys, adolescent males, and young men (who make up approximately 50% of the population aged under 24) have been "left behind." Increasing levels of violent crimes by groups of armed young men in the country, and lower levels of educational attainment among males than females evidence this. In addition, males are the main perpetrators of GBV and VAC in Lesotho, a contributing factor to the high HIV infection rates among young women. Consequently, there is an urgent need to also engage with this group to provide them the skills, assets, and opportunities necessary to further their own development and change harmful attitudes and behaviors.

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.

In COP19, the current cooperative agreement that ends in December 2019 will be transitioned to a performance-based contract. COP19 funding supports: 1) DSD at fixed and outreach VMMC sites; 2) demand creation using cost effective strategies; 3) salary support for health care providers and mobilizers and; 4) procurement and logistics for circumcision kits and other supplies. PEPFAR Lesotho plans to provide direct surgical service delivery to circumcise 30,000 men (TBD, 29,500 and DOD, 500). This represents 77% saturation in the age pivot of 10–29 year olds in the five districts of Berea, Maseru, Leribe, Mafeteng, and Mohale's Hoek.

Project implementation will leverage the adopted task-shifting policy and procured mobile outreach surgical trucks to scale-up services in hard-to-reach areas that have shortages of medical doctors. PEPFAR will use 5% of the allocated VMMC COP19 budget to support the integration of early infant male circumcision (EIMC) into MNCH programs in districts that have reached 80% saturation for sustainability. In addition, a medical/traditional male circumcision collaborative task force has been formed by the MOH to ensure males with prior traditional initiation circumcision receive VMMC. An officer already recruited by the MOH will coordinate the task force. Currently, medical circumcision is provided to interested traditional initiates at health facilities prior to the rite of passage ceremonies in the five lowland districts. Traditional circumcisions, most common among men over 20 years old, have a deep-rooted cultural significance in Lesotho. The project is designed to target men under 20, before they become old enough to attend initiation schools where they undergo traditional circumcision. This is an important strategy and it will be critical to continue to medically circumcise males before they opt for traditional initiation circumcision.

The mobile clinic initiative promises to increase access and coverage of VMMC services, 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 COP19 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, FBOs, and workplace VMMC programs. The project 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 project monitoring tools such as Geographic Information System (GIS) and Site Capacity and Utilization enables teams to conduct community mapping, targeted community mobilization, and monitor site productivity in real-time and inform targeted demand creation among the age pivot. Advocacy by community, traditional, and government leadership will continue to be leveraged to create demand for the project. Peace Corp

Volunteers and FBOs, working through their counterparts and with implementing partners, will link men to VMMC services and support demand creation through girls and boys camps and clubs.

Given the need to achieve 80% coverage and attain sustained epidemic control in all ten 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 includes conducting SIMS 4.0, data quality assurance (DQA), external quality assessment (EQA), and continuous quality improvement (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 monitor: 1) real-time, focused, age-pivot impact; 2) infections averted and; 3) associated cost savings of VMMC services. In addition, partner performance will be tracked through weekly reports, monthly site performance reports, and mandatory quarterly performance presentations to the PEPFAR team to ensure the sites are performing at capacity. This strategy provides a basis to refine programmatic approaches on an ongoing basis. The recently 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 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 COP19 target of 30,000 VMMCs to reach 77% 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 COP19, PEPFAR aims to provide PrEP treatment to 18,460 new beneficiaries, which include: 1) AGYW in DREAMS districts; 2) serodiscordant couples across all 10 districts; 3) pregnant and breastfeeding women across all ten districts; and 4) KPs in Berea, Leribe, and Maseru. The GOL has branded the national PrEP program and has committed to procuring PrEP medication for the beneficiaries, as well as guaranteed access to infrastructure and laboratory services. The policy has not only resulted in increased access to PrEP services, but also geographic expansion of the program.

In COP19, the project 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 project will strengthen referral linkages from HTS and HIVST, VMMC, family planning, STI clinics, adolescent youth corners, and serodiscordant clinics. This will be catalyzed by transitioning the program to performance-based contracting through continued support of staff salaries, DSD, HTS, risk assessment, demand creation, and CQI. Partner performance will be tracked with weekly review reports and mandatory quarterly performance presentations to the PEPFAR team. Technical assistance for robust data and service quality will involve conducting SIMS 4.0, 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 Additional country-specific priorities listed in the planning level letter

4.3.1 TB/HIV

Lesotho has one of the world's most severe epidemics of tuberculosis (TB) and HIV, with an estimated TB incidence (including HIV/TB co-infection) of 665 per 100,000 population (15,000 incident TB cases, out of which 11,000 are estimated to be TB and HIV co-infected). Lesotho has committed to the End TB strategy and UNHLM on TB (2018) targets. It has favorable policies in place to address TB and TB/HIV epidemics, but implementation with fidelity and scale remained unsatisfactory in COP17 and COP18. Lesotho is currently conducting its first TB prevalence survey to validate the current estimates for TB incidence in Lesotho. COP19 TB/HIV priorities are aligned to support the national TB/HIV response and address two major gaps -- low TB case identification and low TPT coverage.

TB program data show that the rate of TB patients with a documented HIV status is 95%. Ninety four percent of the TB/HIV co-infected patients are being initiated on ART. HIV program data show that at the end of FY18, 177,418 (81%) of 218,493 had been screened for TB. FY18 program data demonstrated extremely low TPT among PLHIV who screened negative for TB symptoms for both new ART initiations and those already on ART. The PEPFAR program has identified specific health system and patient-level barriers that affect TPT uptake. Health system barriers affecting TPT provision include continued stock-outs of isoniazid (INH) and vitamin B6. In addition, health care workers have gaps in knowledge on latent TB and the role of TPT. Poor completion of facility TPT tools results in under reporting of TPT provision. Patient factors include concerns regarding side effects and PLHIV already enrolled in differentiated care models like CAGs and MMD being required to report monthly for TPT.

To improve the TPT program in COP19 PEPFAR Lesotho will prioritize the identification, initiation, and completion of TPT in eligible PLHIV. PEPFAR Lesotho is prioritizing the following interventions:

- Procure TPT commodities to supplement GOL efforts; $742,370 is allocated for this purpose. The funds are sufficient to cover a 6-month course of isoniazid for approximately 132,566 PLHIV who have never been on TPT. Lesotho TB guidelines have adopted rifapentine and isoniazid weekly for 3 months as an alternative to 6 months of isoniazid monotherapy. The funds may be repurposed to procure this regimen depending on when it becomes available.
- Attain high TB screening coverage among PLHIV, including TPT initiation and completion. PEPFAR clinical partners will be required to report weekly TPT initiations in COP19.
- Ensure implementation fidelity for facility-based trainings, updated training materials, updated SOPs, and job aides (e.g., posters, registers, IPT cards) to reinforce guidelines.
- Improve TB/HIV data capture, recording, and reporting through intensified supervision, mentorship, training, update of reporting tools, and development of SOPs.
- Provide continuous quality improvement for TPT tools, including completeness, patient-level data collection (TPT registers, e-registers), stock monitoring systems (monitoring uptake) and toxicity monitoring at monthly refills.

- Support HRH at facility and community levels to ensure a proportion of staff members' time is dedicated to TPT activities.
- Leverage community partners and PLHIV networks to create demand for TPT

Prioritized activities to address low TB case detection include attaining 100% TB screening coverage and improving the quality of TB screening in the HIV clinic and OPD through continued focused training and mentorship for poor performing sites and optimization of PEPFAR and GOL staff for TB screening activities. PEPFAR Lesotho will continue to implement TB screening for patients enrolled in CAGs and TB contact tracing. PEPFAR Lesotho will use LENASO focal persons in the community. In addition, it will leverage village health care workers for community TB screening and referral and resources from the TB CaP program focusing on TB case finding in children. In collaboration with NTP's initiatives supported by the World Bank and GF, PEPFAR Lesotho will ensure that high-risk populations like children, miners, migrant populations, and prisoners are screened for TB at every encounter. PEPFAR Lesotho will continue to procure Xpert/RIF cartridges (approximately 70% of the annual country needs) and support the roll-out of TB LAM for patients with $CD4 < 200$. PEPFAR Lesotho will continue to optimize site-level HRH to track TB presumptive cases through the diagnostic and TB treatment cascade, ensuring that there is no attrition along the TB cascade through utilization of the TB detection registers.

PEPFAR Lesotho will support the following TB infection prevention activities: trainings on the facility TB infection control dashboard and routine implementation assessments, revival of infection control plans based on the universal concept of hierarchy of control, and advocate for minor renovations by LMDA to address gaps identified in the recent CDC TB infection control review.

At the national level, PEPFAR Lesotho will continue to support national strategic positions (TB/HIV technical advisors and TB strategic information staff) to strengthen TB/HIV management at district and site levels, train and mentor healthcare workers, and support data quality improvement for TB indicators.

4.3.2 HIV Case Finding Approaches

The goal of the PEPFAR Lesotho program is to reach epidemic control by 2020 among men and women of all age groups. The PEPFAR Lesotho HTS program's main role therefore is to ensure sufficient case identification and strong linkages to ART to meet the treatment targets in the PEPFAR supported sites for all sex and age disaggregation. HTS targets are back calculated to achieve a national ART coverage of 90% and 95/95/95 across all sex and age bands to achieve epidemic control at the national level. These HTS targets were derived using the unmet ART need data by age and sex and taking into consideration the positivity rates by age/sex/modality of testing.

In FY20, the PEPFAR Lesotho program will provide HTS to 328,270 adults and children to identify 25,567 new PLHIV and link 95% to care and treatment services; resulting in an aggregate positivity

rate of 8%. The yield for adults will be 10% while the yield for children will be 1-1.5%. Sixty nine percent (69%) of HIV cases will come from facility-based testing (PITC) and thirty one percent (31%) will be generated through community testing program (CBHTS). CBHTS will identify 7,896 PLHIV in the 5 lowland districts through various testing approaches; 67% of these cases will be generated through index testing with an average adult yield of 20%. Facility-based testing will identify 17,671 HIV cases, with 34% of the cases through index testing. Overall, community (5,290) and facility-based (5,987) index testing will contribute to 44% of all newly identified HIV cases. Recency testing will be rolled out nationally and integrated within testing modalities to inform targeting and hotspots mapping for new HIV infections. Real-time epidemiological data analysis for recent infection results, index testing, and partner notification services can identify clusters of recent infection to be prioritized for targeted prevention interventions.

Particular focus will be placed on men and adolescents in COP19 as informed by the treatment coverage gap in these groups. In COP19, the program will identify 10,094 men living with HIV, including 476 male children under the age of 15 nationally. Of the total case identification among adult men, 44% of the cases will come from index testing with an average adult yield of 20% with a 52%/48% community and facility index spilt respectively. While "other PITC" remains the second biggest contributing modality after indexing at 35%, TB and mobile testing will continue to identify a significant number of male HIV cases, contributing to 9% and 11% respectively in COP19. HIVST will continue to be integrated within all testing approaches, especially for men. Targeted community distribution and risk and demand-based distribution at facility level will be intensified to reach men. A total of 100,823 HIVST kits will be distributed in both facility (40%) and community (60%) among the male adult population. Data driven hotspots mapping and targeted mobile testing will continue to be used to reach high-risk men with HTS. Strict adherence to the national testing protocol and screening tools will minimize unnecessary testing. PEPFAR Lesotho will also engage faith based organizations (FBOs) as sub-recipients of our main HTS partner/s to find individuals who do not routinely interact with the healthcare system, such as boys and men. Our HTS partner will provide leadership, capacity building, and support to local, faith-based sub-partners in case identification, linkage, and retention of these vulnerable and priority populations.

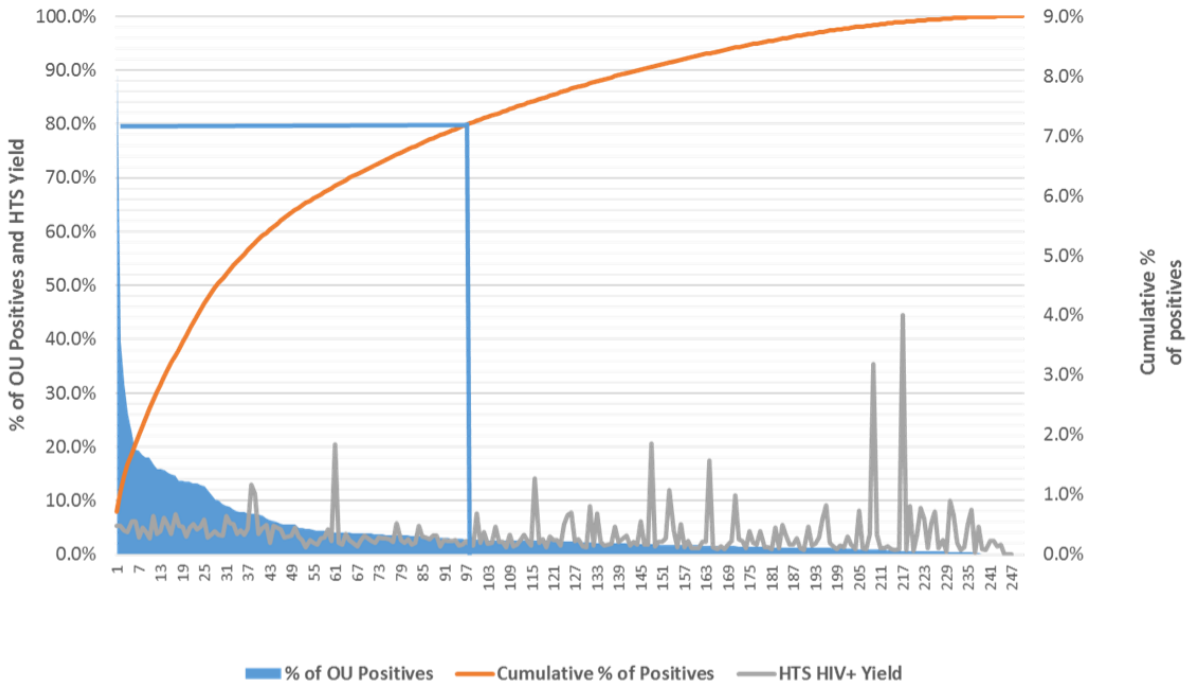
Young women and adolescents remain a priority for the program in reaching epidemic control. LePHIA showed higher incidence among women aged 15-24 at 1.49% compared to their male counterparts at 0.78%. Additionally, program data also reveals the highest unmet need for ART among the same age group at 53%. While the lowland districts have the highest unmet need among adolescents and young men, the highlands districts have comparatively low treatment coverage across most age/sex bands. In COP19, the program will identify 15,472 women, including 478 female children under 15 years of age. While facility-based testing will still be used to reach 32% of females through risk-based testing in PITC and adolescent corners, index testing and partner notification will be the main testing strategy for identifying 44% of young women and adolescents living with HIV and linking them to treatment. The remaining 24% will be identified through mobile, ANC and TB entry points collectively. Although the DREAMS initiative is another platform for reaching AGYW, the focus of this initiative is prevention and not case identification. However, the program

will ensure HIV cases identified through DREAMS are rapidly linked to treatment services, and the eligible negative cases to PrEP and other prevention services.

PEPFAR Lesotho will optimize facility-based testing through various strategies such as risk-based testing, use of screening tools to prevent unnecessary repeat testing, and use of HIVST for low-risk individuals. Testing volumes by site will be monitored on a weekly basis to ensure an increase in the positivity yield. All HTS partners at facility and community levels will continue to report on index testing on a weekly basis to monitor trends and ensure scale and fidelity with this testing strategy. Program monitoring will be strengthened at site level to identify performance issues, target interventions to poor performing sites, and use best practices from the highest performing sites across the program.

The graph below shows that as of APR18, 80% of Lesotho's HIV cases came from 40% (98 of 246) of the sites. However, looking at the graph, the majority of those sites fall well below the 5% yield mark, indicating high levels of testing. Using routine site-level yield analysis, the aim of the program is to ensure all sites improve on case finding and reduce the overall volume of testing.

Figure 4.3.1 : **Site level Yield, % of OU Positives & Cumulative % of Positives at APR18**



In FY20, the PEPFAR Lesotho program will therefore scale with fidelity the following case identification strategies:

- Scale up index testing and partner notification services prioritizing new index clients to ensure an adult positivity of at least 20%
- Scale up recency testing and integrate with the index modality to target recent infections and hotspots
- Intensify and monitor the use of screening tools and re-testing protocols to decrease unnecessary testing at all venues
- Integrate HIVST in all testing modalities and use it as a screening approach for low-risk groups such as in VMMC and routine repeat testers, such as clients receiving PrEP and pregnant and breastfeeding mothers
- Use site-level data to monitor yield and testing volumes by modality
- Continue weekly reporting on case identification by site and hold monthly progress meetings with implementing partners
- Strengthen community education and mobilization for HIVST and U=U messaging to increase acceptability for index testing and partner notification
- Strengthen linkages to treatment through the community ART initiative, linkage coordinators, and transport support
- Engage local FBOs to reach and identify priority populations such as men and children living with HIV; link and support their retention in care.

4.3.3 Recency Assays to Control the Epidemic

In COP18, Lesotho is integrating recent infection testing into routine HIV services to detect, characterize, monitor, and intervene on recent infections among newly diagnosed PLHIV. This began in COP18 in a phased approach with 24 sites under the Motebang hospital catchment area. COP19 will focus on the national rollout of the recent infection surveillance system. The results of recent infection testing will be used to monitor trends and identify locations within Lesotho and subpopulations associated with ongoing transmission to inform targeted prevention interventions. Recent infection surveillance data will also be utilized to develop a Lesotho specific public health response. Following a confirmed recent infection test, patients will be immediately linked to treatment and prioritized for index and partner notification services. Indexed HIV-positive sexual partners will be immediately linked to treatment and HIV-negative sexual partners offered PrEP services. Real-time epidemiological data analysis for recent infection results, index testing, and partner notification services can identify clusters of recent infection to be prioritized for targeted prevention interventions. COP19 prioritized activities will include: (1) transitioning from phased to full-scale national implementation of recent infection testing; (2) coordinating mechanisms and establishing policy and guidelines for recent infection testing for all newly diagnosed PLHIV in COP19; (3) integrating recency testing services into the national HTS algorithm; (4) procuring recent infection test kits; (5) training HTS counselors, laboratory staff, and other related staff on recent infection surveillance; and (6) developing and implementing national recent infection data analysis and reporting with full integration of recent infection data into the national health information systems. Recent infection surveillance implementation is a collaborative effort including PEPFAR testing partners, MOH, and CDC. The CDC centrally-funded mechanism Tracking with Recency Assays to Control the Epidemic (TRACE) will provide technical assistance for continuous quality improvement to ensure the quality of recency surveillance data, support the national policy and guidance development, provide training of trainers, develop dashboards for real-time review, and develop recency cluster strategies and other activities identified by the country team.

4.4 Commodities

By end of FY20, PEPFAR Lesotho is expected to achieve saturation in all the 10 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 2019 PEPFAR Lesotho Commodities Budget

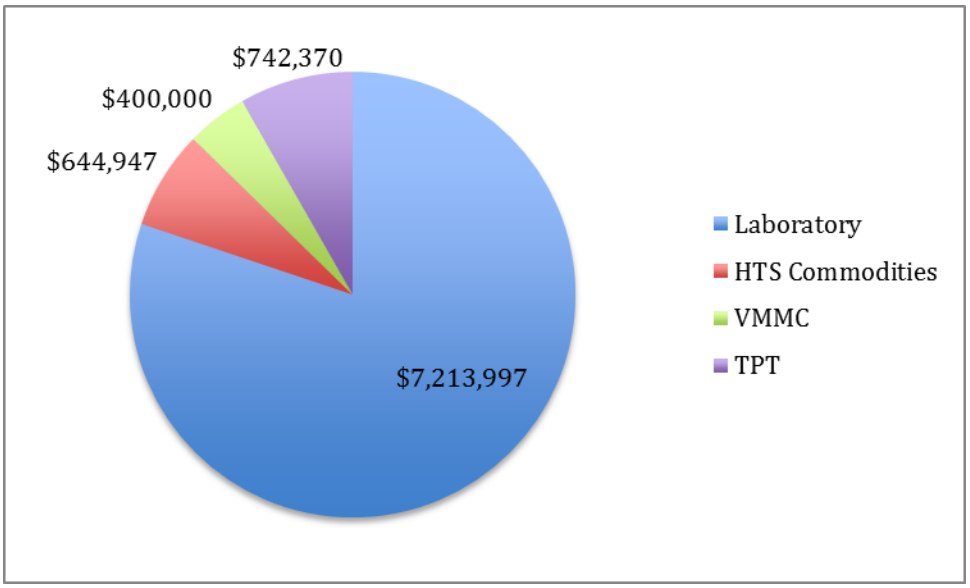


Figure 4.1.1 shows the COP 2019 commodities budget that PEPFAR has committed towards the HIV response in Lesotho. In FY20, PEPFAR Lesotho will spend $9,001,314 to support procurement of laboratory commodities, VMMC kits, HTS commodities and TPT commodities. PEPFAR has allocated sufficient funds for laboratory commodities to cover 75% of VL monitoring, EID, and TB diagnosis needs in the 10 districts. ARVs and rapid diagnostic test kits (RTKs) will be funded by GF and MOH. GF will also support 25% of the laboratory commodities requirements to cover all sites in the 10 districts of Lesotho.

To address continued stock outs of laboratory reagents and consumables, PEPFAR Lesotho in FY18 (and continuing in FY19) has collaborated with the MOH, GF, Roche, Cepheid and other development partners to develop a strategy and plan to ensure commodity security. In addition to the revision of the current equipment and reagent lease contracts to include key performance indicators (KPIs), PEPFAR will support the MOH to complete regular and budgeted commodity supply plans, which will then be shared with Roche and Cepheid ahead of planned procurement timetables. PEPFAR in COP 2019 will transition most of its DSD support to the district logistics officers (DLOs) who will then provide direct supportive supervision to sites who have challenges managing their inventory control systems for HIV tracer commodities and challenges reporting through the Informed PUSH. The Informed PUSH is a supply chain management report and requisition (R&R) tool integrated within the DHIS II, where site level staff input information such as stock-on-hand and dispensed-to-user data. The Informed PUSH was developed to assist frontline staff manage their inventory control system for HIV tracer commodities, saving time on commodity calculations. In order to ensure that this support happens, PEPFAR has reduced their program management costs from 68% as reported in the 2018 Expenditure Report to 23%. We are moving the majority of the investment to site-level support, which has increased from 11% to 59%. The Global Health Supply Chain Management (GHSC) program will continue to provide central-level,

direct management support to the NDSO and the SCMD for HIV commodity forecasting; procurement and supply planning; distribution; and inventory management and control systems.

PEPFAR Lesotho will continue to coordinate with GF and MOH to ensure that there is an adequate budget and commodity stocks in order to attain 95-95-95 across all the 10 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 forecasting and quantification tools (Pipeline and QuantiMed) to complete the needed analysis to fill in supply plans for all HIV and AIDS tracer commodities.

Supply chain data visibility, especially consumption information from the service delivery sites through the Informed PUSH, continues to be under-utilized by frontline staff to make supply chain informed decisions. In COP 2019, the GHSC program is expected to continue monitoring the effective use of the informed PUSH. The DLOs will be expected to provide supportive supervision visits to all sites lagging behind. This is even more important as Lesotho transitions to TLD because every site will be expected to provide monthly updates on patient data and ARV consumption to inform the progress towards treatment optimization for pediatrics, adolescents, and adults.

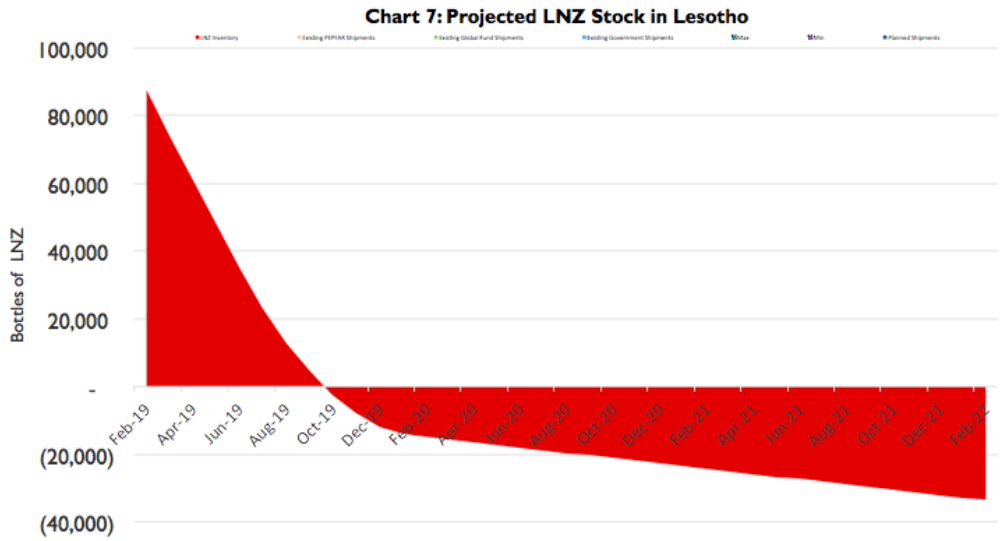
In anticipation of stock outs, PEPFAR will allocate buffer-stock funds for test kits (RTKs and HIVST) as a stop-gap measure. Through the CDC cooperative agreement, resources have been allocated to the MOH to procure laboratory reagents and supplies for VL, EID, and TB diagnosis for all the 10 districts in Lesotho. PEPFAR has also budgeted for recency testing and VMMC commodities.

4.4. 1 TLD Transition

Optimizing antiretroviral regimens can increase access to treatment and improve treatment outcomes through impact on treatment adherence, viral suppression, and quality of life of PLHIV. This can significantly affect the speed at which 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. In addition, the fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is currently priced as the least expensive FDC.

The MOH has shown commitment and political will to transition the majority of PLHIV in Lesotho from nevirapine and TLE regimens to TLD. Beginning November 2018, the MOH has led the revision of the ART treatment and prevention guidelines, in line with the WHO recommendations, and revised the adult first-line treatment regimen from TLE to TLD. In addition, the MOH has also revised the regimens for pediatrics to include lopinavir/ritonavir pellets/granules (LPV/r) for children <20 kg, DTG50 for children >20kg, and TLD for children >35 kg.

In order to ensure that the ARV Optimization and TLD transition occurs, the MOH has committed to phase-out both pediatric and adult nevirapine regimens by June 2019 and October 2019, respectively. Both GF and MOH have provided resources to fund ARV supply plans that align with the new optimized regimens for pediatrics, adolescents, and adults in their FY 2019 to 2020 budgets.



The most significant change in the national TLD transition rollout plan is that the MOH has been inclusive and has collaboratively involved all stakeholders in developing and pledging support for the full implementation of the TLD transition strategy and rollout plan. PEPFAR Lesotho and implementing partners have committed to participate in the TLD transition task team that will meet monthly to assess the site-level implementation and progress on a monthly basis.

Based on the availability of commodities, the national rollout of TLD scheduled for July 2019 will prioritize the following patients: 1) newly diagnosed HIV-positive patients; 2) patients with a current suppressed VL; 3) patients on a nevirapine-based ART regimen; 4) TB-HIV co-infected patients. Women of child bearing potential and pregnant women will be transitioned to TLD based on informed consent and following the WHO guidelines. Those that turn down TLD will be offered TLE 400 as an alternate.

The revised Lesotho National ART guidelines now recommend TLD as the preferred first-line regimen and TLE 400 as the alternative. The guidelines will be printed by May 2019 and fully disseminated to all service delivery sites by June 2019. The TLD Transition rollout plan will be completed within 8 months, from July 2019 to March 2020. The following activities remain to be implemented based on the approved TLD transition strategy and rollout plan: 1) sensitization of patients, communities, and health care workers of eventual TLD rollout; 2) training of health care workers and production of job aids before rollout; 3) site monitoring of the TLD transition implementation in accordance with the job aids and; 4) monthly patient and commodity consumption information starting in July 2019.

4.5 Collaboration, Integration and Monitoring

In the past few 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 key 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 Ambassador and Minister of Health also hold bi-annual health summits to discuss high-level issues that need the highest level of engagement and decision making. These summits have helped solidify the Ambassador's role as the leader of "Team PEPFAR" in Lesotho.

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 building, with agency staff intermingled throughout the office.

Four key health systems barriers standout as the critical enablers for the Lesotho HIV clinical cascade and Lesotho's quest to reach 95/95/95. These include HRH, supply chain management, laboratory systems, and availability of strategic information for decision-making.

The first key health system barrier for Lesotho is HRH. The Lesotho PEPFAR HIV response currently invests approximately 21% of the annual COP funds towards direct HRH service delivery

across the clinical cascade. The recruitment of staff to support partner interventions is critical to the success of PEPFAR programs in Lesotho.

The significant PEPFAR HRH investments were driven by the need to scale-up rapidly to meet the 95/95/95 goals. The MOH HRH establishment at the time could not meet gaps in the HIV clinical cascade. PEPFAR partners conducted HRH assessment based on the care and treatment targets to specifically determine what number and skills mix would be required to meet targets and address critical gaps like linkage, retention, and reporting needs for both MOH and donors. Each site's HRH skills mix was tailored to the identified gaps. The PEPFAR implementing partners continue to assess sites to ensure adequate supply and appropriate skills mix to deliver PEPFAR supported services mainly at high volume sites (>1,000 ART patients). All PEPFAR supported positions have been aligned to the MOH establishment list and a comparison of compensation packages done. The next step is to work with the MOH to develop and implement a human resource transition process.

To improve performance and ensure quality of services, PEPFAR supports in-service trainings for all facility staff and community staff to cover capacity gaps, ongoing clinical mentorship, and development of training and supervision tools that can be sustained locally. PEPFAR Lesotho implements a number of unique models to improve quality services: corners focused on addressing specific adolescent HIV treatment issues, men's clinics to address critical gaps in the male friendly service package, and differentiated service delivery for advanced disease. Lesotho utilizes CAGS and MMD as alternative service delivery models to improve quality and service delivery across community and facility sites. These are examples of improving efficiencies and quality by ensuring immediate linkage to ART and addressing hard to reach populations like men and migrant populations.

The scale-up of differentiated models like CAGS, multi month dispensing, and community ART delivery through outreaches and the planned MOH health posts will improve efficiencies at facilities by reducing work loads and require reduced facility staff needs as more patients transition to six month ART deliveries.

Recently, the PEPFAR program recruited HRH2030 to assess the HRH inventory for both PEPFAR and GF with an objective of designing a human resources transition plan aligned to the MOH staff establishment list. PEPFAR and GF are currently working with the MOH to develop an HRH transition plan that would ensure that critical services across the clinical cascade do not suffer as a result of the transition of facility and community services to the host government and local partners.

The second and third key health system barriers for Lesotho are supply chain management and laboratory systems. In Lesotho, these two issues are closely linked. PEPFAR Lesotho utilized short-term technical assistance (STTA) to assist with developing a strategy and rollout plan to improve laboratory systems integration and performance. The activity included the two main suppliers of laboratory reagents and supplies in Lesotho: Roche and Cepheid. This activity also included three PEPFAR partners: the GHSC, the MOH, and University Research Co (URC). In Lesotho, PEPFAR

funds 75% of the laboratory commodities requirements and GF funds the remaining 25%, so the GF was also included as a key partner in the activity. The key deliverables from the STTA include: (i) revision of current laboratory contracts for Roche and Cepheid to include key performance indicators; (ii) recommendation to the Supply Chain Management Directorate to share laboratory commodities supply plans with suppliers to enhance data visibility and procurement planning; (iii) recommendation for clinical, supply chain and laboratory partners coordination meetings to enhance information sharing and VL coverage implementation in all PEPFAR sites; (iv) expand VL results e-reporting to all PEPFAR sites; and (v) improve VL and other laboratory results turn-around time by using efficient sample and results transportation methods.

In COP19, PEPFAR support to the MOH supply chain involves two main interventions: placing human resources in the SCMD, NDSO and DHMTs; and systems strengthening support to build processes and procedures that will ensure commodity security. These interventions are expected to result in 100% availability of all HIV tracer commodities and zero stock-outs across the clinical cascade. The implementation strategy for the ARV Optimization and TLD transition plan stipulates that all programs that require HIV commodities meet monthly to ensure that both patients and commodities are monitored to avoid any disruption to services. The task team will ensure that suppliers are provided with all HIV tracer commodities as soon as they are funded and approved by the MOH. In COP19, PEPFAR Lesotho will continue collaboration and support supervision of site level reporting of commodity consumption data, which would inform national commodity orders/ procurements to ensure commodity availability for all HIV tracer commodities.

PEPFAR Lesotho will support TB/HIV diagnostic integration within the tiered laboratory network and ensure patients access to appropriate testing services. This support includes VL optimization, specimen transport system, integrated platform utilization, and timely delivery of quality results to improve patient care. To increase competency of health care workers, site-level training and supportive supervision will continue. In addition, PEPFAR will continue supporting salaries for health care providers across the cascade that have major impacts in achieving 95/95/95. PEPFAR will continue implementing a quality management program that includes quality assurance (QA) and quality improvement (QI) activities through SIMS, routine data collection and analysis, monitoring partner's performance using key indicators.

The final key health system barrier for Lesotho is the availability of strategic information for decision-making. Lesotho, with PEPFAR-funded technical assistance, developed a client-level e-register in 2018. The e-register was developed to capture client level information and to identify and track individuals across the 95-95-95 HIV care cascade. Two modules have been implemented during COP17 and COP18, the care and treatment module and the testing module.

During COP18, e-register expanded to 45 public facilities. During COP18, an Open Health Information Exchange has been developed and implemented. This platform has the Open Shared Record allowing the e-register to uniquely identify and track individuals throughout Lesotho. In

COP19, the e-register, with its unique ID system, will scale up to comprehensive national coverage of 172 public facilities.

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 FY20) HTS_TST	Newly Identified Positive (APR FY20) HTS_TST_POS	Newly Initiated on ART (APR FY 20) TX_NEW
Total Men	**127,513**	**10,094**	**10,447**
Total Women	**200,757**	**15,472**	**15,457**
Total Children (<15)	**70,301**	**954**	**1,034**
Total from Index Testing	**75,480**	**11,261**	**11,854**
Adults			
TB Patients	**6,016**	**2,002**	**2,002**
Pregnant Women	**33,862**	**1,208**	**1,153**
VMMC clients	**12,213**	**67**	**62**
Key populations	**1,711**	**171**	**163**
Priority Populations	**6,200**	**248**	**236**
Other Testing	**268,268**	**21,870**	**22,289**
Previously diagnosed and/or in care		**788**	**749**
Pediatrics (<15)			
HIV Exposed Infants	**8,352**	**117**	**117**
Other pediatric testing	**61,949**	**837**	**917**
Previously diagnosed and/or in care		**2**	**2**

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

SNU	Target Populations	Population Size Estimate (SNUs)	Current Coverage (FY18)	*VMMC_CIRC* (in FY20)	Expected Coverage (in FY20)
Berea	10-29yrs	53,045	54%	5,130	80%
Leribe	10-29yrs	68,419	51%	5,700	68%
Mafeteng	10-29yrs	35,841	45%	3,135	68%
Maseru	10-50yrs	110,179	67%	13,829	93%
Mohale's Hoek	10-29yrs	32,446	35%	2,280	47%
	Total/Average	**299,930**	**55%**	**30,074**	**77%**

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY20)	FY20 Target
AGYW	**93,279**	**60%**	**55,967**
KP_PREV	**10,361**	**66%**	**6,844**
PP_PREV	**1,217,123**	**11%**	**130,535**
TOTAL	**1,227,484**	**11%**	**137,379**

Table 4.6.4 Targets for OVC and Linkages to HIV Services			
SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY20Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC
Berea	25,504	14,015	11,969
Butha Buthe	10,940	2,885	2,736
Leribe	33,418	16,341	13,974
Mafeteng	20,741	9,058	7,752
Maseru	47,860	21,662	18,406
Mohale's Hoek	20,556	6,929	5,923
Mokhotlong	12,311	3,311	3,151
Qacha's Nek	8,889	2,390	2,274
Quthing	14,608	3,972	3,786
Thaba Tseka	15,885	4,247	4,035
TOTAL	210,712	84,810	74,006

4.7 Cervical Cancer Program Plans

Cervical cancer is a major public health issue in Lesotho, which ranks 8th in the top 20 global high burden countries. Cervical cancer is the most frequent cancer among women aged 15-44 years and is a leading cause of death among women in Lesotho. The age-standardized incidence rate was 52.1 per 100,000 in 2018. Every year 477 women are diagnosed with cervical cancer and 346 die from the disease. Lesotho has significant programmatic gaps in the uptake of cervical cancer services with only 47% of women aged 15-49 years having heard of cervical cancer screening and only 4% have had a screening test in the past 12 months.[20] WLHIV have a four-five times higher risk of developing cervical cancer compared to HIV negative women.

[20] LDHS, 2014

The PEPFAR Lesotho goal is to scale up services for secondary prevention of cervical cancer as a strategy to reduce morbidity and mortality among WLHIV aged 25-49 years of age. This initiative builds on existing health systems to increase access to cervical cancer screening services, treatment of pre-cancerous lesions, and timely referral of women who screen positive for invasive cancer to the national referral hospital or to South Africa.

In order to attain this goal, the PEPFAR Lesotho program is providing technical support to the MOH to update national cervical cancer clinical guidelines, job aides, training manuals, and monitoring and evaluation (M&E) tools. Capacity building to improve the knowledge and skills of national, district, and site-level staff is being offered through on-site trainings, clinical attachments to the Senkatana cervical cancer center of excellence, and on-going mentorship to ensure quality service delivery. Site-level implementation in COP18 entails a phased approach at 35 high volume sites that will offer "screen and treat" services to 37,000 WLHIV aged 25-49 years. Eligible WLHIV are screened within the ART and MNCH clinics using visual inspection with Acetic Acid (VIA), and treatment for precancerous lesions is offered mainly through the use of thermal coagulation and LEEP. During COP18, the PEPFAR Lesotho program will establish three additional LEEP centers, making a total of four LEEP centers in the country. Screen and treat services will be enhanced through procurement of equipment and supplies, building on existing national stocks for cryotherapy that are provided by the MOH.

During COP19, the PEPFAR Lesotho program will build on these gains to expand cervical cancer screening services to 46,048 (50.7%) WLHIV aged 25-49 years who are currently on treatment as of FY19 Q1. Geographic expansion will be in sites that account for at least 70% of the WLHIV aged 25-49 years who are on treatment. Based on the FY19 Q1 current on treatment results, a total of 69 sites will be providing "screen and treat" services, which includes 35 COP18 sites and 34 new sites. PEPFAR Lesotho will continue to strengthen the national policy framework to ensure alignment to WHO and PEPFAR guidelines for cervical cancer, build the capacity of district and site-level service providers, institutionalize quality improvement and quality assurance as a core service package, and support histopathology examination of LEEP specimens. In addition to the VIA, PEPFAR Lesotho will support the use of the human papillomavirus (HPV) test so as to increase the volume of women screened at ART and MNCH clinics. The PEPFAR Lesotho program will continue to leverage GOL resources to improve treatment uptake by using cryotherapy procured through the MOH.

The implementation mechanism (IM)-level funds allocation within the COP19 budget have been fully aligned to the Lesotho planning level letter total of $2,393,040, (which includes both COP base and central initiative funds) and agency-specific allocations have retained the COP18 allocation of 40% for CDC and 60% for USAID. A total of three different mechanisms will implement the cervical cancer program. The CDC EGPAF/STAR-L interventions will be implemented in the districts of Berea, Leribe, Qacha's Nek and Quthing with a budget of $957,216 to reach 16,822 eligible WLHIV. USAID will have two awards: 1) EGPAF/PUSH project that will provide services in the districts of Mafeteng, Maseru, Mohale's Hoek, and Thaba-Tseka with a funding allocation of $1,249,167 to screen 25,286 eligible WLHIV and; 2) TBD/Expanding HIV Clinical Services activity that will be

implemented in Butha Buthe and Mokhotlong districts with a funding allocation of $186,657 to screen 3,940 eligible WLHIV.

Site, district, and partner-level performance reviews will be conducted through monthly progress reviews, site-level visits for programmatic monitoring, and SIMS visits.

4.8 Viral Load and Early Infant Diagnosis Optimization

In COP19, the objective is to provide timely and quality-assured TB/HIV diagnosis and patient monitoring services that will contribute to achieving epidemic control and attaining 95-95-95 targets. PEPFAR will support implementation of integrated laboratory services to improve quality, efficiency, and cost-effectiveness. The support will include, but not be limited to, specimen transport, referral testing, results delivery, supply chain, and information systems. The technical support will focus on optimization and integration of both conventional (laboratory-based) and point-of-care (POC) instruments to scale up VL, EID, and TB testing, and ensure demand is met. In partnership with MOH and implementing partners, development of guidance and specific requirements including staff training, biosafety, equipment placement, and maintenance service contracts will be supported.

For VL, EID, and MTB/RIF testing, Lesotho is using three different instruments: Roche (conventional), PIMA (POC), and GeneXpert (Near POC). Currently, a total of 7 Roche instruments for VL/EID, 16 PIMA and 13 GeneXpert (GX-IV) for POC EID, and 37 GeneXpert (35 GX-IV and 2 GX-VIII) for MTB/RIF tests are deployed. The current POC instruments rolled out separately for EID and GeneXpert MTB/RIF will further be integrated across the program and support for multipurpose testing services. Mapping of instruments with capacity and utilization was completed. Specimen transport and laboratory network optimization will be operationalized in COP19. Overall, there is sufficient instrument capacity for EID and TB testing. If optimized, the unmet need will be addressed with no additional placement of instruments. The provision of integrated VL, EID and TB testing services will allow the laboratory and clinicians to use comprehensive information for informed decision making and effective patient care.

1) Scaling up of Viral Load (VL) monitoring services to attain 100% coverage.

By the end of FY19, VL monitoring is expected to cover 90% of eligible PHLIV on ART while in COP19, the coverage will increase to 100%. The strategies to achieve the targets include optimization of platforms, specimen transport, further decentralization of testing services, timely result reporting, and routine monitoring of performance.

To increase the capacity of testing outputs by 20%, the low throughput Roche instruments from three VL laboratories will be replaced with high throughput instruments. The current terms of instrument/reagent rental agreement will be revised to monitor performance of the service provider. To increase coverage to additional geographic areas, VL testing services will be established in Mohale's Hoek and Thaba-Tseka district hospital laboratories. DBS VL will also be scaled up to improve access to hard-to-reach areas where whole blood specimen collection and transport

services are challenging. The laboratories will optimize the use of LIS to improve data flow between laboratories and health facilities and strengthen the VL dashboard to support data analysis and visualization at the national level. SMS notification of patient and web-based result transmission (e-reporting) using LIS and DHIS2 will be scaled to 90% of health facilities. This will substantially reduce turnaround time and improve VL management and enhance adherence and counseling of ART patients whose VL are not suppressed.

Access to VL testing and prompt action for unsuppressed VL among pregnant and breastfeeding women (PBFW) is important to prevent mother-to-child transmission of HIV. POC VL testing will be rolled out using GeneXpert instruments where conventional testing services are not accessible and time-sensitive monitoring cannot be provided to PBFW.

In the coming six months, PEPFAR will work on developing guidance, protocols, and specific requirements including staff training, laboratory validation and biosafety. In addition, POC VL will be piloted in selected sites using the existing POC EID platform (i.e., GeneXpert (GX-IV) instrument). In COP19, all GeneXpert instruments that support EID will be used for VL testing among PBFW. Through specimen transport and optimization, VL testing will be integrated with GeneXpert TB/RIF testing service as appropriate. With this approach, PBFW will have access to POC VL testing while others will continue accessing conventional VL testing services.

Lesotho has completed instrument mapping and already started laboratory network optimization exercises. With the completion of VL/EID optimization and continued monitoring, Lesotho is expected to achieve 100% VL testing coverage of eligible PLHIV on ART. For VL reagents that include instrument rental and consumables, PEPFAR Lesotho has budgeted US$5,985,101, which is expected to cover 75% of the national need. The remaining cost is anticipated to be covered by GF. In addition, about $500,000 USD has been allocated to cover specimen transport services, ancillary equipment, salaries of laboratory personnel, training, and technical assistance support.

2) Optimization of Point of Care Early Infant Diagnosis (POC EID) to ensure 95% of HIV exposed infants under two months old are virologically tested.

In the past two years Lesotho has made considerable progress in increasing access to virologic testing of HIV exposed infants, reducing turnaround time, and improving the quality of services. Through UNITAID support, EGPAF in partnership with MOH rolled out POC instruments in 29 health facilities. PEPFAR supported specimen transport, care and support, and QA/QI activities. Using a hub and spoke approach, 171 health facilities are accessing POC EID services. The overall turnaround time has been reduced to less than 5 days. POC testing covered 80% while conventional testing covered 20% of the national need. The implementation of POC EID has substantially improved coverage in which 93% of HIV exposed infants were virologically tested by 2 months of age.

Since the UNITAID-supported initiative will be closed out by June 2019, the necessary preparation has been worked out by MOH in coordination with EGPAF, PEPFAR and GF to ensure smooth transition and sustainability of POC EID. A close-out committee has been established to ensure

activities are carried out smoothly. In mid-February 2019, PEPFAR organized a stakeholders meeting and reviewed the transition plan and mapped out resources for commodities, personnel, and technical assistance support.

All 29 POC EID sites are HIV care and treatment service delivery sites that are supported by PEPFAR's implementing partner, EGPAF. In COP19, 90% and 10% EID testing will be provided using POC and conventional instruments, respectively. With DSD, PEPFAR will achieve 95% of HIV exposed infants under 2 months to be virologically tested and linked to care. Technical support such as HRH, supervision, and monitoring and evaluation activities will continue as part of pediatric care and treatment services. The support also includes specimen transport, referral testing, result reporting, QA/QI and monitoring activities. PEPFAR Lesotho has allocated US$485,883 for procurement and distribution of POC EID commodities, which will cover 75% of the national need. The remaining gap is expected to be covered by GF. In COP19, there will be no additional cost associated with POC instrument maintenance services and replacement since their warranties have already been covered for an additional two years.

3) Optimization of GeneXpert MTB/RIF testing services to improve coverage to 95% and use for multi-testing purposes.

Lesotho is using GeneXpert technology for diagnosis of presumptive TB cases. In addition to 35 GeneXpert instruments mentioned above, 13 GeneXpert (GX-IV) instruments will be installed in the new mini labs at 13 health centers before end of FY19. Overall, there is enough instrument capacity for MTB/RIF testing. In COP19, GeneXpert utilization will be optimized and 95% of presumptive TB cases will be tested. As part of integration and optimization of services, the GeneXpert instruments will be used for multipurpose testing services (i.e., POC VL and POC EID testing services). PEPFAR will support the development of guidance, protocols, biosafety, and specific requirements including HRH, placement of GeneXpert instrumentation, and maintenance services.

As part of integrated laboratory support, PEPFAR will continue to procure TB lab commodities. In COP19, PEPFAR Lesotho budgeted US$637,100 for TB/GeneXpert supplies, which is expected to cover 75% of the national testing demand. GF will cover the remaining gap, including GeneXpert instrument service maintenance contracts and HR.

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

PEPFAR Lesotho does not have any attained or sustained locations or populations in COP19.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Key systems barriers identified through SID 3.0, MER, and SIMS include: 1) weak supply chain management systems at all levels of the public health care supply chain system; 2) limited capacity in expansion of diagnostic and monitoring services and improvement in laboratory systems and; 3) poor data quality to track 95-95-95 achievements for sustained epidemic control.

In COP19, the areas identified for above-site systems strengthening in order to achieve sustained epidemic control include:

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

Investments in these areas will address current programmatic gaps in health systems strengthening (HSS), which are crucial to achieving national 95-95-95 targets and epidemic control by the end of COP19. PEPFAR Lesotho will: 1) strengthen the supply chain management system in order to prevent stock-outs of HIV-related commodities, such as isoniazid for TPT and VL reagents and consumables; 2) strengthen laboratory systems to support all clinical services along the HIV treatment cascade; and 3) strengthen strategic information to ensure timely, complete, and accurate data management to inform programmatic planning.

PEPFAR Lesotho is currently investing in all the areas that it can to sustain epidemic control. Once the systems for laboratory, supply chain, and health information are established and optimized, knowledge and skills transfer through our current implementing partners should enable the host country to assume operations. For full ownership, however, the host country will need to continually invest resources in the maintenance of these systems, including procurement of essential commodities.

Commodity Security and Supply Chain

Challenges with an inefficient and ineffective supply chain management (SCM) system in Lesotho have led to frequent stock-outs of HIV-related commodities, such as isoniazid for TPT and VL reagents and consumables. Underpinning this are inefficient national-level commodity supply chain and procurement systems, including: (1) lack of supply chain data visibility; (2) lengthy and bureaucratic procurement processes for key HIV commodities; (3) non-adherence to inventory control systems, such as maximum/minimum limits; and (4) lack of coordination and communication with suppliers, such as pro-active sharing of funded HIV commodities supply plans in advance.

In COP 19, PEPFAR Lesotho will continue to provide technical support and capacity building to the MOH through the Supply Chain Management Directorate (SCMD) (formerly Supply Chain Coordination Unit), 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. PEPFAR Lesotho will pay special focus and attention to the efficient implementation of TPT commodities procurement and distribution, adult and pediatric ARV optimization (TLD transition), and laboratory commodity availability and optimization.

The following are COP19 core activities:

1) Support the SCMD 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 12 and a minimum of 6 months, especially as the program continues to rapidly scale up. GHSC will also support the MOH to ensure that the transition of current patients from legacy regimens happens efficiently with limited wastage and follow commodity disposal procedures as stipulated by national commodities guidelines. The monthly TLD transitioning team meetings in collaboration with other stakeholders will play a critical role, especially during the active monitoring and replenishment of stock at all sites. The GHSC will provide more resources to the district logistics officers (DLOs) in order that they can provide more cost-effective, supportive supervision to sites in all 10 districts. Building on lessons learned from the FY 2019 engagements with commodity suppliers, the GHSC will support the MOH to proactively share funded supply plans in order to give suppliers advance information on future commodity requirements.
2) Appropriate warehousing and inventory control for HIV and AIDS commodities at national and service delivery points (SDPs). In FY 2018 and 2019, the NDSO warehouse management system (WMS) was strengthened with the implementation of the new bar-coding system. The new WMS and bar-coding systems enhanced the capacity of the NDSO to efficiently manage, procure, distribute, and account for all HIV tracer commodities within their responsibility. The focus for COP 2019 will be to ensure that key commodities, such as all essential ARVs and laboratory commodities, are procured according to the supply plan schedule and available in all sites to ensure non-disruption of HIV services. The GHSC will, for the first time, directly procure TPT (INH or 3HP) and VMMC commodities using the PEPFAR working capital fund. The GHSC and NDSO will be expected to collaborate during the distribution of the PEPFAR-funded commodities. In the case of VMMC commodities, the GHSC will be expected to deliver the commodities directly to PEPFAR sites. In addition, PEPFAR supported pharmacy and logistics staff at the district and facility levels will be expected to provide monthly updates on site-level inventory control systems performance for HIV tracer commodities (especially TPT, ARVs, and laboratory commodities). The GHSC will assist the MOH to develop a tracking tool which will assist in identifying sites that struggle to manage their inventory control systems.

3) Revise the Informed PUSH in DHIS II to include TPT, TLD, DTG and PrEP commodities. PEPFAR Lesotho has been successful in ensuring that all health facilities in Lesotho have a functional Informed PUSH system. The Informed PUSH allows sites to report through an automated requisition and reporting system in the DHIS II system. In COP 2019, the focus will be on revising the data reporting platforms to include HIVST, 3-HP, TLD, DTG and TDF/3TC. In addition, the revisions of the Informed PUSH will also include enhancing the reporting capacity for 90 and 180 days MMD. The GHSC will also support mentorship programs for all the sites having challenges reporting through the new Informed PUSH system. The Informed PUSH will serve as the key HIV commodity consumption information source for laboratory, ARVs, and TPT commodities.
4) Provide in-service training and mentorship for health workers to the revised SCM SOPs for efficient reporting and implementation of the ARVs optimization strategy and plan. PEPFAR will support the MOH to ensure that the ARV optimization strategy is implemented according to the rollout plan. In FY 2019, the GHSC will support the MOH to develop and implement SCM training materials and job aids for frontline health workers. The new SCM tools will be used for recording ARVs consumption data during the rollout of the TLD transition plan. In COP 2019, the GHSC through their DLOs will work with site-level pharmacy staff to ensure that all health workers have the ability to complete the revised commodities daily tally sheets, which will include all the optimal ARVs for adults, adolescents, and pediatrics. In addition, the GHSC and the DLOs will actively participate in providing supportive supervision for sites that have challenges in monitoring and tracking patients using the new tools.

Laboratory Services

There is limited capacity in Lesotho to increase access and improve quality of diagnostic and monitoring services. These include lack of infrastructure, human resources, and a quality management system. Based on the gaps identified, major activities with performance indicators and expected outcomes were described. Key above-site and site level-activities, such as, laboratory network optimization and quality improvement activities that are directly aligned with overall sustainable epidemic control priorities were indicated in Table 6. Laboratory strengthening will improve both coverage and quality of testing services, which will contribute to achieving 95-95-95 targets.

The purpose of the laboratory system strengthening is to ensure accurate, reliable and timely TB/HIV diagnostic and patient monitoring services are provided and sustained. The strategies include: 1) strengthening of tiered laboratory networks to improve testing coverage for VL, EID, HIV/TB diagnosis, and patient monitoring, 2) instrument mapping and laboratory network optimization to increase efficiency and effectiveness, 4) improving quality of laboratory services through continuous quality improvement activities, and 5) improving laboratory information and M&E system for timely analysis, reporting, and decision making.

1) Optimization of national tiered laboratory networks. In COP19, PEPFAR Lesotho will strengthen the tiered national laboratory network, including optimization and integration of instrument utilization to improve testing coverage for HIV/TB diagnosis and patient monitoring services. The country has completed mapping of instruments and started laboratory network optimization exercises. With the completion of VL/EID optimization and continued monitoring, the COP19 testing coverage of 100% will be achieved.
2) Continuous Quality Improvement (CQI) and Proficiency Testing (PT) program. Improving the quality of laboratory and point of care testing (POCT) services will ensure effective delivery of services. PEPFAR Lesotho will provide laboratory technical support to above-site (reference laboratories) and site-level (18 clinical laboratories and POCT sites that support HIV/TB care and treatment services) laboratories. The support includes, but is not limited to, implementation of quality management system, human resource, above-site and site-level training, site supervision, biosafety, equipment maintenance, and inventory management system.

   As part of CQI, the 12 elements of a quality system will be used as a working framework. Clinical laboratories and POCT sites will be enrolled in the proficiency testing (PT) program. The facilities will be assessed and their 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. The key areas to be reviewed include process control, corrective actions and documentation, and safety and management reviews. By the end of COP19, 3 clinical laboratories will be accredited by the African Society for Laboratory Medicine (ASLM). In addition, 98% of clinical laboratories and POCT sites enrolled in the PT program will successfully pass and have improved performance.

3) Laboratory information systems (LIS) and M&E system. The electronic LIS system will be upgraded to generate quality data and reduce turnaround time of result transmission for prompt management and monitoring of PLHIV on treatment. The laboratories will optimize the use of LIS to improve output, data flow between laboratories and health facilities, and strengthen VL/EID dashboard to support data analysis, visualization at national level, and quarterly reporting of patient and test level data
4) Laboratory equipment maintenance and inventory system. Guidelines and standard operating procedures will be revised for preventive and routine maintenance of major laboratory instruments equipment. An inventory of standardized equipment platforms will be established. Instrument/reagent rental agreements with manufacturers for major laboratory instruments supporting VL, EID, and TB diagnosis will be revised with inclusion of key performance indicators to monitor service providers. These activities will reduce equipment downtime and service interruption to less than 5 days. In

addition, laboratory instruments will be optimized and used for multipurpose testing services to increase efficiency and cost- effectiveness.

Strategic Information

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 implemented at the facility level in 2017. Challenges remain, however, regarding data quality. The national DQA undertaken in COP18 highlighted under-reporting by national health facilities. In COP19, PEPFAR will focus on improving and institutionalizing DQA mechanisms and assessments to improve DHIS2. The alignment of MOH and PEPFAR systems will be a priority in COP19 so that data from DHIS2 can be imported into DATIM. PEPFAR will continue to support DHIS2 at the site, district, and central levels by providing training, equipment, and human resources.

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 LIS functioning at different levels of the health system, and data are not summarized and analyzed on a routine basis. In COP18, technical assistance was provided to the national reference laboratory and district hospital laboratories to link the laboratory LIS to DHIS2 to enhance monitoring on core laboratory indicators, including VL, EID, and TB test data. Links to the national DHIS2 system were developed to ensure indicators can be monitored by decision-makers for targeted programming. Continued work on optimizing the interoperability of these systems will continue in COP19.

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 was developed using OpenMRS during COP17 with a one time award from PEPFAR. The system was set up in 45 facilities in four districts in Lesotho with the HTS and treatment modules operational. The pilot and initial scale up phase of the e-register system will be completed during COP18 and a national shared health record will be put in place ensuring unique identifiers for all HIV clients.

In COP19, e-registers will be scaled up to an additional 127 facilities bringing the total to 172. This ensures that 90% of all people taking anti-retroviral medication will be registered in the e-register system making case-tracking and surveillance possible. A comprehensive e-register consolidation and expansion plan will lead to the phased implementation of the e-register to all of the 127 sites while monitoring data quality entry and providing technical support for the 45 facilities already implementing e-registers. The data visualization module will be refined and updated to enhance access to high-quality, real-time data for facility-level use to inform clinical decisions. An

automated DHIS2-e-register link will be refined and updated to accommodate changes in disaggregations needed.

LePHIA 2

PEPFAR Lesotho will perform a second survey of the population HIV impact assessment (PHIA) in COP19. The survey will take place over four months in FY20, and will include participants 15-64 years of age. The PHIA will characterize HIV incidence, national and sub-national HIV prevalence, VL suppression, and risk behaviors in a household-based, nationally representative sample of the population of Lesotho. The survey results, from both household and adult participant surveys and blood sample testing (HIV rapid testing, LAg avidity assay testing to detect incident infections, HIV VL, ARV metabolite testing along with genotyping and drug resistance testing on those determined to be recent infections) will give Lesotho an opportunity to calculate progress towards the UNAIDS 90-90-90 cascade since the first survey in 2016. In addition, information will be generated on the coverage and uptake of various HIV prevention, care and treatment programs including PMTCT.

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 shift to local partners, 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 districts.

As of March 2019, PEPFAR Lesotho will have five vacant positions, all local hires or EFMs: two with the Department of State, one with Peace Corps, and two with USAID. For State, the Local Capacity Specialist position was approved in a COP18 OPU. This position is currently being caged and should be advertised in the coming months. 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 Peace Corps, the Health Program Manager position is newly vacant since December 2018. The candidate has accepted and is undergoing clearances. For USAID, the DREAMS Coordinator position was approved in a COP18 OPU. This position is currently advertised and will hopefully be filled soon. The Budget/Finance Specialist position has been caged and should be advertised in the coming month.

In COP19, PEPFAR Lesotho is proposing four new positions: two with CDC and two with USAID. For CDC, the two positions are a Monitoring & Evaluation (M&E) Specialist and a HIV Testing Specialist (HTS). The M&E Specialist position will assist the CDC team is meeting the increasing management demands of strategic information initiatives like the LePHIA and recency testing. The HTS Specialist will provide additional support for the PEPFAR Lesotho team's case finding, index testing and partner notification services program, which currently has one staff position. For USAID, the two positions are a Care and Treatment Specialist and a Program Management Specialist. *[REDACTED]*.

There are no large proposed changes from COP18 management and operation costs.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

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																								
				<01		01-04		05-09		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Berea	COP15	Scale-Up	APR16	47%	47%	47%	47%	43%	43%	31%	31%	36%	52%	35%	30%	45%	31%	60%	43%	73%	57%	81%	70%	85%	77%	87%	83%	53%
	COP16	Scale-Up	APR17	63%	63%	63%	63%	50%	50%	42%	42%	42%	60%	43%	39%	55%	40%	69%	52%	81%	66%	90%	79%	94%	86%	96%	92%	63%
	COP17	Scale-Up	APR18	63%	57%	63%	57%	58%	53%	57%	57%	56%	77%	61%	52%	77%	56%	93%	72%	102%	90%	108%	104%	112%	116%	113%	116%	78%
	COP18	Attained	APR19	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
	COP19	Attained	APR20	109%	109%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	96%
Buthal Buthe	COP15	Scale-Up	APR16	107%	107%	107%	107%	97%	97%	70%	70%	40%	58%	39%	34%	51%	35%	68%	48%	82%	64%	91%	78%	96%	87%	98%	93%	76%
	COP16	Scale-Up	APR17	142%	142%	142%	142%	113%	113%	96%	95%	48%	68%	49%	43%	62%	45%	78%	58%	92%	74%	101%	88%	105%	97%	108%	103%	92%
	COP17	Scale-Up	APR18	142%	129%	142%	129%	131%	119%	129%	130%	64%	87%	69%	59%	87%	63%	105%	81%	115%	102%	122%	117%	126%	130%	127%	130%	110%
	COP18	Attained	APR19	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
	COP19	Attained	APR20	130%	130%	95%	95%	95%	95%	105%	106%	95%	106%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	106%	95%	106%	106%	101%
Leribe	COP15	Scale-Up	APR16	60%	60%	60%	60%	54%	54%	39%	39%	33%	48%	32%	28%	42%	29%	56%	40%	67%	53%	75%	65%	79%	72%	81%	77%	54%
	COP16	Scale-Up	APR17	79%	79%	79%	79%	63%	63%	53%	53%	39%	56%	40%	36%	51%	37%	64%	48%	76%	61%	83%	73%	87%	80%	89%	85%	65%
	COP17	Scale-Up	APR18	79%	72%	79%	72%	73%	66%	72%	72%	52%	71%	57%	49%	72%	52%	86%	67%	95%	84%	100%	97%	104%	107%	105%	107%	79%
	COP18	Attained	APR19	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
	COP19	Attained	APR20	107%	107%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	96%
Mafeteng	COP15	Scale-Up	APR16	51%	51%	51%	51%	46%	46%	33%	33%	32%	46%	31%	27%	41%	28%	54%	38%	65%	51%	73%	62%	76%	69%	78%	74%	50%
	COP16	Scale-Up	APR17	68%	68%	68%	68%	54%	54%	46%	46%	38%	54%	39%	35%	49%	36%	62%	46%	73%	59%	80%	70%	84%	77%	86%	82%	60%
	COP17	Scale-Up	APR18	68%	62%	68%	62%	62%	57%	61%	62%	51%	69%	55%	47%	69%	50%	83%	65%	92%	81%	97%	93%	100%	104%	101%	104%	73%
	COP18	Attained	APR19	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
	COP19	Attained	APR20	117%	117%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	106%	95%	97%
Maseru	COP15	Scale-Up	APR16	45%	45%	45%	45%	41%	41%	30%	29%	32%	47%	31%	27%	41%	28%	54%	39%	66%	52%	73%	63%	77%	70%	79%	75%	49%
	COP16	Scale-Up	APR17	60%	60%	60%	60%	48%	48%	41%	40%	38%	54%	39%	35%	49%	36%	62%	47%	74%	60%	81%	71%	85%	78%	86%	83%	58%
	COP17	Scale-Up	APR18	60%	55%	60%	55%	55%	50%	55%	55%	51%	69%	55%	47%	70%	51%	84%	65%	93%	82%	98%	94%	101%	105%	102%	105%	72%
	COP18	Attained	APR19	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
	COP19	Attained	APR20	108%	108%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	96%
Mohale's Hoek	COP15	Scale-Up	APR16	53%	53%	53%	53%	48%	48%	35%	35%	27%	39%	26%	23%	35%	24%	46%	33%	56%	44%	62%	53%	65%	59%	67%	63%	46%
	COP16	Scale-Up	APR17	71%	71%	71%	71%	56%	56%	47%	47%	32%	46%	33%	29%	42%	30%	53%	40%	62%	50%	68%	60%	71%	66%	73%	70%	55%
	COP17	Scale-Up	APR18	71%	64%	71%	64%	65%	59%	64%	65%	43%	59%	47%	40%	59%	43%	71%	55%	78%	69%	83%	79%	86%	88%	86%	88%	66%
	COP18	Attained	APR19	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
	COP19	Attained	APR20	130%	125%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	98%
Mokhotlong	COP15	Scale-Up	APR16	66%	66%	66%	66%	60%	60%	43%	43%	24%	35%	23%	20%	30%	21%	40%	29%	49%	38%	54%	47%	57%	52%	59%	56%	46%
	COP16	Scale-Up	APR17	88%	88%	88%	88%	70%	70%	59%	59%	28%	40%	29%	26%	37%	27%	46%	35%	55%	44%	60%	53%	63%	58%	64%	61%	56%
	COP17	Scale-Up	APR18	88%	79%	88%	79%	81%	73%	80%	80%	38%	52%	41%	35%	52%	37%	62%	48%	69%	60%	73%	70%	75%	78%	76%	78%	66%
	COP18	Attained	APR19	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
	COP19	Attained	APR20	92%	92%	94%	94%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Qacha's Nek	COP15	Scale-Up	APR16	70%	70%	70%	70%	63%	63%	45%	45%	26%	38%	25%	22%	33%	22%	44%	31%	53%	41%	59%	51%	62%	56%	64%	60%	49%
	COP16	Scale-Up	APR17	93%	93%	93%	93%	73%	73%	62%	62%	31%	44%	31%	28%	40%	29%	50%	38%	59%	48%	65%	57%	68%	63%	69%	67%	60%
	COP17	Scale-Up	APR18	92%	84%	92%	84%	85%	78%	84%	84%	41%	56%	44%	38%	56%	41%	68%	52%	74%	66%	79%	76%	82%	84%	82%	84%	71%
	COP18	Attained	APR19	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
	COP19	Attained	APR20	120%	120%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	97%
Quthing	COP15	Scale-Up	APR16	29%	29%	29%	29%	27%	27%	19%	19%	20%	28%	19%	16%	25%	17%	33%	23%	40%	31%	44%	38%	47%	42%	48%	45%	30%
	COP16	Scale-Up	APR17	39%	39%	39%	39%	31%	31%	26%	26%	23%	33%	24%	21%	30%	22%	38%	28%	45%	36%	49%	43%	51%	47%	52%	50%	36%
	COP17	Scale-Up	APR18	39%	35%	39%	35%	36%	33%	35%	35%	31%	42%	33%	29%	42%	31%	51%	40%	56%	49%	59%	57%	62%	64%	62%	64%	44%
	COP18	Attained	APR19	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
	COP19	Attained	APR20	107%	107%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	96%
Thaba Tseka	COP15	Scale-Up	APR16	46%	46%	46%	46%	42%	42%	30%	30%	26%	37%	25%	22%	33%	22%	43%	31%	53%	41%	59%	50%	62%	56%	63%	60%	42%
	COP16	Scale-Up	APR17	61%	61%	61%	61%	49%	49%	41%	41%	31%	43%	31%	28%	40%	29%	50%	37%	59%	48%	65%	57%	68%	63%	69%	66%	50%
	COP17	Scale-Up	APR18	62%	55%	62%	55%	56%	51%	55%	56%	41%	56%	44%	38%	56%	40%	67%	52%	74%	65%	78%	75%	81%	84%	82%	84%	61%
	COP18	Attained	APR19	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
	COP19	Attained	APR20	88%	88%	95%	96%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	94%

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20)** ***TX_CURR***	**Newly initiated (APR FY20)** ***TX_NEW***	**ART Coverage (APR 20)**
Attained	**0**	**0**	**0**	**0**	**0**	**0**
Scale-Up Saturation	**328,577**	**302,106**	**39,244**	**312,921**	**25,904**	**95%**
Scale-Up Aggressive	**0**	**0**	**0**	**0**	**0**	**0**
Sustained	**0**	**0**	**0**	**0**	**0**	**0**
Central Support	**0**	**0**	**0**	**0**	**0**	**0**
Commodities (if not included in previous categories)						
Total	328,577	302,106	39,244	312,921	25,904	95%

APPENDIX B – Budget Profile and Resource Projections

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

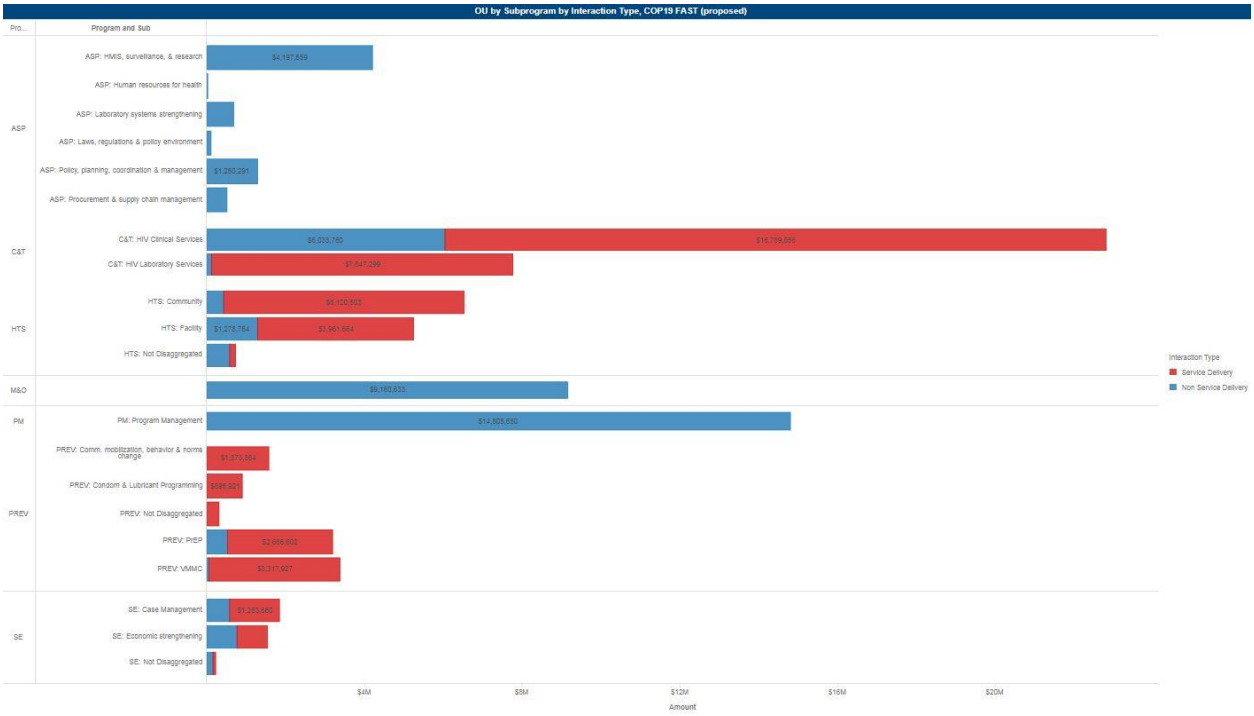


Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$8,907,539	**$77,829,616**	**$86,737,155**

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)	
PEPFAR Budget Code	**Amount Allocated**
CIRC	$4,483,856
HBHC	$1,887,021
HKID	$8,536,022
HLAB	$582,361
HMBL	$0
HMIN	$0
HTXD	$0
HTXS	$31,267,906
HVAB	$1,557,279
HVCT	$11,925,249
HVMS	$6,151,972
HVOP	$6,210,358
HVSI	$1,882,096
HVTB	$5,829,931
IDUP	$0
MTCT	$1,210,182
OHSS	$1,033,845
PDCS	$1,313,458
PDTX	$1,258,082

B2. Resource Projections

Resource projections for COP19 budgeting were done using COP18 budgets as a baseline. In addition, COP19 budgeting used COP17 expenditure data to understand how mechanisms have historical spent money, compared to budgets. For budgeting new initiatives or program shifts, the PEPFAR Lesotho program also had discussions with implementing partners on projected costing data

APPENDIX D– Minimum Program Requirements

PEPFAR Lesotho is supporting all of the following minimum program requirements:

1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups (required in COP16).
2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16).
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens (required in COP18).
4. Scale up of index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established (required in COP18).
5. TB preventive treatment (TPT) for all PLHIV must be scaled-up as an integral and routine part of the HIV clinical care package (required in COP18).
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention (required in COP17 and COP18).
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18).
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management (required in COP17 and COP18).
11. Evidence of resource commitments by host governments with year after year increases (required in COP14).

12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18).
13. Scale up of unique identifiers for patients across all sites.

APPENDIX E – Addressing Gaps to Epidemic Control including through Communities of Faith

In COP19 PEPFAR Lesotho will implement new programming to effectively engage faith communities, including faith-based organizations (FBOs) as these are essential partners in the fight against HIV/AIDS and TB.

FBOs have significant influence within their communities, and as they are often the first point of contact for people in need. They are promising delivery points for key messaging. Their moral authority typically gives them credibility other institutions may lack, and they often have extensive networks and structures enabling them to access hard-to-reach populations. Thirty-five percent (69/199) of public health facilities in Lesotho are church affiliated, run by CHAL.

In Lesotho, the faith sector has been involved in the HIV response since the advent of the epidemic, ranging from prevention, care and treatment, to impact mitigation. In 2007, faith leaders signed a Statement of Commitment by Lesotho's Church Leaders on AIDS. Following this, several documents were developed for use by church leaders to address HIV and AIDS in their various congregations. These included among others, the Sunday Pack (which will be updated with new clinical care guidelines, PrEP and VMMC), an educational toolkit that provided standard sermon guidelines and other material, but was not widely used or disseminated. In addition, a national framework has been developed in 2018, with support from UNAIDS, entitled Lesotho Faith Sector Implementation Framework on HIV and AIDS, which must now be operationalized.

PEPFAR Lesotho is uniquely poised to respond to the new Faith-Based Organization (FBO) Initiative by engaging existing platforms such as religious consortiums, faith community alliances and networks, churches, faith-based leaders and health care workers within religious communities to enhance and amplify key HIV messages, especially for reaching young and adult men in the communities where they live and socialize. In addition, existing DREAMS and OVC platforms can be expanded and enhanced through new faith-based, and community work for preventing sexual violence and HIV risk among 9-14 year-old girls and boys.

In COP19, PEPFAR Lesotho will implement two major focused strategies that are outlined in the **Faith and Community Initiative Priorities** guidance. (1) Engaging communities of faith to understand the epidemic, raise community awareness, and bring critical prevention and treatment interventions to and through communities of faith, especially for finding men living with HIV through CDC; and (2) Preventing HIV risk and sexual violence in 9-14 years old girls and boys through USAID. Current guidance supports the use of already established implementing mechanisms for the immediate implementation of FBO activities that support the objectives of this initiative. Core activities in support of this initiative through PEPFAR Lesotho include the integration of established evidence-based strategies within the area of HIV testing, community education and engagement, prevention of HIV risk and sexual violence and response for 9-14 year-old girls and boys.

HIV Testing Services and Community Education and Engagement (CDC)

As PEPFAR Lesotho moves towards reaching 95-95-95 targets, engagement of community and faith-based leaders will be integral to finding individuals who do not routinely interact with the health care system (e.g. boys and men). CDC HTS partner, Population Services International (PSI), will provide leadership, capacity building, and support to their new local faith-based organizations sub-partners in supporting the linkage and retention of HIV-positive children and adolescents and enhancing demand creation for HIV testing services including self-testing (e.g. especially among young men). PSI will involve their local FBO sub-partners according to their local expertise, culturally sensitive approaches, and access to priority populations to work effectively to implement FBO initiative programming activities. PSI will provide a main sub-award to a local FBO that operates health facilities in the highland districts who will provide HTS, index testing, and PNS through community-based testing, for children and adolescents with a focus on reaching young adult men. PSI may also provide small sub-awards to FBOs that operate as a consortium of local religious institutions to provide additional community education, mobilization, and outreach to local faith-based leaders to provide HIV self-test kits and prevention referrals to their congregants.

PEPFAR Lesotho plans to work closely with PSI to build the knowledge and capacity of local faith leaders to better understand the HIV epidemic in Lesotho and the unique challenges, experiences, and needs of adolescents and adults living with HIV through active community education and engagement activities. Examples of activities **might** include:

1. Conduct a capacity needs assessment among various faith leaders to determine the most appropriate FBO activities for Lesotho faith communities

2. Develop and/or adapt and disseminate new education messaging and materials about HIV testing, linkage, and retention (e.g., Test & Start, U=U), for widespread dissemination in churches and mosques, especially for finding young and adult men. Examples for FBOs might include:

    - Educate about advancements in HIV with emphasis on HIV testing, linkage to care, and adherence support through workshops or trainings

    - Educate faith leaders on existing messages that encompass advancements in HIV testing and linkage to care with specific emphasis on HIVST and Test and Treat

    - Engage and capacitate faith leaders on various HTS models, namely HIVST and PNS, to increase their understanding of these modalities and to garner their buy-in for long-term collaboration through workshops or trainings or events

    - Develop HIV education and testing booklets or pamphlets for faith leaders to disseminate within their congregations to increase demand for HTS and self-test kits

- Provide Training of Trainer (ToTs) to faith leaders and their congregations on basic HIV, testing, care and treatment and referrals to services for capacity building, sustainability and ownership

3. Build capacity among local faith leaders and faith organizations, including among peer counselors in congregations, to create demand for, procurement of, and use of targeted distribution of HIV self-tests in faith communities, by trusted leaders

    - FBOs can work closely with faith leaders to organize events that can help to facilitate information dissemination efforts and targeted dissemination of HIVST

4. Support programming on basic HIV education and stigma reduction for faith communities and leaders

    - FBOs can provide sensitization training among faith leaders to mitigate stigmatizing attitudes and beliefs that often hinder HIV testing, other HIV prevention services, and adherence to treatment.

5. Create an in-country FBO HIV Prevention Taskforce with representatives from various faith communities throughout the country that can come together as stakeholders to share lessons learned and foster collaboration.
    - FBOs can convene key stakeholders to facilitate the sharing of solutions.

6. Engage faith-based organizations to participate in programs that specifically target faith leaders and focus on key issues elucidated during the FBO Mapping TDYs, such as: guiding and supporting ALHIV, U=U, current policies and laws, and expanded information on self- and index testing. Key components would include:

    - Community Resource/Linkages sheets to Faith Leaders in each community to raise their awareness of these services;

    - Information about community programming to Faith Leaders to raise their awareness about referral programs within the community; and shares

    - Information about referrals to OVC/DREAMS programs to help identify 9-14 year old adolescents and their families in need of this programming.

For the new FBO initiative, CDC HTS partner, PSI, will work closely with their local FBO sub-partners, to scale up HIV case identification strategies that have demonstrated potential to identify more HIV-infected persons, especially children, adolescents and young adult males in the highland districts (see Table Appendix E 1.1) using community-based modalities in FBO health facilities. Targeted mobile, index testing, and partner notification services at community level will be significantly expanded and scaled up for men using this FBO approach. For example, many of the CHAL facilities conduct outreaches, but these outreaches are often not targeted. Through the FBO initiative, PSI local FBO sub-partners will conduct targeted outreaches, with a focus on men. It will be especially important for the local FBO sub-partners to have the influence of religious leaders to

have, for example, male-specific outreaches focused on male health issues, such as: multi-disease screening and HIV diagnosis/TB screening; and addressing stigma issues, especially among younger men who may be aware of their HIV status, but are not on treatment.

In addition, through this FBO initiative targeted community mobilization, demand creation and assisted referrals for linkage, care, and treatment will involve existing community health care service providers, village health workers, and focal persons. PEPFAR community testing partners will ensure 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 same–day ART.

Additional information on new case-finding strategies, through the new FBO initiative, is provided in *Section 4.3, Strategies for Case Identification,* in the SDS.

Table Appendix E.1.1. Church-affiliated Health Facilities in the Highland Districts:

Highland Districts	Hospital	Health Centres	Total
Butha Buthe	1	2	3
Mokotlong		2	2
Qacha's Nek	1	3	4
Quthing		3	3
Thaba Tseka	2	3	5
Total	4	13	17

PEPFAR Lesotho recognizes that the local faith-based organizations and faith leaders can be a catalyst for reaching children, adolescents and men and engage in active case-finding and assisted referrals to testing, treatment and adherence support. Through targeted HTS, distribution of self-tests kits and community engagement, faith-based organizations and faith leaders can help identify those most at risk for HIV and, with the right messages, promote linkage to HIV services and improve retention rates.

PEPFAR Lesotho will closely monitor the implementation of the FBO initiative activities through active partner management activities. These activities will include monthly program meetings with PSI and their local FBO sub-partners; site visits to facilities and communities in the highland districts; and weekly check-ins with HTS-funded partner for updates. For HIV case-finding, additional partner management activities include monthly and quarterly tracking of key program outputs (e.g. number of test kits distributed; number of referrals to prevention or care and treatments services) and tracking of outcome indicators (e.g. number of HIV positives; index testing cascade; linkage and retention rates in region of distribution). This data will be stratified by district, facility type, faith-based organization (church or mosque) and HTS modalities (e.g. mobile; index). Close partner management of the new FBO initiative will allow for continuous

assessment and refinement of programmatic activities, improved decision-making, and attainment of specified outcomes.

Primary Prevention of Sexual Violence and HIV among Children 9-14 years (USAID)

As per the COP19 funding level letter, PEPFAR Lesotho will expand CRS/4Children to expand programming to fully engage FBOs and related structures, both Catholic and non-Catholic. Such structures will be strengthened to support HIV interventions, enabling them to: 1) ensure all communities of faith are aware of the most up-to-date strategies for epidemic control as a means of contributing to the 95-95-95 goals and reducing stigma and discrimination and 2) support children, adolescents and adults at risk of and/or directly impacted by HIV and TB including AGYW and adolescent boys and young men (ABYM). Additional FBO funds will be used to buy into a regional capacity building mechanism that will manage sub-grants to FBOs and provide technical and organizational capacity building to these FBOs.

Numerous HIV prevention and empowerment initiatives already target AGYW and are beginning to show results. However, an unintended consequence of this is that boys, adolescent males, and young men (who make up approximately 50% of the population aged under 24) have been "left behind." Increasing levels of violent crimes by groups of armed young men in the country, and lower levels of educational attainment among males than females evidence this. In addition, males are the main perpetrators of GBV and VAC in Lesotho, a contributing factor to the high HIV infection rates among young women. Consequently, there is an urgent need to also engage with this group to provide them the skills, assets, and opportunities necessary to further their own development and change harmful attitudes and behaviors.

APPENDIX F – Acronym List

ABYM	Adolescent boys and young men
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
CBHTS	Community-based HIV testing services
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control
COP	Country Operational Plan
CQI	Continuous quality improvement
CRS	Catholic Relief Services
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
DLO	District logistics officer
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
EPOA	Enhanced Peer Outreach Approach
EQA	External quality assessment
FBO	Faith-based organization
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
HIVST	HIV self-testing
HRH	Human resources for health
HSS	Health systems strengthening
HTS	HIV testing services
IM	Implementing mechanism
INH	Izonazid
IP	Implementing partner
IPT	Isoniazid preventive therapy
IRIS	Immune reconstitution inflammatory syndrome
KP	Key Populations
KPI	Key performance indicators
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
MOH	Ministry of Health
MMD	Multi-month dispensing
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NAC	National AIDS Commission
NACS	Nutrition assessment, counseling and support
NDSO	National Drug Services Organization
NOCC	National OVC Coordinating Committee
NSP	National Strategic Plan for HIV and AIDS
OGAC	Office of the U.S. Global AIDS Coordinator
OPD	Outpatient department
OTH	Online Training Hub
OU	Operating Unit
OVC	Orphans and vulnerable children
PB	Phelisanang Bophelong
PBFW	Pregnant and Breastfeeding Women
PCV	Peace Corps Volunteers

PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHIA	Population-based HIV/AIDS Impact Assessment
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
PPP	Public-private partnership
PrEP	Pre-exposure prophylaxis
PSI	Population Services International
PT	Proficiency testing
QA	Quality assurance
QI	Quality improvement
R&R	Report & requisition
RTK	Rapid diagnostics test-kits
SCM	Supply chain management
SCMD	Supply chain management Directorate
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
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
TLD	Tenofovir disoproxil fumarate/lamivudine/dolutegravir
TLE	Tenofovir/lamivudine/efavirenz
TPT	TB preventive therapy
TRACE	Tracking with Recency Assays to Control the Epidemic
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
URC	University Research Co.
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

Tables and Systems Investments for Section 6.0

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	Elizabeth Glaser Pediatric Aids Foundation	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 911,632.00	Clinical guidelines, policies for service delivery	Weak policy planning and coordination of the HIV program	COP18	COP19	1)Completion of TLD transition, including consideration for women of child-bearing potential and adolescents, and Pediatric ART optimization; 2) Increase coverage of TB preventive therapy to 80%; 3) Update of national ART and TB guidelines to include the TPT regimens (rifapentine and INH/3HP); 4) Quality clinical cascade data as required to measure service access, service uptake, populations covered, quality and acceptability along the entire continuum of of HIV care; 5) Roll-out of advanced disease clinical care package to 50% of the sites
HHS/CDC	University Research Co., LLC	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 67,490.00	Laboratory infrastructure	Limited capacity in expansion of diagnostic and monitoring services and improvement in laboratory systems	COP17	COP20	3% of specimens rejected for referral services; 95% of TB suspects and 95% HIV exposed infants tested; 100% all PLHIV on ART access VL monitoring
HHS/CDC	University Research Co., LLC	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 160,608.00	Laboratory infrastructure	Limited capacity in expansion of diagnostic and monitoring services and improvement in laboratory systems	COP16	COP20	Web-based (e-Reporting) of VL/EID test results reported to 70% (146/208)% of clinics
HHS/CDC	University Research Co., LLC	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 159,352.00	Lab quality improvement and assurance	Limited capacity in expansion of diagnostic and monitoring services and improvement in laboratory systems	COP18	COP20	98% of the testing sites successfully pass PT program; 3 district labs accredited by ASLM
HHS/CDC	MINISTRY OF HEALTH AND SOCIAL WELFARE	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	$ 20,000.00	Pre-service training	Weak policy planning and coordination of the HIV program	COP17	COP20	One MOH staff graduated from FETP
HHS/CDC	MINISTRY OF HEALTH AND SOCIAL WELFARE	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 280,153.00	Lab quality improvement and assurance	Limited capacity in expansion of diagnostic and monitoring services and improvement in laboratory systems	COP17	COP20	Standardized VL, EID, TB referral testing services provided with a median turnaround time reduction by 40%; VL dashboards installed and support data visualization at national level; Patient and test-level data reported quarterly

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	MINISTRY OF HEALTH AND SOCIAL WELFARE	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 61,429.00	National strategic plans, operational plans and budgets	Weak policy planning and coordination of the HIV program	COP17	COP21	All 18 clinical labs and 2 reference labs implement lab guidelines and SOPs
USAID	Elizabeth Glaser Pediatric Aids Foundation	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 80,000.00	Clinical guidelines, policies for service delivery	Weak policy planning and coordination of the HIV program	COP18	COP20	1)Completion of TLD transition, including consideration for women of child-bearing potential and adolescents, and Pediatric ART optimization; 2) Increase coverage of TB preventive therapy to 80%; 3) Update of national ART and TB guidelines to include the TPT regimens (rifapentine and INH/3HP); 4) Quality clinical cascade data as required to measure service access, service uptake, populations covered, quality and acceptability along the entire continuum of of HIV care; 5) Roll-out of advanced disease clinical care package to 50% of the sites
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 100,000.00	Forecasting, supply chain plan, budget, and implementation	Weak supply chain management systems at all levels of the public health care supply chain system	COP16	COP19	zero seconded staff
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 100,000.00	Training in supply chain systems	Weak supply chain management systems at all levels of the public health care supply chain system	COP16	COP19	zero seconded
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 100,000.00	Training in supply chain systems	Weak supply chain management systems at all levels of the public health care supply chain system	COP16	COP20	SC_STOCK = 100%
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 100,000.00	Forecasting, supply chain plan, budget, and implementation	Weak supply chain management systems at all levels of the public health care supply chain system	COP16	COP20	HQ and 10 districts

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 100,000.00	Training in supply chain systems	Weak supply chain management systems at all levels of the public health care supply chain system	COP18	COP20	HQ and 10 districts
DOD	Population Services International	ASP: Laws, regulations & policy environment	Priority Pops: Military & other uniformed services	$ 100,000.00	Assessing impact of policies and regulations on HIV	Weak policy planning and coordination of the HIV program	COP19	COP20	Stigma and discrimination workshops and trainings for military leadership, military healthcare workforce, troops, and military PLHIV completed
USAID	TBD	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 127,230.00	Clinical guidelines, policies for service delivery	Weak policy planning and coordination of the HIV program	COP19	COP20	1)Completion of TLD transition, including consideration for women of child-bearing potential and adolescents, and Pediatric ART optimization; 2) Increase coverage of TB preventive therapy to 80%; 3) Update of national ART and TB guidelines to include the TPT regimens (rifapentine and INH/3HP); 4) Quality clinical cascade data as required to measure service access, service uptake, populations covered, quality and acceptability along the entire continuum of of HIV care; 5) Roll-out of advanced disease clinical care package to 50% of the sites
HHS/CDC	TBD	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ -	Surveillance	Need for SRE Activities	COP19	COP20	Completion of survey and preliminary data
HHS/CDC	TBD	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 305,600.00	Program and data quality management	Poor data quality to track 90-90-90 achievements for sustained epidemic control	COP19	COP21	Data quality assurance plan at all 172 facilities; 3% agreement between DATIM and DHIS2
HHS/CDC	TBD	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 100,000.00	Training in coordination and management of health systems	Weak policy planning and coordination of the HIV program	COP19	COP21	Fully functional DHIS2 system at 200 facilities
USAID	TBD	ASP: HMIS, surveillance, & research	Females: Young women & adolescent females	$ 200,000.00	HMIS systems	Poor data quality to track 90-90-90 achievements for sustained epidemic control	COP19	COP19	Utilization of database among all DREAMS partners

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	Elizabeth Glaser Pediatric Aids Foundation	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Adults	$ 700,059.00	HMIS systems	Poor data quality to track 90-90-90 achievements for sustained epidemic control	COP18	COP20	100% of all newly diagnosed receive testing for recent HIV infection.
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 2,992,000.00	Program and data quality management	Poor data quality to track 90-90-90 achievements for sustained epidemic control	COP19	COP21	eRegister functioning with TX_CURR and HTS data collection and unique identifiers feeding into the national shared health records at 172 facilities