Country Operational Plan

(COP/ROP) 2020

Strategic Direction Summary

March 16, 2020

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1.0 Goal Statement

The PEPFAR Lesotho's Country Operational Plan (COP) 2020 is the culmination of tireless work from the PEPFAR Lesotho interagency team and strong collaboration with The Global Fund and the Ministry of Health. With COP20, PEPFAR Lesotho will achieve the 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. PEPFAR Lesotho is hopeful that the LePHIA 2020 results will show that we have already reached the UNAIDS 90-90-90 goals. The results will be a testament of PEPFAR Lesotho's hard work over the past five years to scale up case-finding and treatment services.

It is against this background that COP20 will begin to look different. PEPFAR Lesotho will evolve our program towards maintenance and begin to critically evaluate how to transition the PEPFAR program to the host government and local partners. Since COP19, our program has reflected a shift in approach for our testing services and case-finding strategies being increasingly targeted. In COP20, the PEPFAR Lesotho program will shift our focus to retention on treatment to ensure that PLHIV are virally suppressed, especially considering the current public health threat with the novel coronavirus outbreak. PEPFAR Lesotho will increasingly work with and implement activities through indigenous partners to build local capacity, increase program sustainability, and ensure sustainable epidemic control.

In COP20, we will continue to prioritize finding men 20-35 years, put them on treatment and ensure that they are retained. Lesotho's signature men's clinic model will continue to be fully utilized and scaled-up to at least 50 sites in COP20. These men's clinics will be combined with risk-screening-informed testing and HIV self-testing for efficient and effective case-finding. To promote retention, male-friendly expert clients will be identified both at men's clinics and health facilities to improve men's experiences.

COP20 will continue to focus resources and investments in the supply chain management system (SCM). PEPFAR Lesotho conducted a root-cause analysis of deficiencies in the SCM and developed a corrective action plan. One key component of this plan was the establishment of a coordination body called the Supply Chain Management Directorate to bring governance, accountability, and improved performance to SCM. For COP20, the GOL confirmed their commitment to appropriate M470 million for the explicit procurement of a full year of ARVs for all Basotho living with HIV.

PEPFAR Lesotho has worked with a wide range of stakeholders in developing COP20. 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. The PEPFAR Lesotho team has worked exceptionally closely with GF to ensure complementary scale up of the DREAMS program to two

additional districts and are collaborating on a national effort to bring community-led monitoring to Lesotho. Through the 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. Not only has the PEPFAR team always worked well at the interagency level, they have expanded this collaborative spirit to stakeholders and other donors, always keeping in mind the larger goal of achieving their targets and reaching epidemic control. COP20 is a direct result of this strong interagency and stakeholder collaboration.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Lesotho has a total population of 2,050,426 people, 51% of whom are women and 31% of whom are under the age of 15.[1] The country is divided into ten districts, five considered highlands and five lowlands. Lesotho is classified as a lower middle-income country with a Human Development Index of 0.518 and a Gross National Income (GNI) per capita of $3,244. [2] Seventy-two percent of the population live in rural areas.[3]

In 2019, the Lesotho Bureau of Statistics completed population projections for each year up to 2036 based on the 2016 Census. These updated numbers have been incorporated into our population-level estimates in the UNAIDS Spectrum model along with the 2016-2017 Lesotho Population Based HIV/AIDS Impact Assessment (LePHIA) district HIV prevalence and incidence and country 2018 program data. This model forms the basis for PEPFAR planning. Prevalence among men and women 15-59 was 25.6% in 2018[4]. 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 COP20 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 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 are ongoing in Maseru, Berea and Leribe urban centers that border South Africa, where female sex workers (FSW) and men who have sex with men (MSM) are concentrated. In 2019 the report of the second Integrated Bio-Behavioural Surveillance Survey for Key Populations in Lesotho (IBBSS2) was released giving size estimates for FSW and MSM in four Districts: Butha Buthe, Leribe, Mafeteng, and Maseru.

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% identified in the 2014 Demographic and Health Survey (DHS) to 1.1% from the LePHIA in 2017.[5] Lesotho was the first country in sub-Saharan Africa to implement Test and Start in June 2016. In 2017, Lesotho adopted multi-month dispensing (MMD) for stable patients. During COP20, Lesotho will continue to scale

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[1] Lesotho Population Projections 2016-2036, 2019
[2] UNDP, http://hdr.undp.org/en/data, 2019
[3] World Bank, http://data.worldbank.org/country/lesotho, 2018
[4] UNAIDS, https://www.unaids.org/en/regionscountries/countries/lesotho, 2018
[5] LePHIA 2016-207, Dec 2018

up index testing in health care facilities, HIV self-testing (HIVST), Pre-Exposure Prophylaxis (PrEP), TB preventive therapy (TPT) and differentiated models of care completing a transition to TLD that began in August 2019.

In COP20 Lesotho will consolidate and enhance the eRegister program and health information exchange in 172 facilities supported by PEPFAR, enabling a unique identifier for all people living with HIV allowing case monitoring from the time the person tests for HIV. Retention in treatment is a barrier to epidemic control in Lesotho. The eRegister and health information exchange will provide the ability to track those on ART across facilities and clarify the extent of retention within the program. In February 2020 the Ministry of Health endorsed the Health Management Information System (HMIS) Strategic Plan 2018-2022 providing a policy for electronic medical records.

Lesotho's government has been supportive of PEPFAR efforts overall, however stigma remains a barrier to HIV testing and treatment. Identifying the HIV infected and treating men and women 15-24 years of age is a key challenge and urgently needs to be addressed to reach the 90-90-90 goals in these populations. 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
    i. 95% of people aged 15 and over have accessed combination prevention;
    ii. MTCT eliminated and 95% of children living with HIV on treatment;
    iii. Test and treat cascade fast tracked to attain 95-95-95 targets.

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

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	2,050,426	100	319,393	15.6	318,091	15.5	198,166	9.7	200,831	9.8	527,237	25.7	486,708	23.7	2018, BOS Population Projections
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)	5499		235		241		248		183		2071		2521		2019, Spectrum
# PLHIV	336,006		5,316		5,301		19,871		8,854		173,381		123,283		2019, Spectrum
Incidence Rate (Yr)		1.10		---		---		1.49		0.13		1.22		1.00	2017, LePHIA (25+ is 15-59)
New Infections (Yr)	10,352														2019, Spectrum
Annual births	47,163	---													2018, MICS
% of Pregnant Women with at least one ANC visit	---	91.3	---	---			---	89.6			---	91			2018, MICS
Pregnant women needing ARVs	9268	---													2019, Spectrum
Orphans (maternal, paternal, double)	194,814		77,926		77,926		19,481		19,481		---		---		2019, Spectrum
Notified TB cases (Yr)	7,129		143		143		---		---		2424 (15+)		4419 (15+)		2019, Global TB Report
% of TB cases HIV infected		65%	---	---	---	---	---	---	---	---	---	---	---	---	2019, Global TB Report
% of Males Circumcised	217,874				102,401	47			76,256	35			39,217	18	2019, Program Data Q1
Estimated Population Size of MSM*	6081	---													2018, IBBSS2 (4 Districts)
MSM HIV Prevalence	---	24.6													2018, IBBSS2 (4 Districts)
Estimated Population Size of FSW	7587	---													2018, IBBSS2 (4 Districts)
FSW HIV Prevalence	---	47.2													2018, IBBSS2 (4 Districts)
Estimated Size of Priority Populations (Prisoners)	2,447	31.4 prev													2014, LCS
Estimated Size of Priority Populations Prevalence (Taxi Drivers)	4,947														2017, in-country estimate (15+)
Estimated size of population (Military)	3,000	11.1%													2017 SABERS

Table 2.1.2 95-95-95 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	2,050,426	25.61^	336,006	274,597	246,174	90%	95%	906,050	25,599	28,146
Population <15 years	637,484	2.1	10,617	10,249	8,275	81%	87%	166,517	700	691
Men 15-24 years	200,831	3.4	8,854	6,490	4,816	74%	85%	74,607	875	719
Men 25+ years	496,135	20.8	123,283	96,194	86,526	90%	95%	173,046	10,578	9642
Women 15-24 years	198,166	11.1	19,871	13,448	9,440	70%	92%	190,920	4,908	4,483
Women 25+ years	535,561	30.4	173,381	148,216	137,117	93%	95%	300,932	12,538	12,611
MSM∞	6,081	24.6	1,496	---	---	---	---	4,458	190	36
FSW∞	7,587	47.2	3,581	---	---	---	---	3,040	519	124
PWID	No data	---	---	---	---	---	---	---	---	---
Priority Pop (Prisoners)								1,642	94	81

*Lesotho Population Projections Report, 2016-2036
**LePHIA, 2017
†Spectrum 2020
‡Program data, Qtr1 FY20
^15-59 year prevalence
∞IBBSS, 4 Districts, 2018

Figure 2.1.3. National and PEPFAR trend for individuals currently on treatment

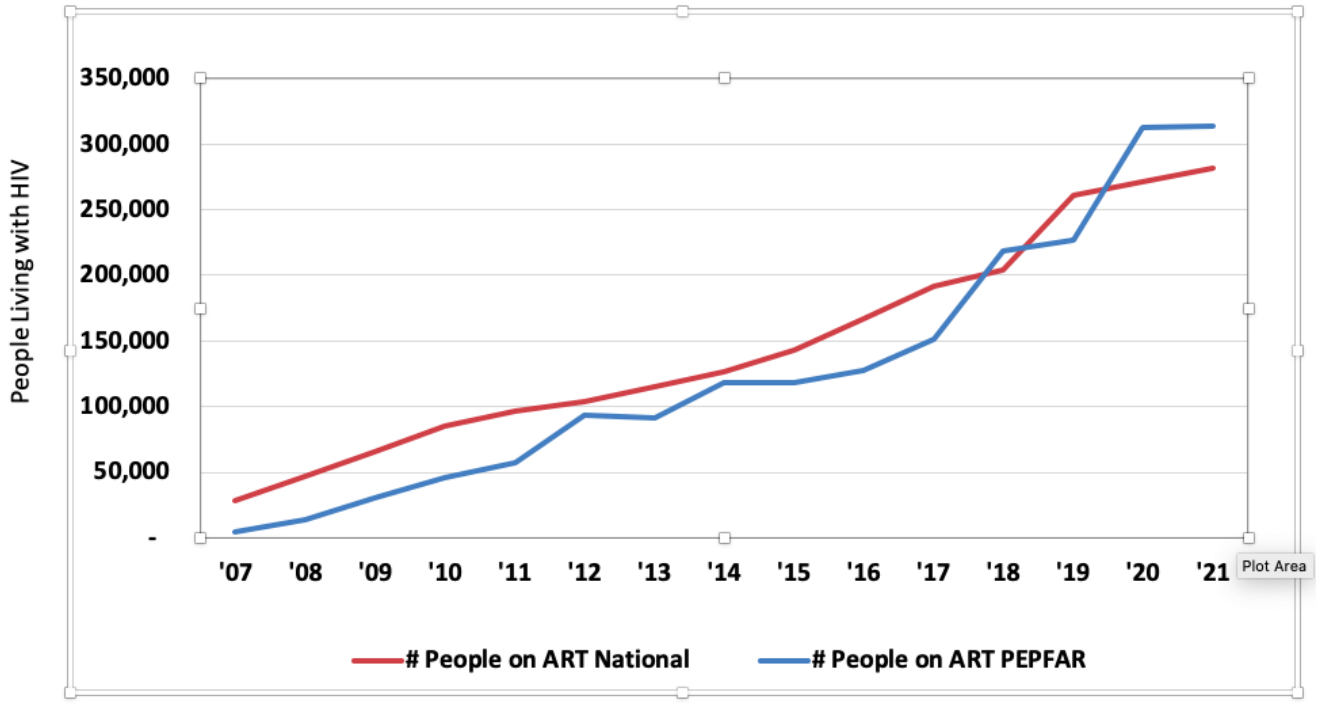


Figure 2.1.4. Updated Trend of New Infections and All-Cause Mortality Among PLHIV

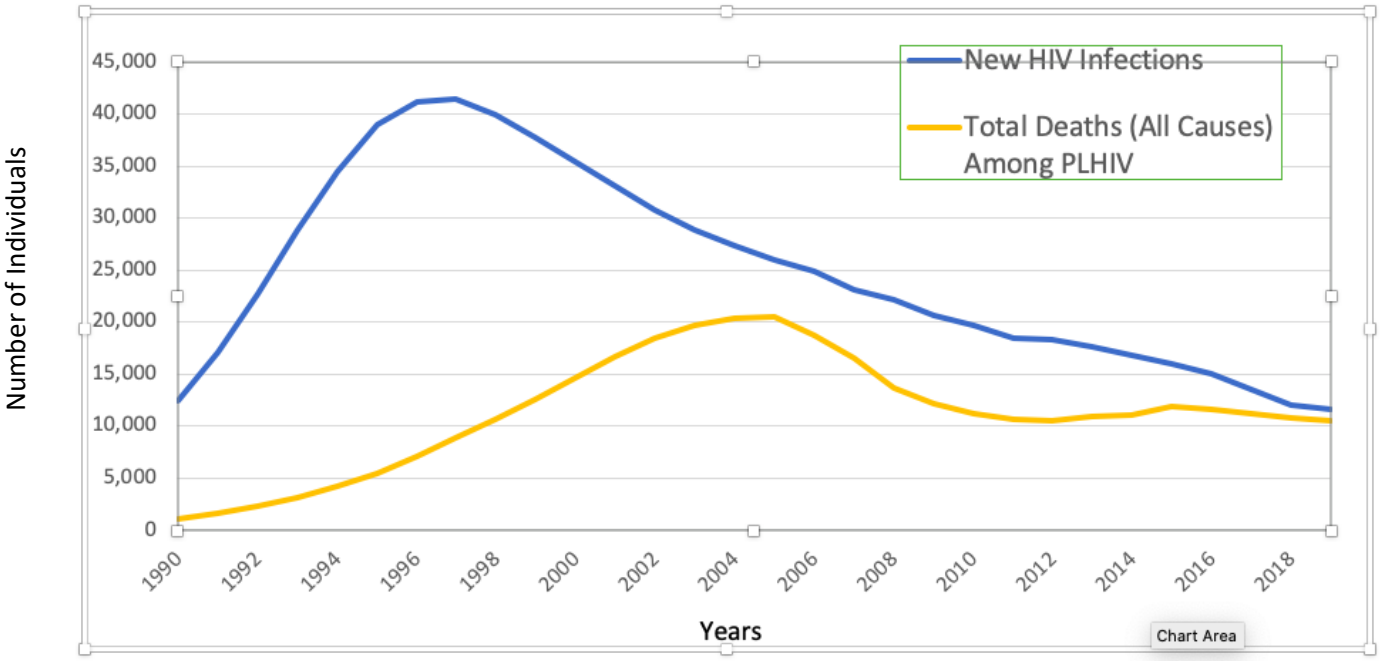


Figure 2.1.5. Progress retaining individuals lost in life long ART in FY19

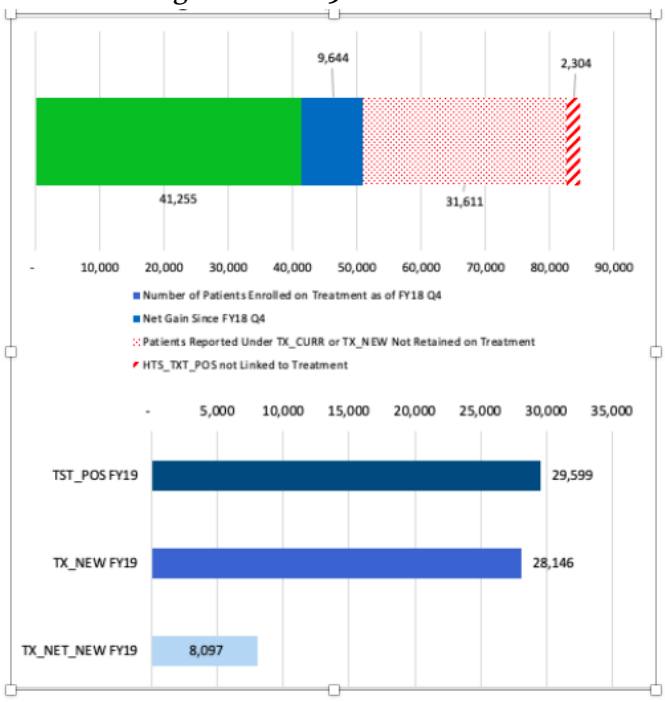


Figure 2.1.6. Proportion of clients from ART 2018 Q4 to 2019 Q4

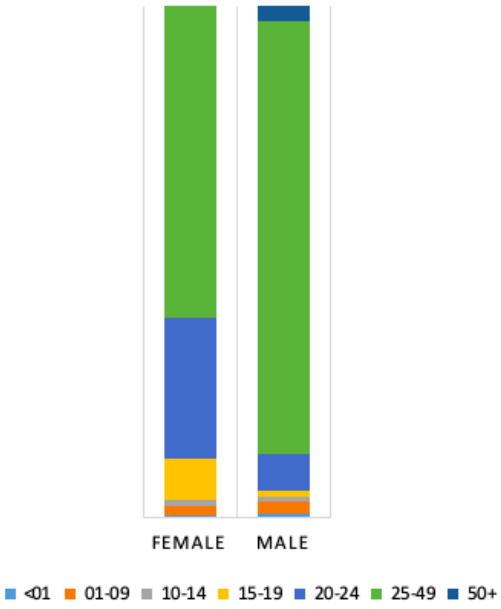
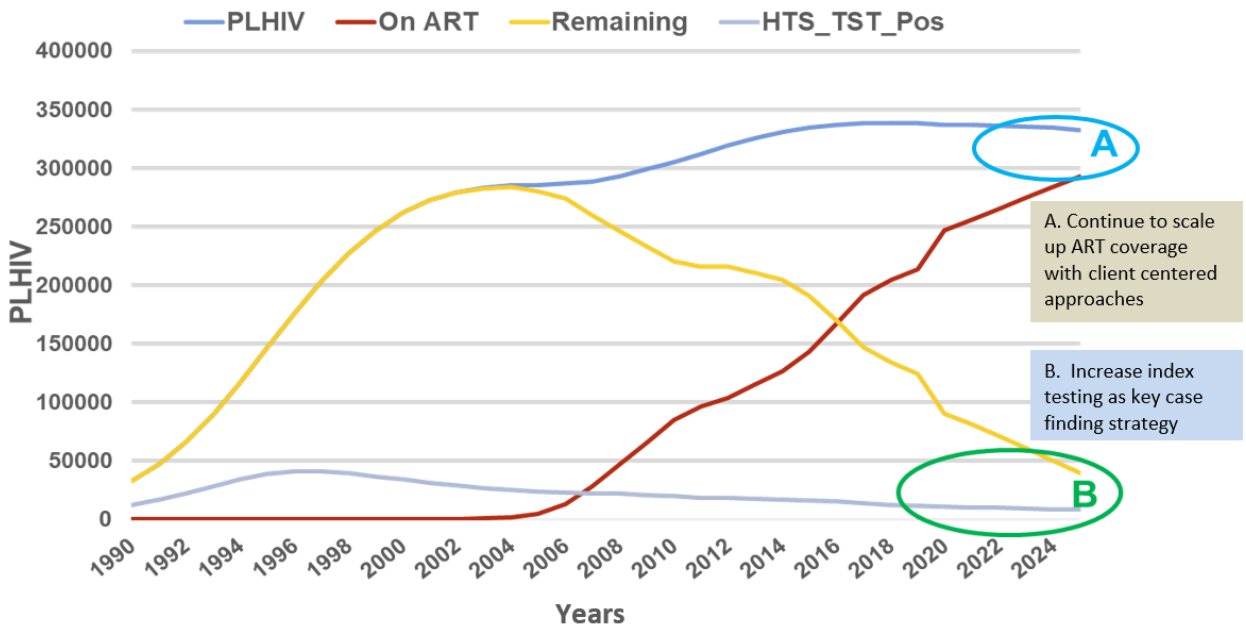


Figure 2.1.7. Epidemiologic trends and program response for your country (Figure 2.1.1.3 in COP20 Guidance)



2.2 New Activities and Areas of Focus for COP20, Including Focus on Client Retention

Client retention

Retention remains a major strategic priority for treatment program growth. The COP20 goal for retention is to ensure increased access to quality and client centered ART services to attain durable viral suppression, prevent HIV transmission, and improve the health and wellbeing of all PLHIV in all sexes and age-groups. The APR19 results show that although the retention proxy was high at 96%, with 95% virally suppressed and 28,146 newly initiated on ART- the treatment growth is low at 3.7% (TX_NET_NEW of 8,097). Lesotho's TX_CURR net growth is affected by high attrition of 20,049 PLHIV with men and women aged 15-44 years accounting for >90% of the clinical cascade attritions. Mortality rates maintain low at 1%. Lost-to-follow-up (LTFU) is the main cause of clinical cascade attritions with 14% lost within the first three months of ART initiation and 86% lost after having been on ART for > 3 months.

The main reasons accounting for 80% of missed appointments include working in South Africa (16%), at-work locally (14%), site documentation errors (12%), temporary travel (10%), felt cured/healthy (8%), forgot (6%), transport challenges (6%), self-transfers (4%), wrong addresses (4%), and at school (3%). A programmatic root cause analysis identified service delivery and systems-related barriers that included sub-optimal ARV ordering to meet the demand for services, incomplete documentation and triangulation of data across multiple clinical cascade registers, and frequent staff rotations impacting understanding of the PEPFAR and MOH reporting requirements.

During COP20, HIV treatment program growth will be fostered through three strategic priorities:

i. improving the uptake of test-and-treat services for newly diagnosed PLHIV and improving linkages to >95%;
ii. active case management and proactive tracking of treatment defaulters and LTFU to re-engage them back in to care;
iii. expanding access and uptake of differentiated service delivery models based on client needs and retention barriers.

Lesotho has a strong policy framework fostering same-day or rapid ART initiation for all PLHIV irrespective of CD4 status. The program will consolidate the gains of intra-facility linkages using Retention Case Managers and strengthen the facility-community linkages either through active escort or integrated outreach. Early retention of newly initiated clients will be fostered through day 7 counsellor check-ins, provision of optimized treatment regimens that have fewer side effects, strengthening counseling on treatment literacy prior to ART initiation, and active tracking of those initiated at community level to ensure they receive their facility refill on time.

Program results demonstrate that active community tracking of missed appointments using community linkage coordinators and focal persons results in 74% return to care. In COP20, the program will expand the eligibility criteria of tracking efforts to include all beneficiaries at high risk

of LTFU (i.e. newly initiated on ART, children, adolescents, pregnant and breast-feeding women, viremic patients, and those with advanced HIV disease). During COP20, the PEPFAR Lesotho program will consolidate all facility- and community-based treatment linkage and retention supporters into one optimized role of Retention Case Managers. Based on the client's needs, a Retention Case Manager might be a professional counsellor, LENASO Focal person, mentor mother, adolescent ambassadors, or peers. Retention Case Managers will be utilized to proactively track these high-risk clients, in addition to tracking all missed appointments. Scheduled community follow-up visits will also be provided based on client needs e.g. caregivers of children living with HIV for assisted disclosure, OVC-case management, pregnant & breastfeeding women and their infants.

Programmatic shifts for tracking will involve

- ensuring that >95% of all patients on ART are enrolled in the CommCare App to enable them receive SMS appointment reminders
- eliciting of >1 phone contact for all clients, including South African numbers to improve follow-up,
- shortening the duration of the first tracking to be within 24 hours of a missed appointment,
- ensuring that all LTFU clients are tracked at least three times to ensure linkage to care,
- and institutionalizing a data triangulation day in all ART sites where the tracking outcomes are updated in the client ART cards, tracking tools, registers, and eRegister systems.

ART re-engagement services

Re-engagement services will be expanded in all sites that account for 80% of the LTFU, ensuring that at least 95% have documented tracking outcomes including facility to facility transfer documentation and linkage back to treatment. Clinical cascade attritions will inform site level performance benchmarks for return to treatment services and all sites will be monitored weekly to ensure they are on schedule to re-engage clients on ART. Professional Counsellors will serve as initial case managers for all newly re-engaged clients providing enhanced adherence counseling, telephone follow-up check-ins, and support to ensure timely viral load monitoring. All re-engaged clients will be linked to existing differentiated service delivery models, e.g. male-friendly health care, adolescent friendly health care, viremia clinics for the unsuppressed, weekend clinics for children, and PMTCT settings for pregnant and breast-feeding women.

Multi-month scripting and dispensing (MMD)

MMD will be expanded for all stable children, adolescents, and adults on ART to attain 90% coverage, including provision of 3-6 month refills and appointment spacing. Two models of MMD will be implemented to meet client need: (i) facility-based MMD, including pharmacy fast-track to reduce waiting times and decongest clinics; (ii) community based MMD, provided through peer-led models that include community ART groups (CAGs), mentor-mother support groups for stable pregnant and breast-feeding women (including CTX refills for their HIV exposed infants), and

mobile clinics for the high transit areas in Maseru and Maputsoe and the factory workplace program. All PLHIV receiving MMD will have at least one annual clinic visit to ensure timely viral load monitoring.

Decentralized drug distribution (DDD)

DDD will be a new initiative implemented in COP20, targeting clients who are virally suppressed but either prefer to pick up ARVs in the private sector, or face barriers to returning to collect drugs in the public sector (e.g. due to work schedule, in-country travel, or transport challenges). DDD is a patient-centered opt-in service delivery model, leveraging existing private sector providers (e.g. hospital or community pharmacy, e-lockers, or pharmacy-in-a-box) to expand availability of ARVs drugs in urban and peri-urban settings located in catchment areas of high-volume, low-retention sites that may have long waiting times. The program collaborates with the MOH, other donors, and private sector entities to layer on additional non-HIV-related disease areas to leverage resources and reduce stigma and discrimination for PLHIV served through this model. The model is anticipated to improve retention among key target groups, including men, and will be initially implemented initially in Maseru district, which registered the highest cascade attritions in APR19. The DDD program will seek to integrate services with FP, condoms and other non-communicable disease drugs.

All participating beneficiaries will provide informed consent to enable the drug distributors reach them at convenient locations for their ART refills, adherence counseling, and retention support. Enrolled clients will set an appointment schedule for drug delivery and at least one annual clinic visit for viral load monitoring and will receive SMS reminders to ensure they are available to receive their refills on the agreed dates. Patients who miss scheduled pickups or have a change in clinical status (e.g. acute opportunistic infection, malnutrition, etc.) will be reverted to the health facility-based care until stable.

The MOH will provide ARTs for the DDD model (through the NDSO or targeted health units) and all distributors will ensure real-time updates of the site pharmacy stock records, client ART cards, and eRegisters. PEPFAR, the MOH and private-sector pickup points will sign MOUs to agree upon incentives (e.g. delivery fee of estimated at $2 or consultations fee per client per drop-off) to ensure private sector participation in the program. Beneficiaries will receive ARV refills for free, but may be required to pay a fee-for-service for non-HIV related commodities.

Key implementation activities will entail a market analysis to identify potential alternative distribution points, attaining Government of Lesotho commitment to provide ARVs for this program, defining the initial population segments and program targets, training of private pharmacists in dispensing and reporting, and demand creation activities. Program performance will be monitored through monthly reports and support supervision to ensure that quality of services, proper documentation and commodity storage are maintained.

Closing the Treatment Gap initiative

The Closing the Treatment Gap initiative will build off lessons from the initial pilot that tracked Basotho that had been recorded as LTFU. External migration is a key determinant of sustained treatment retention with 24.3% Basotho aged 15-59 years (i.e. 30.9% of men and 17.8% of women) reporting having lived outside of Lesotho, at least 6% are away for one or more months, and with 95% being in the Republic of South Africa, (LePHIA, 2016-1027). The pilot program matched the LTFU clients using first name, surname, date of birth and gender to identify them on the Tier Net system in four districts in South Africa. Preliminary results of the 45 matched clients showed that 76% were active on ART, 13% were LTFU in South Africa, 9% had transferred out, and 2% died. This initial pilot identified the economically active group aged 32-43 years, who had been on ART for at least 48 months, indicating it reached the sub-population that contributed to the highest cascade attritions.

The COP20 program interventions for Closing the Treatment Gap will be expanded to additional districts in Lesotho and South Africa, which will then be discounted off the TX_CURR targets, especially in the context where national treatment program data is lower than the Spectrum 2020 and LePHIA, 2016-2017 population surveys. A community tracking component will be included to identify treatment outcomes for Basotho who are lost in South Africa or transferred to other sites to confirm treatment re-engagement.

These COP20 strategic priorities will be scaled-up based on the volume of clients and collaborative quality improvement interventions for different target populations will be implemented at facility level. The PEPFAR Lesotho program will continue to foster learning to improve retention using facility QI teams and district QI coaches to improve the quality of services. Retention interventions by specific subpopulations are covered in section 4.2 of the SDS.

2.3 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 COP20. PEFPAR's percentage of the national HIV response has therefore increased. Historic GF expenditure for the two-year grant from 2016-2018 was just under 80%. The current grant 2018-2021 is $67 million. In the first year, they spent $21.46 million.

Historically, the GOL has maintained their commitment to the HIV response, especially the procurement of ARVs. In the past year, this commitment has waivered and gaps in funding have required immediate attention from GF and PEPFAR.

Table 2.3.1 shows that the total HIV expenditure in 2019 (PEPFAR) and 2018 (GF and GOL) was $144,768,756. The 2020 Resource Alignment showed that PEPFAR's contribution to the national response in 2018 was 52% of the HIV expenditure. The largest cost categories are those directly associated with achieving the 90-90-90 goals.

Table 2.3.1 Annual Investment Profile by Program Area				
Program Area	**Total Expenditure**	**% PEPFAR***	**% GF***	**% Host Country†**
Care and Treatment	$64,032,264	38%	26%	36%
HTS	$16,840,650	68%	19%	13%
Prevention	$19,561,097	55%	27%	18%
OVC	$7,301,649	51%	6%	43%
Above Site Programs	$10,985,463	37%	17%	46%
Program Management	$26,047,633	90%	10%	0%
Total	**$144,768,756**	**54%**	**21%**	**25%**

*2020 Resource Alignment: PEPFAR 2019

**2020 Resource Alignment: Global Fund 2018

†2020 Resource Alignment: Government of Lesotho 2018

Table 2.3.2 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. In 2019, the GOL was not able to fulfill their historic contribution to ARVs. This caused an immediate response from GF to fill the gap.

Table 2.3.2 Annual Procurement Profile for Key Commodities				
Commodity Category	**Total Expenditure**	**% PEPFAR[1]**	**% GF[2]**	**% Gov. of Lesotho[3]**
PSM	$1,927,991	71%	29%	0%
Consumables	$304,200	100%	0%	0%
RTKs	$1,985,474	30%	70%	0%
Viral Load commodities	$434,878	100%	0%	0%
Lab Supplies	$7,431,211	71%	29%	0%
Health Equipment	$75,895	0%	100%	0%
Medicines	$2,243,823	51%	49%	0%
Condoms	$395,836	0%	100%	0%
ARVs	$28,489,916	0%	22%	78%
Total	**$33,918,935**	**21%**	**28%**	**51%**

[1]2020 Resource Alignment: PEPFAR 2020 Budget
[2]2020 Resource Alignment: Global Fund 2020 Budget
[3]Ministry of Health self-reported ARVs only

As Table 2.3.3 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	$1,738,200	$1,738,200	1	$976,618	FY20 funding for Peace Corps Lesotho. FY21 is expected to be similar.
MCC	$9,740,000	$0	0	$0	$9,740,000 is the updated funding amount for feasibility studies and compact stand-up. The funding for the full MCC second compact is still undetermined.
Total	**$11,478,200**	**$1,738,200**	**1**	**$976,618**	

2.4 National Sustainability Profile Update

PEPFAR Lesotho completed a Sustainability Index Dashboard (SID) in August 2019 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 17 sustainability elements, sustainability strengths were "planning and coordination" (dark green), "policies and governance" (light green), "technical and allocative efficiencies" (dark green), and "performance data" (light green). All elements within the *national health system and service delivery* and *strategic information* domains (except for performance data) were identified as sustainability vulnerabilities. Lesotho's COP19 above-site investments have been appropriately allocated to address these sustainability vulnerabilities, specifically in the following elements: 1) service delivery; 2) commodities security and supply chain, 3) laboratory; and 4) epidemiological and health data. There has been a modest increase in the SID score for commodities security and supply chain, laboratory, and epidemiological and health data between 2017 and 2019. Service delivery, however, has decreased slightly in the SID score. In light of this, PEPFAR Lesotho will continue to invest in HIV program coordination and policy and guidelines development, particularly for technical assistance in TLD transition, pediatric ART optimization, and update of National ART guidelines.

In COP20, PEPFAR Lesotho will continue to focus above-site investments in commodity security and supply chain, laboratory systems, and epidemiological and health data due to sustainability vulnerabilities in these areas as the program transitions to host-country led.

Commodity security and supply chain

PEPFAR Lesotho will continue to support the MOH to strengthen commodity security, an element that is critical in helping Lesotho reach epidemic control. For example, Lesotho has experienced various commodities stock-out challenges and has been unable to provide a secure supply of ARVs at the site level for 3-6 months of MMD. PEPFAR Lesotho will provide technical support and capacity building to the newly announced 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.

Laboratory systems

Laboratory services are vital to HIV service delivery and will be supported in COP20 through: 1) laboratory network optimization by strengthening the local referral networks through tiered lab services; 2) strengthening the Laboratory Information System (LIS) and monitoring and evaluation (M&E) system, including dashboard and data visualization; 3) supporting the laboratory quality system, biosafety, and waste management and; 4) supporting the development of lab policies, strategic plans, and guidelines. This will ensure improved VL coverage of 100% by the end of COP20 (refer to Section 5.0 for more details). The second 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.

Epidemiological and health data

Optimization of information systems such as eRegisters 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 (eRegisters) 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, identifying HIV recent infections will enable a system of case-based surveillance to prevent, detect, and intervene on the epidemic, especially once Lesotho reaches epidemic control.

Donor investment and transition to indigenous partners

PEPFAR Lesotho is currently investing in the appropriate areas 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. In addition, the host country will need to determine the level of human resources, including types of health cadres, needed to maintain the epidemic and be ready to increase investments in human resources. It should also be mentioned that political instability, 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.

Since COP19 and COP20, PEPFAR and GF have maintained and synergized resources in Lesotho to address gaps in sustainable epidemic control. In its current grant, GF has been investing in resilient and sustainable systems for health through human resources (including village health workers), strategic information systems, and procurement and supply chain management systems.

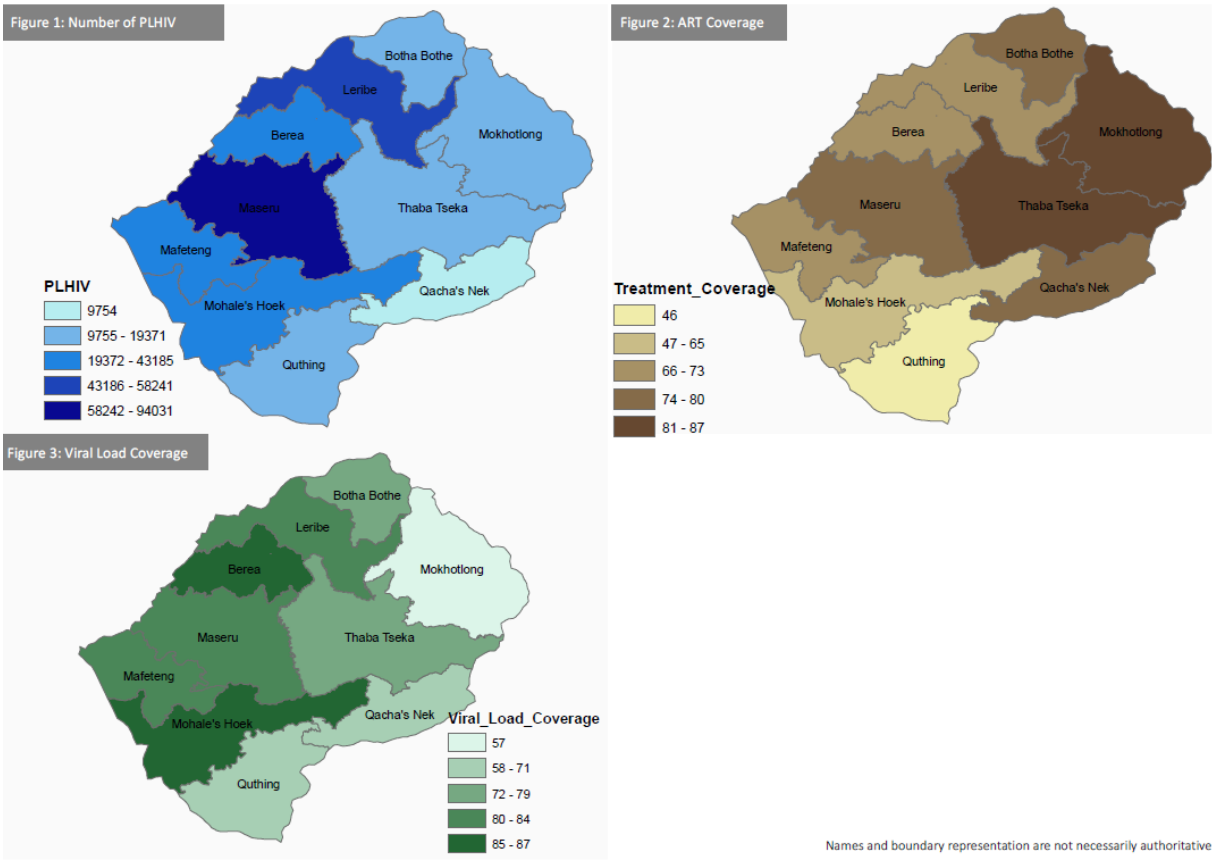
PEPFAR Lesotho will increasingly work with and implement activities through indigenous partners to build local capacity, increase program sustainability, and ensure sustainable epidemic control. PEPFAR agencies have taken measured steps to increase funding towards local, indigenous prime partners. For USAID, current transition milestones are set at 30% for COP19, reaching 48% of their portfolio to be implemented by indigenous entities, by COP22. USAID awarded the OVC/DREAMS grant and transferred portions of their care and treatment portfolio to local partners in COP19. CDC will provide preference points to local applicants in their upcoming treatment and laboratory cooperative agreements, to be awarded in COP20. Furthermore, they will incorporate health system strengthening activities for the MOH in all new awards to develop local capacity.

2.5 Alignment of PEPFAR investments geographically to disease burden

According to LePHIA 2016/2017, HIV prevalence is similar among most districts in Lesotho, ranging from 23% in Berea to 29% in Mohale's Hoek. The exception to this is Butha-Buthe where the prevalence is 18%. The HIV burden in Lesotho, however, remains in the more densely populated and more urban lowlands to the west and southwest of Lesotho, which encompasses the districts of Maseru, Leribe, Berea, Mafeteng, and Mohale's Hoek. These five districts account for 74% of all PLHIV and have been PEPFAR "scale-up" districts since COP15. With Lesotho approaching epidemic control, PEPFAR expanded to 45 sites in the five highland (formerly "sustained") districts in COP17 and COP18, leading to 99% coverage of PLHIV on ART. In COP20, PEPFAR will remain in these 207 sites to maintain care and treatment activities and ensure retention of patients on ART.

In COP20, PEPFAR Lesotho will be expanding DREAMS from the districts of Maseru (59,050 AGYW) and Berea (27,234 AGYW) to the districts of Mafeteng (17,498 AGYW) and Mohale's Hoek (15,524 AGYW). This expansion will provide DREAMS coverage in four of the five lowland districts, which contain majority of the AGYW (as well as AGYW living with HIV) in Lesotho. The GF has traditionally implemented DREAMS-like activities in all the other 8 districts in Lesotho. In COP20, GF will exit Mafeteng and Mohale's Hoek and reinvest the efficiencies generated from this transition into Leribe (34,734 AGYW) to scale-up the AGYW programming in this district, while maintaining level investments in the other five highland districts.

Figure 2.5.1. PLHIV, treatment coverage, and viral load coverage by SNU.



2.6 Stakeholder Engagement

COP20 development included various stakeholders from the MOH, civil society organizations (CSOs), GF Country Team, National AIDS Commission (NAC), United Nations Agencies, faith-based organizations, PEPFAR implementing partners, and other select local non-government organizations in a three-day stakeholder retreat from 28th to 30th January, 2020. 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, Phelisanang Bophelong (PB), Mantsopa Institute, Sentebale, Community of Women Living with HIV (CWL), Society for Women and AIDS in Africa Lesotho (SWAALES), Sesotho Media, Bacha Re Bacha, Master of Healing Foundation, Women and Law South Africa (WLSA), and Migrant Workers. Faith-based organizations (FBOs) that participated included Christian Health Association of Lesotho (CHAL), Lesotho Inter-Religious AIDS Consortium (LIRAC), World Vision, Center for Impacting Lives (CIL), and Christian Council of Lesotho (CCL).

Prior to these meetings, COP20 guidance, along with critical data and materials (POART FY19 Q4 presentation slides and web links to PEPFAR Solutions Platform, COP19 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 COP20 strategic approaches, particularly: 1) client-centered care; 2) enhanced retention strategies for PLHIV on ART, especially MMD and TLD transition; 3) expansion of DREAMS and 4) establishment of community-based monitoring.

Representatives from the MOH, CSOs, GF Country Team and GF prime recipients, WHO, and UNAIDS participated in the five-day, in-person planning meeting in Johannesburg from 24th to 28th February. Stakeholders contributed to effective discussion and agreed on the collaborative objectives and strategic priorities for COP20. GF contributed to important discussions and ensured complementarity regarding: 1) community-based monitoring; 2) PEPFAR DREAMS expansion into two districts where GF was already providing AGYW prevention activities; 3) procurement of TPT commodities; 4) shifts in testing approaches in the highlands; and 5) commodities security and establishment of the supply chain management directorate. 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 COP20 priorities. These strategic directives included: 1) implementation of the HIV risk assessment tool for testing; 2) provision of 3-6 month MMD as an option for all stable PLHIV on ART; 3) rapid transition to optimized ART regimens; 4) supporting the national rollout and use of HIV recency testing and eRegisters.

CSO representatives were given the opportunity to convene with other CSO representatives to put together a proposal for community-led monitoring (CLM) that can be presented at the COP20 Johannesburg meeting. CSOs believed that the goal of CLM is to improve comprehensive and quality health service delivery in all PEPFAR-supported sites in Lesotho. The two objectives were

to: 1) gather information and observations to provide feedback for improvement on quality health service delivery and 2) promote community ownership and leadership through engagement of independent CSOs and local community groups. They cited the following service delivery factors contributing to low retention rates in Lesotho: unfriendly service providers, stock-out of drugs and diagnostic tests, stigma and discrimination at the health facilities, and long wait times. They would like to: 1) assess quality and accessibility of health service delivery through the adoption of existing scorecards on community and AGYW; and 2) train expert clients on patient's rights, expectations, data collection, and reporting through hotlines. Information from the scorecards would be channeled to community committees, health center committees, DHMT meetings, stakeholder meetings, technical working groups, and PEPFAR POART meetings. This approach would involve collaboration with GF and existing scorecards from the LCN to avoid duplication. They proposed a mechanism where funding would be channeled through one independent CSO who would then subgrant to other legally registered independent CSOs.

After much deliberation and difficult discussions, it was decided that the funding mechanism for CLM would remain with PEPFAR small grants, as was stipulated in Lesotho's COP20 planning level letter. In addition, it was noted in the Johannesburg meeting that any CSO who is currently a prime or sub partner under PEPFAR would be barred from receiving a grant for CLM, the reason being that a CSO cannot monitor PEPFAR activities while implementing PEPFAR-funded activities at the same time. This limits many of the larger CSOs from receiving funding for CLM. PEPFAR Small Grants was therefore deemed the most appropriate mechanism for Lesotho since small CSOs or local organizations would be able to apply. Ten small grants would be made available to local originations and one grant for a CSO that can provide coordination and capacity building for those receiving Small Grants.

The draft COP20 strategic direction summary was distributed to all stakeholders prior to submission on 16th March 2020.

3.0 Geographic and Population Prioritization

As described above, a total of 207 treatment sites have been supported since COP18 with nearly all facilities having a minimum of 200 PLHIV on treatment. Supported sites accounted for 99% of persons currently on treatment in Lesotho.

Table 3.1 presents the current status of ART saturation and progress towards 95/95/95 across SNUs.

Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP20	# Current on ART (FY19)	# of SNU COP19 (FY20)	# of SNU COP20 (FY21)
Attained	N/A	N/A	N/A	N/A
Scale-up Saturation	335,440/100%	247,840	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

As of quarter 1 in COP19, PEPFAR Lesotho had not reached attained status for ART for any of the ten districts. However, results of the 2016-17 LePHIA show good progress towards the UNAIDS 90-90-90 goals with national coverage of 81% of PLHIV 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, making it difficult to accurately measure Lesotho's progress. The LePHIA is currently being repeated with preliminary results expected by July, which again should provide an accurate measure of progress. The goal in COP20 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.

In COP20, populations to be prioritized include adolescents/young adults and males as they currently have the lowest ART coverage rates. Efforts to reach these priority populations include HIV testing services (HTS) focused on self-testing and indexing and 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 HTS yield, linkage to treatment, and retention.

In COP19, PEPFAR is providing VMMC in the five lowland districts, with a target population of ages 15-29. Enhanced efforts will be made to provide VMMC to men who have already undergone traditional circumcision. Overall coverage as of COP19 Q1 was 59% for males 15-29 years of age, ranging from 38% in Mohale's Hoek to 72% in Maseru. The COP20 goal is to achieve 74% VMMC coverage among males 15-29 years of age in the five lowland districts supported by PEPFAR (GF provides support for VMMC in the five highland districts).

4.0 Client Centered Program Activities for Epidemic Control

4.1 Finding the missing and getting them on treatment

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 effective and sustainable case identification and strong linkages to ART to meet the treatment numbers in the PEPFAR supported sites for all sex and age disaggregates. HTS targets are back calculated to achieve a national ART coverage of 90% and 95/95/95 across all sex and age bands by SNU for epidemic control at the national level. In FY21, the PEPFAR Lesotho program will provide HTS to 166,098 adults and children to identify 17,191 new people living with HIV and link 95% to care and treatment services; resulting in an aggregate positivity rate of 10% (10% for adults, while the yield for children will be 2%). These targets were derived using the unmet ART need data by age, sex and district, factoring in yield by age and modality assumptions for the different populations and approaches.

FY21 HIV case finding approaches reflect a pivot in HTS programming to evolve with the country's changing epidemic. In FY21, the PEPFAR supported care and treatment implementing partners will be responsible for all HIV case identification and linkages to treatment to ensure minimal loss of patients through the cascade and ensure cost efficiencies in the program, building towards sustainability in the era of epidemic control. Community case identification will be limited to tracking of index contacts that are not able to come to the health facilities and/or prefer community-based testing. HIV self-testing will be used as an additional approach for index contacts that are not reachable by other means.

In FY21, 58% (men at 65% and women at 54%) of all cases will be from index testing, and only 17% from other PITC which will be highly targeted and based on risk. TB, PMTCT and diagnostic testing will be other entry points through which positives are identified. Index testing all new HIV positive and unsuppressed women living with HIV will be the main modality for identifying children living with HIV (CLHIV)- contributing 75% of positives, while other PITC contributes 15%, and the rest are identified through other approaches. Beyond index testing, intensive screening in malnutrition and inpatient wards will also be utilized to identify CLHIV at the facility level.

In COP20, the program will identify 6,848 men living with HIV nationally. Particular focus will be placed on young men 20-35 years of age and CLHIV in COP20 as informed by the treatment coverage gap in these groups. For male case finding, Lesotho's signature men's clinic model and other male friendly approaches which offer HIV services integrated with primary health care for men will continue to be fully utilized and combined with risk screening informed testing.

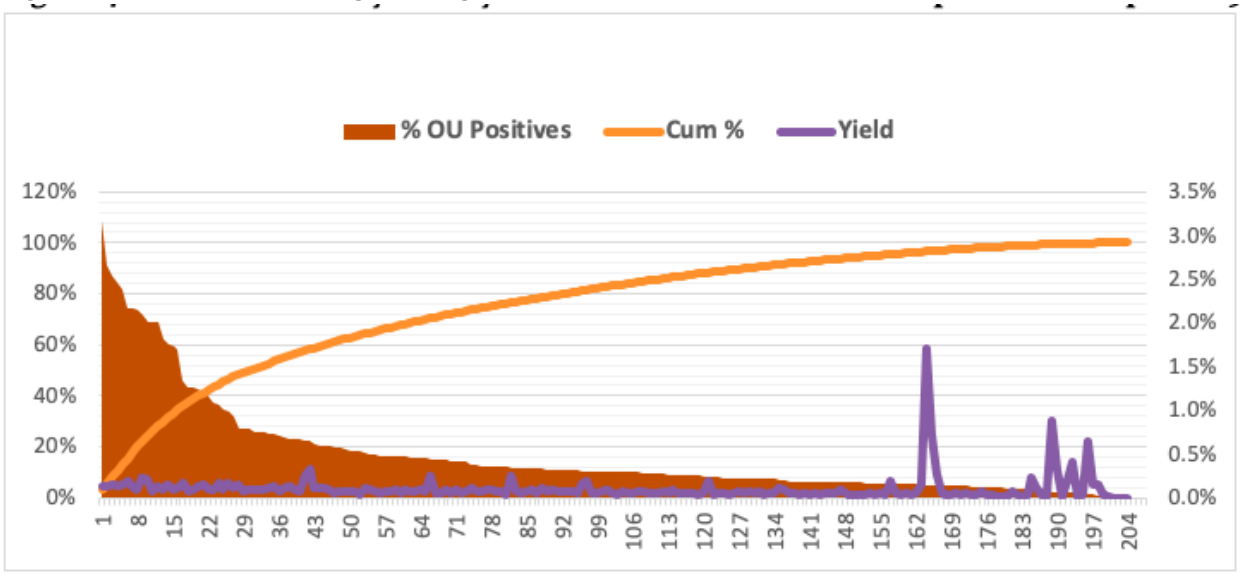
- Index testing: Health facilities have traditionally been successful in identifying mainly females living with HIV; these new female cases will be effectively indexed to reach their male partners. The program will use supportive client-centered approaches to enhance testing of partners such as assisted partner notification, transport reimbursement, flexible testing hours, and client-preferred testing venues.
- Self-test**:** Targeted primary and secondary distribution of HIV self-test (HIVST) kits will also be used to reach men who do not normally interact with the health system. Targeted community and risk and demand-based distribution at facility level will be intensified to reach men. For the adult population, a total of 165,743 HIVST kits will be distributed in FY21, with 88,827 among females (54%) and 76,916 (46%) among men. Among men, over 65% (51,729) will be distributed among men aged 20-39, a group that has the highest unmet need for treatment.
- Recency**:** Routine surveillance data from the recency testing program will be fully utilized to map hotspots for targeted HIVST distribution, index testing, prevention and other related services to target areas of new infections.
- Other: Intensive screening of TB suspects and cases will be another modality which will bring in 16% of the male HIV cases in FY21 while risk based PITC will contribute 17% of the new male cases.

Higher than acceptable volumes of HIV testing numbers continue to challenge the health system with a decreasing positivity rate as the country approaches epidemic control. The program has taken a data driven approach to develop and roll-out a risk screening tool in FY20, and this will be strengthened in FY21. Close monitoring of site level performance in FY20 will guide the program on sites that need to retain only diagnostic testing in FY21.

Testing volumes by site will be monitored on a weekly basis to ensure an increase in the positivity yield and decrease in the volume of testing numbers. All HTS partners will continue to report on index testing on a weekly basis to monitor trends and ensure scale and fidelity with the 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.

Figure 4.1.1 shows that as of APR19, 80% of Lesotho's HIV cases came from 45% (91 of 204) of the sites. However, the majority of the 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 through the use of the screening tool.

Figure 4.1.1. Site level analysis for yield and % contribution to OU positives in April 2019



In FY21, the PEPFAR Lesotho program will therefore make the following pivots in the case identification strategy to enhance case finding for underserved age and sex populations:

- Roll out and monitor the use of the risk screening tool to increase case identification in facilities
- Use site-level data to monitor yield and testing volumes for outpatient departments
- Scale up index testing and partner notification services prioritizing new positives and viremic clients to ensure an adult positivity of at least 20%, and contribution of 58% from index modality

- Scale up recency testing and integrate with the index modality to target recent infections and hotspots with relevant interventions including HIVST and PrEP
- Integrate HIV self-testing in all testing modalities and use it as a screening approach for low-risk groups such as in VMMC clients and other testing for prevention program.
- Support and collaborate with key stakeholders to promote community education and U=U messaging to increase acceptability for index testing and partner notification services
- Strengthen linkages to treatment through same day ART and physical intra-facility escorts

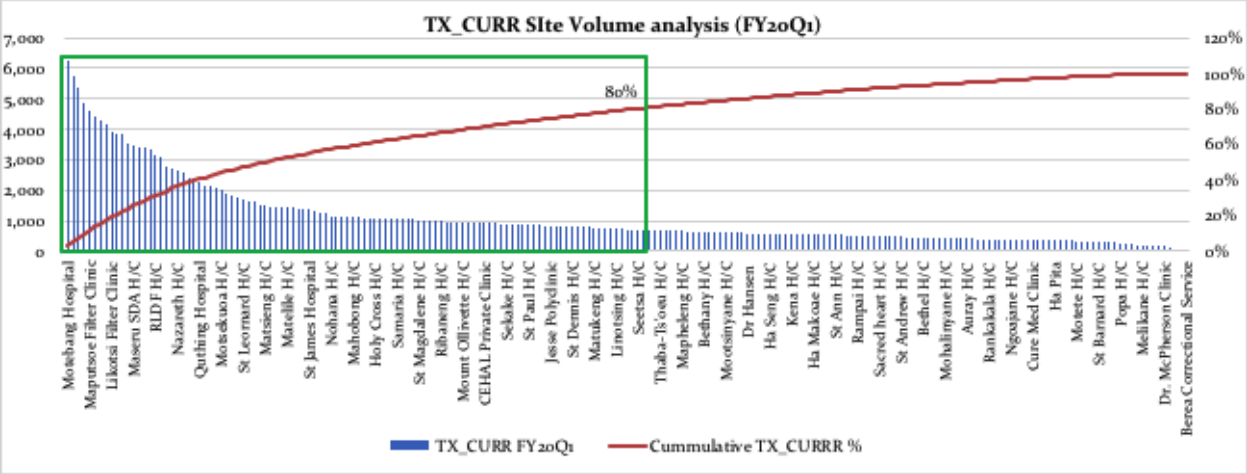
4.2 Retaining clients on treatment and ensuring viral suppression

The COP20 goal for retention is to ensure increased access to quality and client centered ART services to attain durable viral suppression, prevent HIV transmission, and improve the health and wellbeing of PLHIV in all sexes and age-groups. This is in alignment with PEPFAR/ Lesotho's strategic framework goal of ensuring HIV programs are accessible and responsive to the varying needs of Basotho so that they can lead healthy productive lives that are not disrupted by treatment and prevention services. As noted in section 2.2, the APR2019 results show treatment retention is affected by high attrition rates along the HIV clinical care cascade, with a total of 20,049 (8.8%) of those currently on treatment lacking clinical contact for more than 28 days. Treatment losses are highest among those aged 25-39 years (i.e. 68% of the total losses in men and 78% of the losses in women).

The FY20Q1 program results show that among PLHIV who did not have any clinical contact for more 28 days, 69% were lost-to-follow up, 14% were confirmed to have transferred out to another site, 12% refused treatment, and 5% died, (with more deaths recorded among those ages 50+ and 30-39). Among the LTFU, 14% are lost within <3 months of ART initiation and 86% are lost after having been on ART for >3 months. These results demonstrate increased need to tailor retention services to sub-populations with the highest attrition rates and strengthening service delivery to reduce LTFU, treatment refusal, and mortality. Successful retention of transfer-outs will also be fostered through continued provision of differentiated service delivery, including MMD for eligible beneficiaries.

PEPFAR Lesotho direct service delivery support at site level is limited to health units that have at least 200 PLHV on ART and a few specialized clinics that offer services for KP, prisoners, and tertiary institutions (see Figure 4.2.1 below). The COP20 site level support for improved retention will continue to focus on these clinics. Site volume analysis shows that 51.2% of sites account for 80% of the total FY20Q1 treatment results and these will be prioritized for scaling up the core client-centered retention service package that includes differentiated care, active tracking for re-engagement back in to care, integration of collaborative quality improvement to address site-level clinical cascade gaps, and community treatment literacy.

Figure 4.2.1. TX_CURR site volume in FY20Q1



The sections below provide core COP20 treatment retention priorities for different sub-populations that include newly initiated, viremic/unsuppressed, children and adolescents living with HIV, and stable adult women and men.

4.2.1. Newly initiated on ART treatment

The national policy guidelines for 2016 recommend Test-and-Treat for all people living with HIV irrespective of CD_4 cell counts. During COP20, the PEPFAR Lesotho program will focus on retention but continue providing same-day ART initiation for all PLHIV who are ready to start ART at facility and community levels. The program will continue to strengthen intra-facility and community-facility linkages to attain >95% proxy linkage through the use of linkage navigators and focal persons to escort clients to clinicians to initiate ART. The program will continue to provide integrated outreaches to increase access for hard-to-reach areas and health posts, and expand differentiated care for priority populations like men, children, adolescents, and youth through provision of client-friendly health care, flexible working hours (e.g. weekends, early morning or late evening), and one-stop shop-shop ART refills. Treatment retention will be strengthened through the provision of more efficacious ART regimens including DTG-based regimens and more optimized pediatric regimens, including LPV/r pellets.

Early retention will be fostered through counseling on ART literacy during the pre-ART initiation, counselor-led 7-day follow up, SMS reminders on clinic appointments, and linkage to Retention Case Managers that will provide adherence support and peer support on coping with a new diagnosis. Adherence assessments will be conducted at each clinic visit and enhanced adherence counseling will be offered to those who are at risk of LTFU. Active community tracking will be strengthened prioritizing those who are not ready for same-day ART initiation or those with a presumptive TB diagnosis to ensure access to treatment. Patients with advanced HIV disease will be screened to rule out Cryptococcal Meningitis or active TB disease to enable rapid ART initiation.

4.2.2. Unsuppressed or viremic PLHIV

The FY20Q1 results show that 4% (9,829) of the total adults and children current on ART are virally unsuppressed, with 65% being women and 35% men. Age-specific analysis shows that viremia rates are higher in those aged 25+ years who account for 80% of unsuppressed PLHIV, followed by adolescents and young people at 12%, and 9% in children <15 years. During COP20, all viremic PLHIV will be prioritized to intensified clinical monitoring at facility and community levels. PEPFAR will continue to support the national and district ART Advisory Committees who oversee and recommend the provision of more efficacious second line regimens for those confirmed to have treatment failure. Health care service providers will be trained on the management of unsuppressed PLHIV, including provision of enhanced adherence counseling, repeat viral load monitoring, ensuring timely evaluation for second line if no improvement.

Retention Case Managers will be allocated to each viremic client to provide ongoing adherence and retention support at facility and community levels, including appointment reminders and peer support to improve treatment literacy. Active tracking will be initiated on the day that the viral load results are received at the site to ensure clients return back to the clinic early to start enhanced adherence counseling.

Professional counsellors will be trained on the provision of age-appropriate enhanced adherence counseling, including caregivers of viremic children. The inter-partner collaboration of the OVC and clinical implementing partners will be strengthened to ensure all viremic children are linked to OVC case managers for additional socio-economic support at community levels. Sites with a high volume of viremic PLHIV will be prioritized to establish viremic clinics, including weekends to reach children, adolescents, men, and external migrants.

4.2.3. Children and adolescents

PEPAR Lesotho will support MOH to achieve >95% treatment coverage for CLHIV, initiate more efficacious ART regimens by age, and ensure viral suppression and retention in care. As of APR 19, program data shows low viral suppression rate and coverage for children and adolescents. Pediatric ART optimization will be fast tracked, with national strategies in place to improve CLHIV transition from nevirapine-based regimens from 38% to 100% during FY20. Viral load DBS roll-out is underway to address the unmet need for viral load coverage among children and adolescents. Clinically stable CLHIV and adolescents will be enrolled into differentiated service delivery including MMD and CAGs to support retention in care. MOH will facilitate focused group discussions with adolescents and young people to how services can be improved to address unmet needs and improve access and adherence.

The ANC sentinel survey 2018 revealed that adolescent girls aged 15-19 years account for 22% of ANC attendees, while those aged 20 -24 represents 33% of pregnant women in ANC. Therefore, PEPFAR Lesotho support to adolescent friendly health corners will be strengthened to support prevention and screening for HIV, STIs and TB and incorporate Operation Triple Zero (OTZ) into the already existing teen clubs and get children and adolescents more self-resilient and responsible for their own health. Children who weigh >20kg will be transitioned to DTG based regimen as soon as possible.

Children who are under the age of 10 and those who are not able to enroll into teen clubs/ OTZ will continue to have their age appropriate psychosocial (PSS) support groups which will meet on a monthly and quarterly basis. During the PSS group meetings children will also receive clinical services as well as viral load /DBS specimen collection so that they do not have to miss school during weekdays coming for clinical consultations. As a strategy to improve retention in children and adolescents the country will scale up DSD for children and continue to explore other means of getting health care facilities comfortable for them.

Caregivers who have challenges disclosing HIV status to their children will have trained health workers to support them during the disclosure process. There will be regular scheduled meetings of caregivers and health workers to train and refresh caregivers on the importance of ART, methods of treatment administration, reasons why it should not be stopped unless there are some clinical indications and address potential challenges which come with age and lifelong treatment and have them share the strategies that may work better under different circumstances.

Lesotho MOH with PEPFAR support will continue to coordinate clinical and supply chain implementing partners to ensure that the health facilities do not run out of recommended efficacious ART regimens and regularly review progress on pediatric ART coverage and retention in care. Children who experience challenges with adherence and viral suppression will be linked to the OVC program for continued support at the community level.

OVC Program

In COP20, the Lesotho OVC program has evolved and will focus on the key challenges for children in the epidemic specifically the pediatric treatment gap, the high rate of sexual violence against adolescent girls, and the risk to children posed by poor adult treatment retention and viral suppression rates. The leading priority for Lesotho currently is working on clear and confirmed collaboration with the clinical partners. This will be done through the signing MOUs, agreeing on shared confidentiality and working together on bi-directional referrals protocols to ensure full support on retention of children and adolescents in treatment and care

OVC community networks will help to find children who are infected with HIV (including those who are older and/or asymptomatic), but whose lack of routine contact with health centers makes them less likely to be diagnosed through traditional clinic-based HIV testing modalities. The OVC program is prioritizing the scale-up of index testing of biological children of mothers living with HIV.

To date (FY20) the OVC implementing partner (IP) has establish formalized partnerships with testing and treatment partners to rapidly increase the number of "well" children found and treated. The Treatment partners shared the list of CLHIV to the OVC IP, M2M through their mentor mothers also is linking the new mothers to OVC partner for household assessments for comprehensive OVC services. The Lesotho OVC program had enrolled 90% of all children living with HIV below 18 who are currently on treatment, and they are also being used as an index to the family.

In COP20, the Lesotho OVC IP, with its wide community reach and social protection expertise, will play a key role in ensuring that HIV-infected or HIV-affected children and their parents are retained in care through home visits that promote adherence to ART, accompaniment to clinics, and provision of socioeconomic assistance. Lesotho also prioritized the other four subpopulations to be served under the OVC program: the children of PLHIV, children of female sex workers, children exposed or experiencing violence, and HIV exposed Infants. The GOL through the Ministry of Social Development acknowledges the association of HIV and violence with orphan-hood and disability in Lesotho, and has included these groups in the priority subpopulations.

4.2.4. Adult women on ART

According to the LePHIA, (2016-2017) results, women have a higher HIV disease burden with HIV prevalence at 30.4% and service uptake shows 82% of women living with HIV know their status, 91% of those who know their status are on treatment, and 88% of those on treatment are virally suppressed. Treatment retention rates are low in women aged 25-39 years who account for 60% of net losses, followed by adolescent girls and young women (AGYWs) aged 15-24 years who account for 39% of total net losses in WLHIV (APR2019). Although the program has sustained high viral load coverage at 82% and virologic suppression rates of 95% among WLHIV on treatment, major retention barriers exist that are related to long waiting times, sub-optimal differentiated service delivery, lack of transport, sub-optimal knowledge on the benefits of treatment, and socio-cultural barriers (e.g. disclosure of HIV status, intimate partner violation/gender-based violence, stigma and discrimination). External migration has an effect on sustained retention especially for the 17.8% of women who report that they live outside of Lesotho, including 4.8% who live outside of the country for one month or more, (LePHIA, 2016-2017). Over 58.9% travel outside of the country due to work, mainly in the Republic of South Africa.

During COP20, the program will use a women-centered approach to address retention barriers among stable adult women. The program will continue to implement the revised national treatment policy guidelines by scaling up the provision of optimized ART regimens, (e.g. DTG, including women of reproductive potential to improve treatment retention, ensure sustained virologic suppression, reduce morbidity and mortality, and reduce the risk of HIV transmission).

Differentiated service delivery models to reduce long clinic waiting times and risk of LTFU will be scaled up through the provision of MMD, pharmacy fast-track refills, CAGs, and peer-supported drug delivery using mentor mothers to attain at least 90% coverage for all stable WLHIV. Three- to six-month MMD will be provided based on national ART commodity stock levels. Clinic appointments for stable adult WLHIV will be reduced to at least annually to ensure timely viral load monitoring. High volume clinics in urban or near border crossings will provide migrant-friendly services during the peak seasons of December and April for those traveling home from South Africa that will include extended working hours (including weekends), 6-month MMD, fast-tracking viral load testing and return of results. Enhanced adherence counseling will be provided at each clinic visit and during community peer support group sessions (e.g. CAGs and mentor-mother support groups) to enhance treatment and viral suppression literacy and address any knowledge gaps on treatment benefits.

Community-facility tracking for all missed appointments, defaulters, transfer-outs, and LTFU will be strengthened to enhance linkage back to care. Retention Case Managers that include Lay Counsellors, LENASO Focal Persons, and mentor mothers will be utilized to track both facility-community and inter-facility service uptake and all tracking outcomes will be updated in the tracking tools. All community tracking efforts will be informed by granular site data analyses by age- and-gender to identify clinical cascade attritions, and service delivery models will be adopted to match the reasons for defaulting treatment. Differentiated service delivery models will be maintained for those who are re-engaged back in to care, including welcome back messaging.

Socio-cultural barriers will be addressed through the provision routine intimate partner violence (IPV)/gender-based violence (GBV) screening in all service outlets (e.g. ART Clinic, PMTCT, OPD clinics, etc.) and training health care workers on the minimum post-GBV care package. The program will collaborate with existing community structures to strengthen health education on treatment literacy, U=U messaging, and creating demand for MMD uptake.

Integrated PMTCT, ART, FP, and EID services will be provided to all adult women of reproductive potential to reduce any retention barriers related to clinic transitions. Health care workers will be multi-skilled to provide client-centered services for mother-infant pairs with a greater focus on family centered care and clinic appointment spacing based on the HIV, obstetric, or child health care needs of program beneficiaries. Point-of-care viral load monitoring for PBFW will be provided to ensure 100% coverage of eligible women based on national guidelines.

4.2.5. Adult men 15+

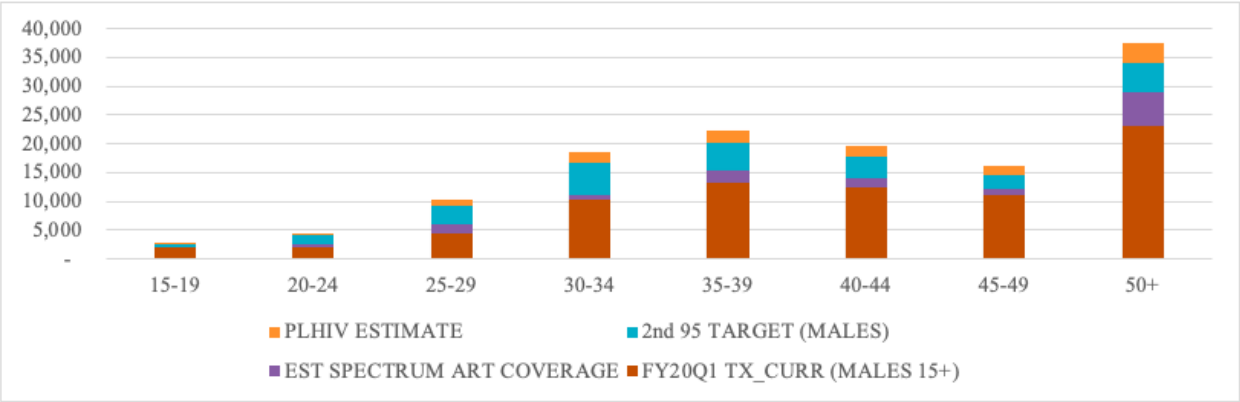
During COP18/COP19 Implementation, the program's treatment growth has remained flat since FY19Q1 for adult males due to the high treatment new net losses among adult males (TX_NET_NEW). The FY20Q1 treatment data shows overall net loss of 1,635 males ages 15+ between FY19Q4 and FY20Q1, with males aged 25-29 accounting for 65% of treatment losses for adult males aged 15+. At the end of FY20Q1, a total of 78,410 adult 15+ males were reported to be current on treatment. Estimated viral load coverage was 82% for all adult males aged 15+, but with 74% coverage among ages 20-34. Of the 57,514 adult stable ART adults virally suppressed (TX_PVLS, N) in FY20Q1, only 51% of the adult males were receiving MMD ≥3months, and only 5% were receiving a 6-month supply (see table 4.2.5.i). Community partners conducted a root-cause analysis for defaulting/LTFU ART patients and found 80% of LTFU could be addressed by scaling up MMD (i.e. patients reported being away from home, travel to South Africa, being at work, and transportation issues as primary reason for defaulting). Additionally, delayed scale-up of optimized ART regimens like TLD contribute to low VLS, especially among males aged 15-34.

Table 4.2.5.i. MMD coverage for adult males ages 15+

ARV Dispensing quantity	FY20Q1 Adult males receiving
ARV Dispensing Quantity - 3 to 5 months	26,251 (46%)
ARV Dispensing Quantity - 6 or more months	3,059 (5%)
ARV Dispensing Quantity - Less than 3 months	44,428 (49%)

Figure 4.2.5.ii presents ART coverage available from program data and 2019 UNAIDS Spectrum data against the 95% coverage target. Based on the recently updated UNAIDS Spectrum data, program data may underestimate ART coverage for males 15+. Lesotho's ART program data estimates ART coverage at 59% whereas UNAIDS spectrum data estimates coverage for males aged 15+ at 70%, with discrepancies largest among age groups 20-24, 25-29 and 30-34. However, the ART coverage for these age groups is still lower than other populations both by the ART program data and the spectrum estimates. This calls for innovative ways to return to care males aged 20-34 who are being missed to the program as well as identification of undiagnosed HIV infected males.

Figure 4.2.5.ii. Adult males ages 15+ ART coverage/treatment gap



Retention among this age group is key to achieve and sustain epidemic control and reduce new infections. For the remainder of COP19 and COP2020, PEPFAR Lesotho aims to improve retention among adult males, with special attention to ages 20-34, to greater than 95% and ensure that net losses do not account for more than 1% of the treatment program.

MMD

To address barriers identified by the community root causes analysis PEPFAR Lesotho will leverage MOH and GF investments to scale up MMD and fast-track refill models adopted at facilities to improve patient experience, with an aim to achieve >90% MMD coverage for stable virally suppressed ART adult males. To improve adherence, improve patient experience with ART and address low VLS among adult males, PEPFAR Lesotho will continue to monitor the MOH's TLD transition plan to ensure that it stays on course and a complete scale-up of TLD for all eligible adult males is achieved by the end of COP19. PEPFAR Lesotho will continue to track MMD scale-up and ART optimization by age and sex, with corrective actions promptly implemented. To address the low coverage, PEPFAR Lesotho will ensure that supported facilities develop and weekly track continuous quality improvement (CQI) activities focused on MMD addressing gaps identified using fish-bone root cause analysis.

Men's clinics

The collaborative effort between PEPFAR and MOH for establishing and scaling-up men's clinics have demonstrated convenient access to ART for adult males, peer support and stigma reduction by providing expanded hours for working males and a one-stop-center for the men's service package. Currently 26 Men clinics are active, with a goal to reach 35 active men's clinics by the end of COP19 and scale-up to at least 50 men's clinics in COP20. PEPFAR partners will continue to provide training to all facilities to ensure that providers are sensitized to provide adult men friendly services. PEPFAR supported sites will be required to continuously refine interventions based on feedback received from the CLM initiatives to address site specific challenges and enable providers to align interventions to the needs of the patients.

Facility CQI

Interventions to address retention at specific sites or districts will be guided by the nationally led quality improvement framework. During COP19, PEPFAR partners have been implementing "ART documentation surge" as part of retention continuous interventions to reduce documentation issues resulting into inaccurate counts. This has already demonstrated reduction in the net losses for both females and males. PEPFAR partners will continuously refine interventions to address emerging reasons for attrition using a CQI approach, root cause analysis and community monitoring specific to retention issues for adult men. PEPFAR Lesotho will ensure that all CQI initiatives are focused on client-centered care. Promising interventions will be reviewed during monthly meetings and POART meetings with key stakeholders and considered for scale-up.

HRH optimization

To return adult men back to treatment (estimated 14,000 adult men) and address other retention gaps described above, PEPFAR will conduct an HRH optimization exercise in COP19 to ensure that HRH support is aligned to retention and capacity strengthened for tracing and returning patients to care. Expert clients will be identified at men's clinics to provide peer counseling and promote retention. PEPFAR partners will implement interventions using the MenStar approach and framework (see table 4.2.5.iii). Staff with relevant skills working as lay counselor or focal persons will be repurposed to focus on retention and returning patients to care.

Health data

PEPFAR Lesotho is also supporting the scale-up and improvement of eRegisters to include the pharmacy module that would address documentation issues. Supported sites will routinely identify PLHIV who do not initiate ART the same day that they were diagnosed (not linked) and those who miss appointments using appointment registers, missed appointment lists, tracking logs, and LTFU reports from the Lesotho eRegister. Monitoring and reporting of tracking results into the national reporting system has previously been a challenge. It's expected that the scale-up of the eRegister with a functional shared health record (SHR) system linked with community systems will be scaled

-up to support the patient tracking initiatives and ensuring that tracking outcomes are routinely used to update the treatment program report.

CAGs

At the end of FY20Q1, 38,000 ART patients were enrolled in CAGs, with men representing 30% of CAG participants. CAGs enrollment will continue to be scaled-up for adult men to meet patient needs for peer psychosocial support. CAGs will be recommended specifically for virally unsuppressed males to support adherence and increase viral load suppression through peer counseling.

Table 4.2.5.iii. COP20 retention strategies aligned to the MenStar Approach and Framework

Descriptor	Who are they	Key Health care need	Key Emotional need	COP2020 Priority
Newly in Treatment	Newly initiated on treatment. First 90 days are critical.	A positive healthcare experience from day one	Support to incorporate treatment into his life	Peer Engagement Expand Men's Clinics at high impact sites. HRH optimization/re-allocate Expert men clients) Treatment literacy Messaging
Lost to Follow Up	Lost to follow up, including those who cycle in and out of care	Proof that the medication and the clinic/system have changed and will now meet his needs	Proof that it's "worth it" to give it another try	Addresses client needs related to expanded hours, stigma reduction, and long wait times. Peer engagement
Virally Suppressed	Engaged in treatment and virally suppressed	Convenient differentiated service delivery options	Continued access to support and a move towards the feeling that HIV does not define him	Differentiated Service delivery Models (DSDM) Scale-up 6months drug supply from current 5% to >80% for adult males

4.3 Prevention, specifically detailing programs for priority programming:

4.3.1. HIV prevention and risk avoidance for AGYW and OVC

The OVC/DREAMS implementing partner will coordinate with other clinical partners to facilitate targeting and referrals for HTS and treatment. OVC and DREAMS programming substantially overlap; OVCs needing DREAMS services will be referred for such services, which helps to foster synergies. The caregivers or OVCs who are found positive will be linked with other OVC services such as psychological support, household economic strengthening, social grants, and other social welfare services as necessary. 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

PEPFAR Lesotho will have coordinated DREAMS and OVC Meetings, DREAMS coordinator monthly meeting with IPs, monthly targeted supportive supervisions, monthly site Improvement

through Monitoring System (SIMS) and quarterly Data Quality Assessment. These monthly and quarterly check-ins are an important tool to manage partners and provide opportunities for improved collaboration, as well as, create platforms to share program experiences, identify programmatic bottlenecks, and map out strategies for collaboration and linkages.

OVC

The OVC program in COP 20, will implement the intergenerational framework, where two distinct but complementary strategies of (a)Comprehensive and (b) Preventative programming will be rolled out.

Time and resource intensive comprehensive programming will be reserved for children and their families with known high-risk characteristics including and especially HIV infection. For <2 children LTFU in PMTCT and CLHIV, the OVC program had already forged linkages with Clinical partners (i.e. MOUs, bi-directional referrals protocols, shared confidentiality, case conferencing and joint case identification) and intentional follow up at the household level will support adherence and retention. For child survivors of sexual violence, the OVC program will provide trauma counselling through an evidence-based curriculum (Trauma Informed Cognitive Behavioural Therapy), link children to statutory services (including removal by the Ministry of Social Development (MOSD) where necessary), and provide ongoing psychological counselling by MOSD professional Social Workers. Children of HIV+ FSWs will be enrolled and provided on-going home visits to continue providing comprehensive services. The OVC program will provide Community Linkage Officers to be stationed at the highest volume sites to help strengthen the bi-directional linkages between OVC IP's and Clinical IP's for children of HIV+ adults with chronic retention problems and low VLS. There will also be rigorous assessment to identify Primary caregivers to be enrolled in the OVC program together with children under their care to disclose and be provided with socio economic strengthening, nutrition, parenting and life skills building.

The second area of Preventative programming will provide evidence-based violence and HIV prevention interventions to the wider community of at-risk girls and boys during the critical window between ages 9-14 in high burden areas, particularly in areas where poverty and violence are endemic. For boys and girls, the developmental period of pre and young adolescence entails unique opportunities but also rising exposure to risks including sexual violence, particularly for girls. Because this group is "at risk" but does not have known risk exposure, the OVC program approach is different from the Comprehensive Program both in intensity and longevity. The main focus for this group is evidence-based programming that prevents sexual violence, delays sexual debut, and prevents HIV.

The OVC program will work towards ensuring that there is integrated overlap between DREAMS and OVC for girls and young women between the ages of 10-24.

DREAMS

AGYW ages 15-24 years account for over 25% of new HIV infections in Lesotho. There are widespread structural, social, and biological factors that contribute to the unique vulnerability of AGYW. 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.

In COP20, the DREAMS initiative will continue its implementation in the two priority districts of Maseru and Berea in order to reach 75% saturation. There will also be geographical expansion of DREAMS into two other high burden lowland districts, Mafeteng and Mohale's Hoek. GF will continue to implement DREAMS-like activities in the other 6 districts with increased resources focused on Leribe. 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. DREAMS will enhance the vulnerability criteria to ensure that DREAMS beneficiaries are AGYWS at highest risk for HIV acquisition through targeting those that have multiple sexual partners, experienced violence, have sexually transmitted diseases, no or irregular condom use, transactional sex, are out of school, and experience orphanhood. The risk assessment tool and enrollment forms will be updated to ensure that AGYW enrolled meet the vulnerability criteria.

Peace Corps volunteers (PCVs) will undertake DREAMS-like activities in their villages in all ten districts, including: primary and secondary school-based HIV prevention and sexual reproductive health and life skills curricula, OVC parent/caregiver training, and community-based economic strengthening. In addition, PCVs support 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.

Linkages and layering services: In COP 20, there will be a greater emphasis on linkages and layering and reducing over-testing among AGYW through increased risk assessment. HTS has been moved from the primary package to secondary package, with emphasis on screening AGYW for risk before testing. PEPFAR Lesotho will strengthen DREAMS linkages and referral to ensure proper layering of services from different implementing partners. This will be achieved through defining entry points and tracking referrals, bridging the gap between the community and facilities, engaging the community linkage officers who will be point of contacts for referrals from community and facility, and recruitment of full time DREAMS ambassadors to ensure clear referral mechanisms from community and facility for successful linkages. DREAMS and the OVC data system, DHIS2, will ensure interoperability between the DREAMS IPs to monitor and report AGYW_PREV and enhance layering through automated referrals, managing overlap between DREAMS and OVC, and tracking of both primary and secondary packages service completion for AGYW.

In COP20, the DREAMS program will pivot to enroll eligible AGYW 20-24 and provide them with the entire DREAMS primary and secondary packages, with scale-up of the socio economic strengthening activities and initiation of an education subsidy intervention. Enhanced Economic Strengthening Approach will prepare the AGYW for employment thorough gender specific training on financial literacy, savings groups, facilitating access to and acceptance in social and business networks, and issuing starter kits for some AGYW to start small business and obtain business licenses. The program will also facilitate paid internships with ongoing mentorship and support.

The comprehensive and layered services that will be provided for AGYW (9-24 years) through DREAMS 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.

PrEP: Through DREAMS, PrEP services (added in COP17 as a core DREAMS component) will continue for AGYW ages 15-24 in Maseru and Berea, implemented under PrEP community partner and for new districts the local partner that is implementing DREAMS will implement PrEP as complementary service to DREAMS services. The program will continue integration of FP and PrEP services; collaboration with high schools, tertiary schools, and factories; and use of peer volunteers, community voluntary advocacy, PrEP STARS and Generation Aspire.

GBV: 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. In COP20, the GBV Clinical partner will strengthen the integration of GBV and HIV services provision to do more on case identification across the HIV clinical cascade, particularly cases of intimate partner violence (IPV). This will ensure that GBV survivors are being identified and offered quality services in order to improve HIV outcomes. Robust strategies will address GBV and inequality across HIV Cascade by addressing IPV in the context of PrEP, index testing, and care and treatment (routine and clinical enquiry); providing post-violence clinical care services at HIV care and treatment sites; improving linkage between community-based HIV and GBV prevention interventions and clinical post-GBV care services; improving monitoring of GBV case identification, prevention, and response activities.

4.3.2. Preventing Mother-to-Child Transmission (PMTCT)

The MOH with PEPFAR support continues to implement the comprehensive package of PMTCT services which follows the cascade from the first antenatal care (ANC) visit through labor and delivery until the baby is 24 months old. This includes screening and testing for HIV and rapid ART initiation for those who test HIV positive. The main goal of the PMTCT program is to achieve virtual elimination of mother-to-child transmission of HIV. Since the adoption and roll-out of test and treat policy in 2016, program data shows that about 76% of HIV infected women in ANC come with

already known HIV positive status and are already on ART with most virally suppressed. The 2018 ANC sentinel survey results show a decline in positivity rate in ANC from 27.9% in 2016 to 22.8 % in 2018.

The first ANC service uptake remains high at 95%, and 76% of pregnant women have 4 ANC visits by the end of their gestation. HIV testing uptake remains high at 99%. Women who test HIV negative during their first ANC are periodically retested to rule out the possibility of sero-conversion before labor and delivery. The country will re-enforce integration of Pre-Exposure Prophylaxis for women who test HIV negative and are at risk for potential HIV infection. In COP 20 GBV services will be incorporated into the PMTCT program.

FY20 Lesotho plans to achieve >95% viral load coverage and close monitoring of PBFW and respond on time to those who are not virally suppressed. Currently the PMTCT program strives to improve viral load coverage from 37% in APR19 to >95% in APR 20. The Lesotho MOH will decentralize viral load testing for PBFW and their HIV infected children so as to reduce turnaround time of viral load results and improve timely management of patients who are not virally suppressed. Adherence to treatment will be monitored at every clinic visit. The country has adopted WHO recommendations for TLD based regimens and PBFW are included as group eligible for TLD.

4.3.3. Key Populations

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.[6] The FSW and MSM size estimates is 2.5% and 1.96% respectively of the adult female and male population aged 15 – 49 years (Lesotho 2016 Census). According to the results of the Biological Behavioral Surveillance Study (IBBS2) May 2019, FSW and MSM in Lesotho have an increased burden of HIV, as compared to other adults of reproductive age. Sixty–one to 74% of FSW and 80% to 92% of MSM reported having tested for HIV in the previous 12 months. HIV prevalence among MSM ranged from 7% in Mafeteng to 36% in Leribe, while FSW HIV prevalence varied from 39% in Butha Buthe to 60% in Leribe.

Technical considerations for COP20 are aimed at addressing gaps, improving efficiency, and ensuring the quality of HIV services. These include optimizing HIV testing and case finding through social and risk screening strategies. HIV self-testing will be scaled-up and social media and ICT platforms (Facebook, WhatsApp etc.) will be leveraged to reach hidden MSM networks. Additional community-based peer navigators will be recruited to enhance case finding. Enhanced peer outreach activities (EPOA) will be conducted on a routine basis across the supported districts as it has shown to yielding good results. The program will also expand use of one-stop-shop integrated

6 UNAIDS, 2012

service delivery models to other districts for improved service delivery of KP competent services and tracking of KPLHIV across the prevention, care and treatment continuum.

In COP20, geographical expansion of KP programming will target other community councils in Leribe (Sephokong) and Maseru (Mazenod). In addition, supply chain and logistics for condoms and lubricants will be improved by leveraging on the newly formed Directorate of Supply Chain in the Ministry of Health. LINKAGES will build local CBOs capacity for a sustainable and coordinated KP response in Lesotho with KPIF leveraged to support KP-Led and KP-competent organizations and to support the KP coordinator at the MOH.

In COP20, PEPFAR through LINKAGES, will support NAC to coordinate work focused on identifying and eliminating barriers directly faced by KPs, including structural barriers. Program approaches such as promotion of health-seeking behaviors, including consistent condom use, STI screening and treatment, regular HIV testing and access to PrEP, and treatment as prevention for KP living with HIV will continue to be implemented to ensure attainment of UNAIDS 90-90-90 targets in this population.

4.3.4. 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 medical circumcision. PEPFAR Lesotho is working with the GOL to scale up VMMC coverage to 80% among males 15+ years in the five lowland districts, where there is 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.

Beginning in COP20, the VMMC and community-based PrEP work will be implemented by a new partner, under a new performance-based contract. COP20 funding will support DSD at fixed and outreach VMMC sites, demand creation using cost effective strategies, salary support for health care providers and mobilizers, and procurement and logistics for reusable/disposable circumcision kits and other supplies. PEPFAR Lesotho aims to provide direct surgical service delivery to circumcise 20,000 men. This represents 60% saturation in the age pivot of 15 – 29 year in the five districts of Berea, Maseru, Leribe, Mafeteng, and Mohale's Hoek.

In COP20, PEPFAR Lesotho will stop providing technical assistance for early infant male circumcision (EIMC) to the Ministry of Health. Traditional circumcisions, most common among men over 20 years old, have a deep-rooted cultural significance in Lesotho. Medical/traditional male circumcision collaborations with traditional initiation schools will be scaled up to ensure males with prior traditional initiation circumcision receive VMMC. This initiative will be mostly scaled up in Mafeteng and Mohale's Hoek, districts with highest prevalence of traditional circumcision, and will be offered to all interested age 15+ traditional initiates at health facilities prior to the rite of passage ceremonies in the five lowland districts.

Project implementation will leverage mobile outreach surgical trucks to scale-up services for hard-to-reach populations and in hard-to-reach areas that have shortages of medical doctors. The mobile clinic initiative will increase access and coverage of VMMC services to rural areas that do not have access to a health facility, as well as to populations such as herd boys and farmers who do not have the time to travel to a facility due to their work. Mobile clinics will be used to provide extended working hours at outreach sites and a service delivery platform to male initiates who prefer to anonymously access medical circumcision for fear of community discrimination.

Demand creation strategies will be scaled up in COP20 to increase access to services, and include referrals from HIV testing sites and men's clinics, as well as the strategic engagement of faith-based organizations, workplace VMMC programs, and women and female community groups as champions. The program will also undertake time-limited campaigns in Mafeteng and Mohale's Hoek, where there is a high unmet need, to address the seasonal nature of demand. Program monitoring tools such as GIS and site capacity and utilization will enable teams to conduct community mapping, target community mobilization, monitor site productivity in real-time, and inform targeted demand creation among the age-pivot. The program will leverage on supporting performance based small grants/incentives to local community-based organizations for demand creation and linkages. Advocacy by community, traditional, and government leadership will also support demand creation. Peace Corp Volunteers and FBOs, working through their counterparts and with IP, 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 Lesotho will prioritize focused technical assistance on selected indicators to ensure quality of services and data for decision-making. Technical assistance for robust data and service quality will involve conducting SIMS 4.0, data quality assurance (DQA), external quality assessment (EQA), and CQI on a regular basis, as well as training and mentorship of site-based M&E officers, in the areas of data management and use. Above-site partner performance monitoring online tools which include Decision Makers Program Planning 2.0 (DMPPT), Site Capacity Utilization Analysis, and Site Performance Index will be used to monitor real-time focused age pivot impact, infections averted, and associated cost savings of VMMC services.

In addition, partner performance will be tracked through weekly reports and monthly site performance reports as well as mandatory quarterly performance presentations to the PEPFAR team to ensure the sites are performing at capacity. This strategy will provide a basis to refining programmatic approaches on an ongoing basis. 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 COP20 target of 20,000 VMMCs to reach 60% saturation among men 15 – 29 years in the five lowland districts.

4.2.5 Pre-Exposure Prophylaxis (PrEP)

In COP20, PEPFAR aims to provide PrEP treatment to 20,398 new and 21,418 current on PrEP beneficiaries, which include AGYW in DREAMS districts, sero-discordant couples and PBFW across all ten districts, and key populations in Berea, Leribe, and Maseru. PEPFAR Lesotho is working with the GOL to scale up PrEP services for AGYW to two additional districts of Mafeteng and Mohale's Hoek. The GOL has branded the national PrEP program and committed to procuring PrEP medication for beneficiaries as well as guaranteed access to infrastructure, such as laboratory services. The policy has not only resulted in increased access to PrEP services, but also geographic expansion of the program.

Family planning services and PrEP for PBFW will be integrated as part of the minimum package of service delivery. Additional three community resource centers will be established in Maseru (Maseru Central and Roma) and Leribe to increase access to PrEP services especially for AGYW and KPs. Event-Driven PrEP for MSM and MMD will be scaled up to improve PrEP continuation among the beneficiaries. Step-down trainings of health care providers will continue to expand PrEP service delivery to all high-volume health centers. In addition, the program will leverage on strengthened referral linkages from HTS and HIV self-testing, VMMC, family planning, STI clinics, adolescent youth corners, and sero-discordant clinics to increase PrEP uptake. This will be achieved by transitioning the program to performance-based projects and through continued support of staff salaries, DSD, HTS, risk assessment, demand creation, and CQI. Partner performance will be tracked through weekly review reports and mandatory quarterly performance presentations to PEPFAR. 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 on data management and use.

4.4 Additional country-specific priorities listed in the planning level letter

4.4.1 Community-led Monitoring (CLM)

As PEPFAR Lesotho confronts the emerging challenges of assuring retention on life-long ART in patients who may not view themselves as sick, collaboration with communities and patients is urgent and critical. This collaboration can help PEPFAR programs and facilities ensure they are providing quality services that beneficiaries want to utilize. Collaboration with community groups, CSOs, and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level. Most importantly, this collaboration can identify workable solutions that overcome these barriers and ensure beneficiaries have access to services. CLM should be initiated and implemented by community-based organizations and other civil society groups; networks of key populations, people living with HIV and other affected groups; or other entities that gather data and observations about components of HIV services, with a focus on getting input from recipients of treatment services. Through the use of quantitative and qualitative indicators, community

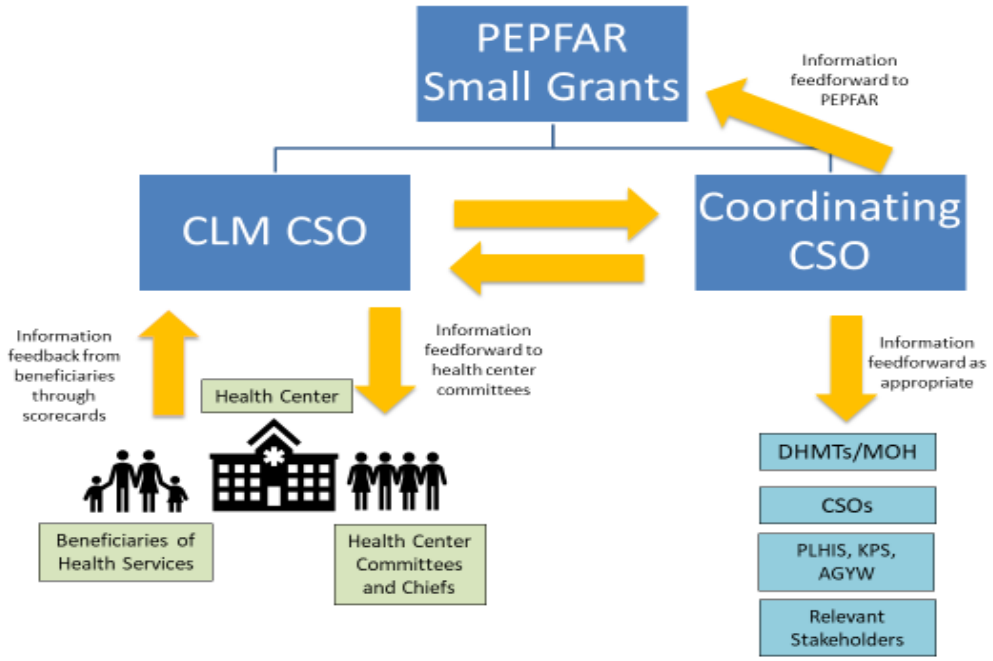
monitoring initiatives can monitor a wide range of issues that are associated with effective and quality HIV service delivery.

During COP20, PEPFAR Lesotho is required to develop, support, and fund CLM activity through the State Department's Small Grants program in close collaboration with independent, local CSOs and host country governments. Informed by discussions with CSO representatives in Johannesburg, PEPFAR Lesotho will make $250,000 available to fund CLM activities. This will allow for ten small grants of $20,000 each to be awarded to a local organization. A larger grant of $50,000 will be awarded to a CSO for coordination and capacity building of the local organizations receiving these small grants.

PEFPAR will be coordinating closely with GF to support the development of a CLM plan, with defined areas, good practices, and key indicators to monitor and provide feedback on access, acceptability, and quality of national interventions. A plan/roadmap will be provided to integrate CLM into current program and national systems in Lesotho, ensuring that community feedback is institutionalized across key program oversight exercises and review processes. GF is currently using the 2017 LCN-developed score card as a starting point for conducting focus groups in all 10 districts to develop an overall plan for AGYW community-based monitoring, including tools. The AGYW tools will then be leveraged into tools for KPs and general population iterations. This community scorecard would be made available by July 2020. To ensure consistency, GF plans to implement a CLM model similar to PEPFAR's in the highlands. PEPFAR-funded CLM can therefore be focused in the lowlands, resulting in larger reach within these districts.

Currently, there are 225 health facilities in the lowland districts. Each grant of approximately $20,000 would provide CLM activities to 20-25 health facilities. Each grant will specify the community councils or catchment areas to be targeted to ensure full geographic coverage of the lowlands. Scorecards will be administered to health facilities quarterly. Local organizations who are recipients of the grants will compile the data from these scorecards and deliver the results to respective health center committees and chiefs as well as the CLM coordinating organization, who will then deliver the results to PEPFAR (through the Small Grants Office), respective district health management teams and MOH as appropriate, CSOs, and other relevant stakeholders quarterly. Figure 4.4.1 presents the flow of information across stakeholders.

Figure 4.4.1. Community-led monitoring information sharing



4.4.2. TB Preventative therapy scale-up and HIV case finding

Lesotho aims to end TB among PHLIV through a combination of widespread ART coverage, early identification and treatment of TB, TB Preventive therapy (TPT) and effective infection control activities. TPT in combination with ART has been shown to reduce incident of TB among PLHIV by up to 89%. In September 2019, Lesotho MOH's National TB Program (NTP) released new guidance on treatment of latent TB based on WHO guidance. Historically, Lesotho has been using 6-months of Isoniazid (6H), but the updated WHO guidelines endorsed the use of three months of weekly rifapentine and isoniazid (3HP/12 doses) for adults and 12 weeks rifampicin and isoniazid (3RH) for children and adolescent <15 years of age.

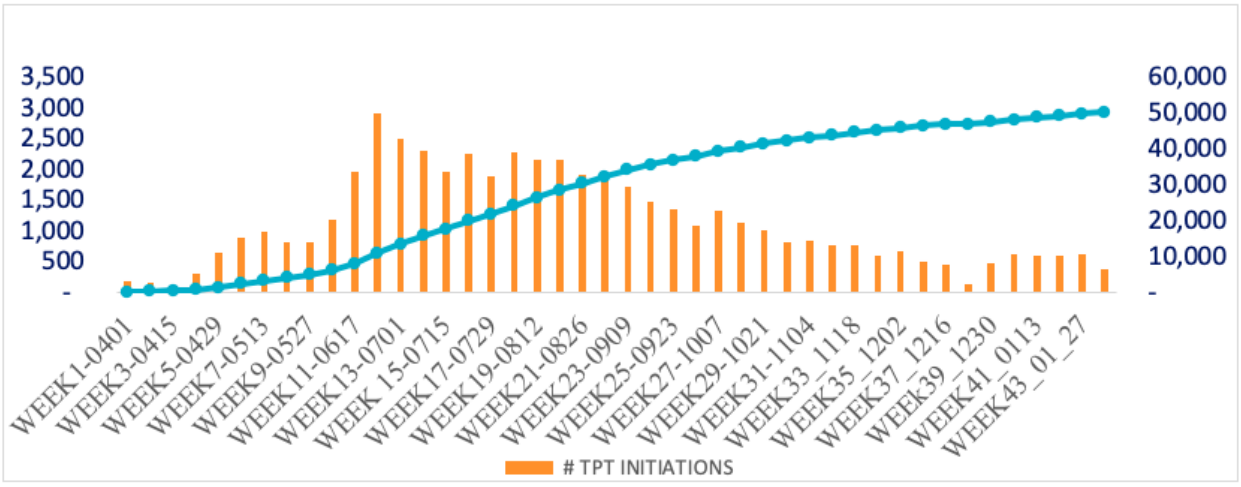
In the past, Lesotho faced challenges including chronic stock-outs/insufficient stock for INH, health care worker attitude and patient specific intrinsic barriers that negatively impacted TPT scale-up. In COP 18, PEPFAR Lesotho conducted patient chart reviews that estimated the historical TPT coverage at 50%. In COP18/19, MOH proactively availed enough stocks of INH and in April 2019 PEPFAR supported implementing partners began a TPT surge to ensure TPT is provided for all eligible patients currently enrolled in care (see figure 4.2.1). This resulted in over 50,000 patients being initiated on TPT with greater than 80% TPT completion rates. PEPFAR Lesotho expects to reach >75% TPT coverage in COP19/FY20 and 90% TPT coverage in COP 20.

In COP 20, PEPFAR Lesotho will support the implementation of Lesotho national guidelines by procuring 3HP commodities mainly for new adult ART patients and current ART patients who may

not have received TPT. PEPFAR will collaborate with MOH and GF to ensure child friendly TPT formulations are available. PEPFAR partners will continue to implement site-level CQI initiatives to address gaps in TPT data collection and reporting and ensuring that MOH data collection tools and eRegister capture TPT initiation and completion. PEPFAR partners will continue to support targeted site level trainings for health care workers and TPT specific job aides to support implementation based on TPT specific issues identified by site. PEPFAR partners will ensure that at entry in care and subsequent clinical interactions, all patients are screened for TB symptoms before initiation and during the TPT course. This will be captured on the MOH's TB detection register or the eRegister.

MOH HIV and TB program will need to provide guidance on the implementation of TPT in DSDM, including recording and reporting. In the current TPT surge, it has been noted that TPT coverage is low among stable PLHIV on ART and already in DSDM (3-6month drug supply or CAGS). Evidence show that TPT can be initiated and completed in DSDM. [7] PEPFAR clinical and community partners will ensure treatment literacy about TB symptoms and TPT side effects to enable less frequent clinical visits.

Figure 4.4.2. Lesotho Launched TPT surge April 2019 (Results-April 2019 to January 2020)



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 611 per 100,000 population (13,000 incident TB cases, out of which 8,400 are estimated to be TB and HIV co-infected). Lesotho has recently completed its first TB prevalence survey and results will be available in COP2020. Lesotho has committed to the End TB strategy and United Nations High-Level Meeting on TB (2018) targets

[7] Adapted from DifferentiatedCare.org "Leveraging differentiated ART delivery models for stable clients to scale up TPT"; Available at: http://www.differentiatedcare.org/Portals/0/adam/Content/3qTmUzah5kWCdeEogdiJ5A/File/IAS%20TPT%20supplement%208-Pager%20DIGITAL.pdf

and the GOL has policies in place to address TB and TB/HIV epidemics. However, implementation with fidelity and scale remained unsatisfactory in COP18/19.

During COP19/COP20 PEPFAR Lesotho is committed to support the MOH/NTP's "Effective TB Case Finding Strategies (ECFS) and Standard Operating Procedures (SOP) to Improve TB Case Detection in Lesotho". PEPFAR Lesotho with ensure that its investments at site level, district/DHMT and above site are directed to address identified gaps including sub-optimal TB screening activities at facility and community, underdiagnosis among children, major leakages across the TB diagnostic cascade, and poor TB treatment outcomes. During COP20, PEPFAR Lesotho will support NTPs efforts for active TB case finding leveraging MOH's recently acquired mobile units with digital x-rays to enhance TB screening and optimal diagnosis.

PEPFAR Lesotho will review the TB program data for last 24 months, triangulating it with the TB prevalence findings to map hot spots for TB and direct TB case finding interventions to these areas. PEPFAR Lesotho will integrate index testing activities with TB contact tracing and defaulter tracing to provide more efficient TB/HIV services. During COP19/COP20 PEPFAR Lesotho is conducting a human resource optimization excise to identify and plug all leakages in the TB diagnostic cascade with the appropriate skilled personnel and resources. PEPFAR will continue to support nurses at ART or TB clinics to ensure TB/HIV interventions are implemented with fidelity and to scale.

As Lesotho reaches epidemic control, some of the lay counselors will be repurposed for TB contact tracing, documenting the TB detection cascade at facility and in the community. 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. In additional PEPFAR Lesotho will provide TB diagnostics support (GeneXpert cartridges GXP, Cartridges, DST, TB-LAM), support TB Diagnostics Optimization, TB strategic information for TB (operational research, TB indicators, TB score card), guidelines development, job aides, and support supervision.

4.4.3. Implementation of Advanced HIV Disease package

In COP 20, PEPFAR Lesotho is committed to reducing mortality for PLHIV by providing differentiated service delivery for patients with advanced HIV disease (AHD). In COP18/19 Lesotho implemented the study "Implementation and Evaluation of Differentiated HIV Care and Treatment for People with Advanced HIV Disease in Lesotho" at two district hospitals, Berea Government Hospital and Motebang Hospital. The aim of the evaluation was to strengthen the program for PLHIV with advanced disease in Lesotho by training clinical providers and laboratory staff on the WHO recommended package of care for PLHIV with advanced disease, and implementing a differentiated care model. Advanced HIV Disease is defined as: PLHIV with CD4 < 200 cells/mm3 or in WHO Clinical stage 3 or 4 (applies to adults, adolescents and children ≥ 5 years of age). The WHO AHD package includes: (a) rapid initiation of ART (if there are no contraindications to ART initiation); (b) screening for co-trimoxazole prophylaxis; (c) screening for active TB disease and

prompt initiation of anti-TB treatment or IPT as indicated; (d) systematic screening for CrAg; and (e) intensive follow-up.

The prevalence of AHD among newly enrolled ART patients was estimated 28%, 51% had a CD4 of less 100 (CD4 results were available for 65% of the study participants) and mortality was estimated at 10%; males accounted for 57% of the patients with AHD. Critical gaps identified that will be addressed in COP19/COP2020 include (1) lack of critical commodities for AHD package (Stock outs of CD4 reagents, GXP cartridges, CraG test, stock out for basic tests like renal function tests, stock-out of critical pharmaceutical commodities like Amphotericin B and Fluconazole. Health care capacity for clinical, laboratory and pharmacy staff to manage AHD was also identified as critical gap.

For COP19/COP2020 PEPFAR Lesotho is leveraging other investments from MOH, the Clinton Health Access Initiative (CHAI) and GF to implement the WHO recommended AHD package. PEPFAR Lesotho will specifically support the development and training of multidisciplinary health care workers on the MOH's AHD manual, mentorship of health care workers, and development of related job aides like the algorithm for providing a package of care for people with AHD. To manage risk of AHD in children, PEPFAR Lesotho will support pediatric case finding and ensure that all children < 5years are started or transitioned to more optimized/effective regimens.

PEPFAR Lesotho will also support improved laboratory capacity/abilities for critical point of care tests like TB-LAM reagents, GeneXpert cartridges for TB diagnosis, and cryptococcal antigen test (CraG). Urinary LAM has not been optimally scale-up and is critical for optimal diagnostic results among very sick patients who may not be able to produce sputum. PEPFAR will support procurement of TPT commodities for all eligible ART PLHIV. CHAI is supporting catalytic procurement of CD4 reagents in COP19, critical pharmaceutical commodities including liposomal Amphoterin B and Flucytosine for treatment of cryptococcal meningitis. PEPFAR will support the MOH's health AHD phased scale-up of AHD management package to the 19 hospitals and eventually to all the lower health units including continuous quality improvement activities for AHD. PEPFAR Lesotho will support the strengthening of M&E reporting processes for AHD through updating eRegisters and related reporting tools. PEPFAR Lesotho is also providing support for viral load monitoring that is the primary method for monitoring response to ART.

PEPFAR Lesotho will leverage key MOH and GF heath systems investments like optimization of CD4 testing instruments include centralized CD4 testing and point of care based testing, basic tests like the full blood count, renal function tests and liver function tests that are critical for the management of patients with AHD. PEPFAR partners will ensure that all cotrimoxazole prophylaxis is prescribed for all eligible adults and children.

PEPFAR clinical implementing partners will routinely be assessed during program monitoring visits, SIMS and will be required to report monthly on the implementation of AHD package in the supported sites. PEPFAR will also track availability of critical commodities for AHD package implementation at national, DHMT and site level.

4.4.4. HIV Drug Resistance surveillance

The LePHIA 2016-17 estimated the transmitted resistance to ARVS in Lesotho at 11.4% with most mutation conferring resistance to non-nucleoside reverse transcriptase inhibitors (NNRTIs). During COP18, PEPFAR Lesotho supported an HIV Drug Resistance survey through CDC centrally supported mechanism. This was a nationally representative survey of acquired HIVDR in adults. Viral load suppression (defined as viral load <1000 copies/ml) among adults on ART was 93.4% in people on ART for 12 months and 92.1% those on ART for 48+ months. Preliminary analyses show a survey weighted prevalence of any HIV drug resistance among patients on ART of 3.23% and 6.9% amongst people on ART for 12 and 48+ months, respectively. All detected mutations were associated with resistance to reverse transcriptase inhibitors, and no PI resistance was detected among survey participants in both groups. The prevalence of NNRTI and NTRI resistances among individuals on ART with viral load ≥1000 copies/ml was significantly higher in those on ART for 48+ months (NNRTI: 88.7%, and NRTI: 79.7%) compared to those on ART for 12 months (NNRTI: 49.8%, and NRTI: 27.4%). The MOH in collaboration with Baylor also conducted a pediatric acquired HIVDR survey estimated in children receiving ART, results may available before the end of COP19.

Lesotho is currently scaling-up DTG-based regimen to all eligible adults and children. DTG has a high barrier to HIV drug resistance (HIVDR) and therefore virological failure among ART naïve patients is very rare. Lesotho is using TLD for both first- and second-line regimen. PEPFAR-supported HIVDR surveillance activities will mainly focus on patients failing on TLD. Samples for monitoring TLD resistance may be obtained from the viral load labs already established in the country and follow the applicable ethical procedures. PEPFAR Lesotho will no longer support conducting NNRTI based regimen surveillance, as Lesotho has already established prevalence and pattern of NNRTI related HIVDR.

4.4.5. Recency Testing/Case-based Surveillance

In COP18, Lesotho integrated recent infection testing into routine HIV services to detect, characterize, monitor, and intervene on recent infections among newly diagnosed PLHIV. This began in a phased approach with 24 sites under the Motebang hospital catchment area. Implementation started in August 2019 and results are reviewed every week at the TRACE Lesotho dashboard.[8] Results indicate approximately 20% recent infection among the newly diagnosed with the highest burden of new infections occurring among the 15-24 aged females (see figure 4.4.5.i and 4.4.5.ii.).

[8]DHIS2, https://dhis-ls-trace.org/dhis-web-dashboard/

Figure 4.4.5.i. Monthly recency trends Aug 2019-Jan 2020

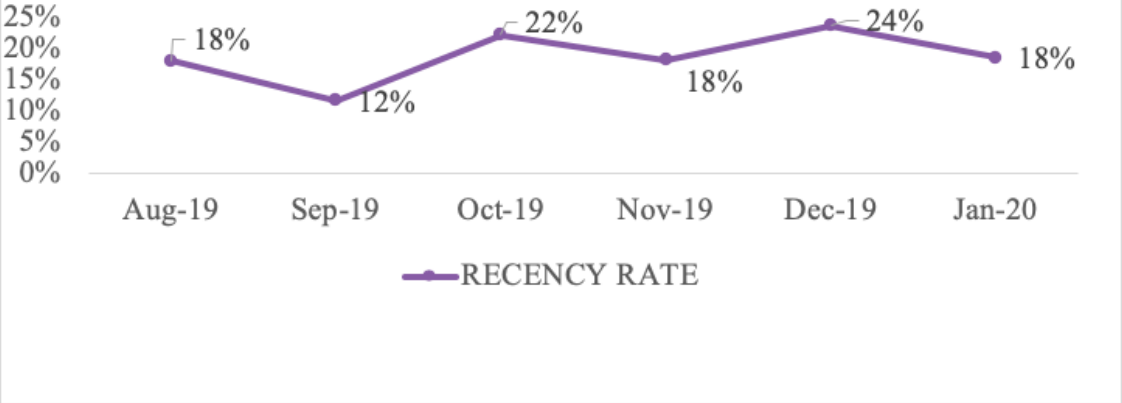
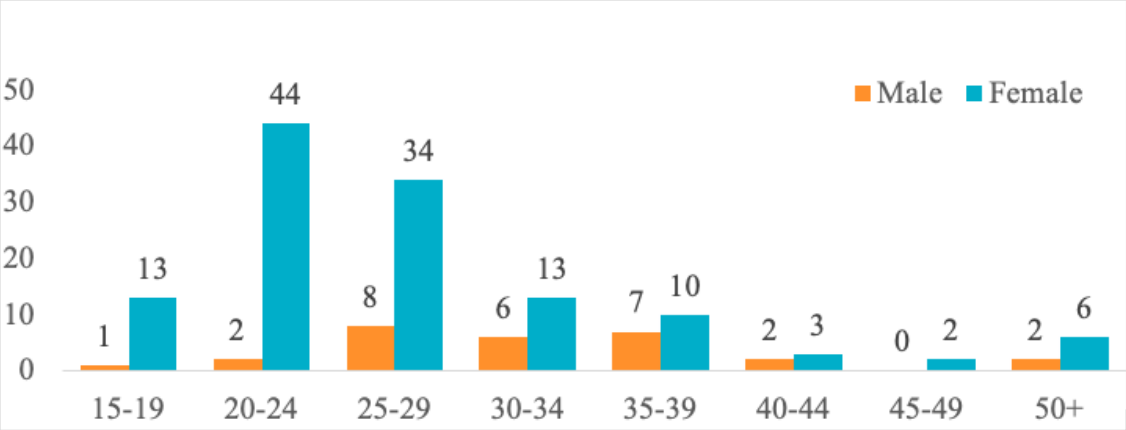


Figure 4.4.5.ii. Recency infections by age/sex, Aug 2019- Jan 2020



The COP19 recency scale-up plan is being reviewed to ensure the quality of implementation and the data standards are maintained during national roll-out, based on findings from the 24 pilot sites and the planned expansion to Berea and Maseru district. Intensive didactic trainings on the rapid test for recent infection (RTRI) and hands on practice are required for all the HTS counselors. For quality assurance and to ensure competency, all current HTS counselors performing RTRI have been certified; this will be a requirement as efforts are scaled-up. PEPFAR recency implementing partners and MOH have been collaborating to provide joint site supervision and CQI initiatives, and to routinely reviewing recency data to monitor trends and identify gaps. The weekly updated recency dashboard reviews focus on; 1) the number of recency tests conducted; 2) final test results by age, sex, location, modes of transmission, and time; and 3) to identify potential clusters of recent transmission on a map.

For COP 2020 PEPFAR Lesotho recency scale-up remains prioritized as Lesotho approaches epidemic control. PEPFAR Lesotho acknowledges that rapid scale-up may compromise the quality of the recency test performance, data quality and interpretation challenges. For COP 20, PEPFAR Lesotho will continue to focus on a phased scale-up ensuring that all required components are available before site expansion to assure quality and meet 100% recency testing for all newly

identified HV positives. PEPFAR Lesotho in collaboration with MOH, CDC HQ staff, and implementing partners will ensure training of trainers on recency testing to develop a pool of experts for scale-up that will be responsible for the step-down trainings and certification of testers/test providers. PEPFAR Lesotho will procure the required recency test kits for implementation and provider training and support recency monitoring activities to ensure quality of testing and test performance.

PEPFAR Lesotho will continue to work with CDC HQ, MOH and WHO on steps required for full integration of recency testing within the HTS program, including integrating recency testing in the official national HTS algorithm. In addition, PEPFAR Lesotho will work with MOH and relevant stakeholders to ensure recency data can be captured by the MOH HTS data collection tools such as the eRegister. In COP20, PEPFAR Lesotho will host recency data use workshops for stakeholders to review compiled recency data on a dashboards; disaggregated by gender, age, geography, and other key variables; show plausibility of recent infections based on epidemiology of transmission patterns in the country; and develop cluster response plans for specific hot spot.

Recent infection surveillance implementation is a collaborative effort including PEPFAR partners, MOH, and CDC. The CDC centrally-funded mechanism Tracking with Recency Assays to Control the Epidemic (TRACE) will provide technical assistance for CQI to ensure the quality of recency surveillance data, support development of national policy and guidance, provide training of trainers, develop dashboards for real-time review, and develop recency cluster strategies and other activities identified by the country team.

PEPFAR partner management during program monitoring visits, calls and monthly/quarterly meetings will focus on real-time aggregate recency data, coverage of recency testing for supported sites, identifying quality related issues, root cause analyses, and taking corrective actions in a timely manner to strengthen program performance. Reviews of expenditure quarterly will ensure that the program is being implemented cost-effectively.

4.5 Commodities

4.5.1. Commodities procurement and security

PEPFAR Lesotho continues to make steady progress and by the end of COP 19 (FY20), Lesotho is expected to achieve saturation in all 10 districts. 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. In addition, TPT, VMMC and PrEP commodities remain vital to ensure that patients don't contract TB and new HIV infections are averted.

Figure 4.5.1. COP 2019 PEPFAR Lesotho commodities budget

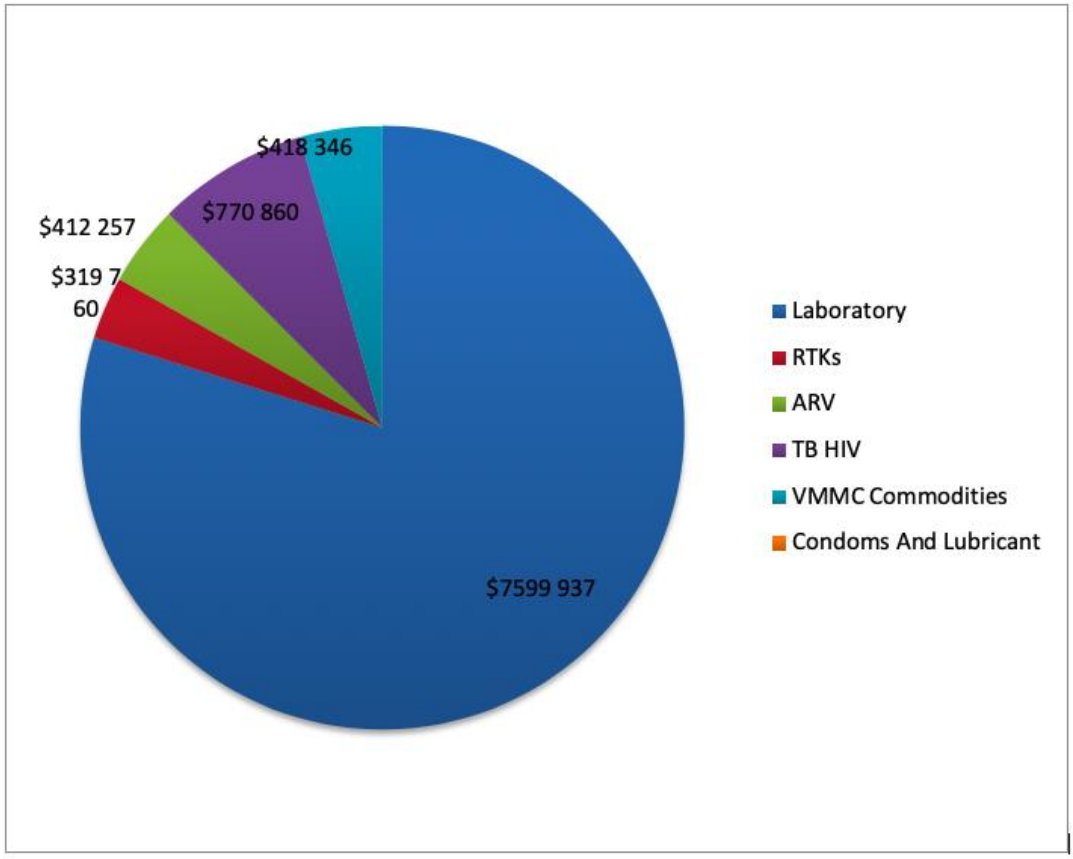


Figure 4.5.1 shows the COP 2020 commodities budget that PEPFAR has committed towards the HIV response in Lesotho. In FY21, PEPFAR Lesotho will spend $9,521,160 to support procurement of laboratory commodities, VMMC kits, HTS commodities and TPT commodities. PEPFAR has allocated sufficient funds for laboratory 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.

In FY 20, PEPFAR Lesotho's collaboration with the MOH, GF, Roche, Cepheid and other development partners to develop a strategy and plan to ensure commodity security resulted in resulted in no reported stockouts of laboratory reagents and consumables. In addition, the GHSC-PSM program is currently working with the MOH to provide procurement and contracting technical assistance to enhance commodity contract performance using key performance indicators (KPIs). The DSD provided by the district logistics officers (DLOs) has had an impact on commodity visibility and requisition orders from the site level to the central medical stores through the Informed PUSH, a supply chain management report and requisition 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. This support provided by

DLOs will continue in COP 20. Another high-level achievement in FY 20 is the official establishment of the SCMD. In COP 20 the Global Health Supply Chain Management (GHSC) program in collaboration with GF 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. The two cooperating partners will provide on a one-year secondment seven out of the 10 staff requirement to keep the new directorate functional. The Ministry of Finance has agreed and committed to taking over the staff costs in FY 2022.

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.

Table 4.5.1 FY 2021 Commodities Budget for MOH, PEPFAR & Global Fund

Commodity	MOH	Global Fund	GF Front Load	PEPFAR	Totals
ARVs-Adult + Paediatric	$30 546 969	$9 212 650*	$6 800 000*	$412 257	**$46 971 876**
HIV Test Kits	$0	$990 680	$0	$228 400	**$1 219 080**
Self-Testing Kits	$0	$222 400	$0	$91 360	**$313 760**
TPT Commodities	$0	$146 093	$0	$770 860	**$916 953**
Laboratory commodities	$1 231 411	$2 303 248	$0	$7 599 937	**$11 134 596**
VMMC	$0	$146 093	$0	$418 346	**$564 439**
Essential Medicines & Supplies	$6 720 932	$0	$0	$0	**$6 720 932**
Grand Total	**$38 499 312**	**$12 875 071**	**$6 800 000**	**$8 750 300**	**$66 924 683**

*Funds spent in FY 2020 to cover the ARV gap

Table 4.5.1 above shows the Commodities budget for the most critical HIV tracer commodities including essential medicines and supplies currently only supported by the MOH. The total HIV commodities budget for FY 20–21 is approximately $66,924,683 (LSL 1,003,870,245). Table 4.5.1 also shows that the budget has adequately catered for TPT, self-testing, VMMC, PrEP, ARVs optimization and laboratory reagents and consumables. PEPFAR will collaborate with both MOH and GF to ensure that commodity procurements are well coordinated using the National Commodities Supply Plan managed by the SCMD and with technical assistance from the GHSC-PSM. Based on the October 2019 commodity forecasting and quantification, this budget is adequate to support all HIV interventions and the associated COP 20 targets.

Specific to TPT, PEPFAR has budgeted for commodities to cater for 44910 patients including buffer stocks. The national TPT targets for FY 2021 show that Lesotho needs to cater for 74202. The difference between the PEPFAR budgeted clients and national needs is 29,292. With this identified gap, it becomes imperative that GF and MOH set aside funds to cater for the 29,292 patients. During discussions at the Regional Planning Meeting, GF confirmed their commitment to purchasing additional TPT commodities.

In anticipation of possible stock outs, PEPFAR has allocated buffer-stock funds for test kits (HIVST) and ARVs (PrEP medication (TDF/3TC)) as a stopgap 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. Specific to PrEP, PEPFAR has budgeted for buffer-stock commodities for 15,966 patients of the 21,937 possible PrEP clients. The buffer stock will be distributed once NDSO TDF/3TC stocks are below minimum stock-levels (less than 3 month of stocks).

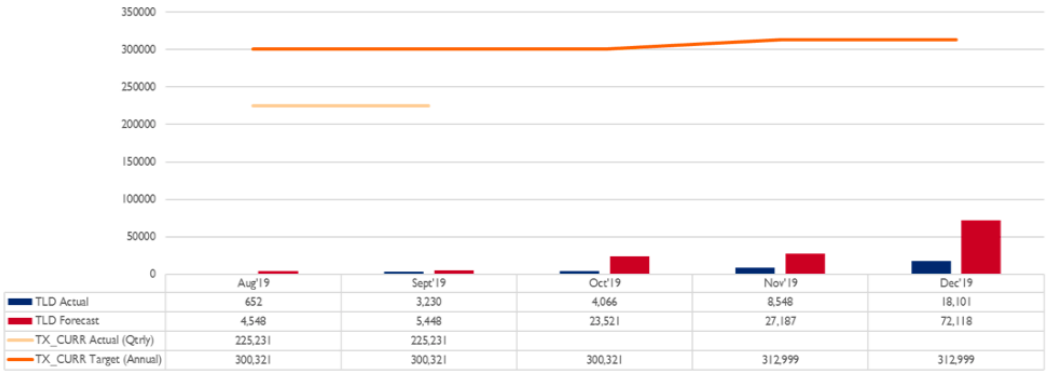
4.5.2 TLD Transition

Optimizing antiretroviral regimens can increase access to treatment and improve outcomes through impact on treatment adherence, viral suppression, and quality of life for PLHIV. This can increase 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 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 all 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 end of April 2020. 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 2020 to 2021 budgets.

Figure 4.5.2.i. Transition Progress and Plan



	Aug'19	Sept'19	Oct'19	Nov'19	Dec'19
TLD Actual	652	3,230	4,066	8,548	18,101
TLD Forecast	4,548	5,448	23,521	27,187	72,118
TX_CURR Actual (Qrtly)	225,231	225,231			
TX_CURR Target (Annual)	300,321	300,321	300,321	312,999	312,999

Figure 4.5.2.i shows TLD transition performance from August 2019 to December 2019. In all months presented, the actual patients initiated on TLD has been lower than the TLD forecast. This is primarily due to clinicians lack of clarity about the viral load requirements (6 months) and the chemistry base line tests. The Directorate of Disease Control has since written a memo clarifying criteria for transitioning patients and removing earlier barriers. By January 2020 the numbers of patients transitioned to TLD increased to 31,725.

Figure 4.5.2.ii. Forecasted consumption breakdown – key adult first line ARVs

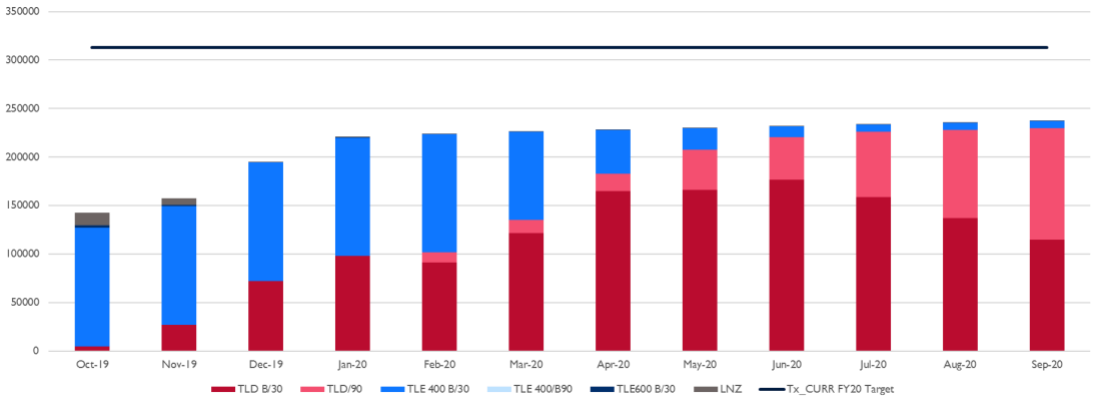


Figure 4.5.2.ii is a visual description of the ARVs optimization consumption patterns transitioning from TLE 400 to TLD 30 and later TLD 90 by September 30, 2020. By the beginning of COP 20 (FY 21), 80% of the adult patients currently on treatment will be on TLD 90 or TLD 180. With the GOL's commitment to providing 100% of the FY 2020 – 2021 ARVs, there should be a seamless effort to the provision of differentiated services for stable and suppressed patients.

4.6 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 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 monthly 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), and in particular, the 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. The agency activity managers have near daily interactions with partners by phone, e-mail, and/or in-person meetings and weekly reporting on key MER indicators by the clinical partners. PEPFAR Lesotho is working very closely with our new, local partners and have two dedicated partners to provide specific, tailored training and capacity building support in the areas of technical programming and organizational capacity. USAID also has begun a new system of high frequency reports that are submitted monthly and help monitor the minimum program requirements to discuss challenges and improve partner performance.

SIMS is another key component of PEPFAR Lesotho program monitoring. SIMS are done monthly and PEPFAR Lesotho ensures that all sites get visited at least once a year. There are also quarterly DQAs to ensure that site level data is complete and accurate. In combination with SIMS, PEPFAR Lesotho conducts routine site monitoring visits to take a more comprehensive look at challenges, help identify best practices, and address gaps in the clinical cascade.

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.

To ensure implementation of innovative strategies across the cascade, PEPFAR Lesotho is enhancing site level mentorship and training to enable rapid policy adoption and service quality

using multi-disciplinary district-based teams. The program is focusing on the minimum programming requirements at high volume sites that includes index testing, MMD, VL monitoring, TPT uptake & completion, and adult & pediatric ART optimization. PEPFAR Lesotho has institutionalized weekly site level performance reviews by site-, district-, and IP-levels to ensure proactive scale-up of PEPFAR care and treatment cascade priorities for linkage, retention, and viral suppression for all PLHIV. These reviews enable real-time course correction and ensure staff at all levels are jointly accountable for performance results. The COP20 cascade interventions that will undergo enhanced monitoring to ensure scale up with fidelity include expansion of differentiated service delivery, (including MMD), sustaining linkage proxy to >95%, and proactive tracking and re-engaging the LTFU back in to care to maintain treatment growth trends.

The PEPFAR program will continue to support the inter-partner collaborative efforts to strengthen optimization of key health system-related interventions that are critical to bridging cascade gaps. Specifically:

- The clinic-laboratory interface will provide opportunities to review whether site level demand for VL, EID, and TB/GeneXpert services meets the national testing capacity, turn-around time of results, and ensuring all sites meet the national QA/QC standards for HIV testing services.
- The collaboration of the clinical and supply chain partners will be strengthened to meet the demand for differentiated service delivery, ART optimization to more efficacious regimens and formulations, and bidirectional feedback on course corrections in cases of stock-outs or delayed commodity ordering
- PEPFAR will collaborate with GF and MOH to conduct an HRH inventory assessment to ensure that current national, district, and site level staffs are effectively optimized to meet critical cascade priorities for linkages, retention, re-engagement back in to care, and sustaining virologic suppression.
- PEPAR/Lesotho will continue to support the MOH in the roll-out of the eRegisters and utilization of the unique identifiers along the prevention and clinical cascades.

To improve quality and efficiencies of service delivery, continuous quality improvement will be integrated in all service outlets to ensure client-centered services are scaled up at community and facility levels. The program will support the training of service providers on CQI principles, developed QI projects based on prevailing programming gaps, and foster district level learning forum to share best practices that can be implemented to scale. During COP20, at least 90% of PEPFAR-supported sites will have a functional site QI team whose membership will be composed of facility and community level service providers.

Program efficiencies will continue to be fostered through implementing partner rationalization, provision of integrated services, and differentiated service delivery to increase case identification, linkage, retention, and treatment outcomes for underserved populations (e.g. flexible working

hours on weekends for children and adolescents in school, and one-stop shop service outlets for men).

During COP20, the community-led monitoring of treatment services will target sites in the lowlands to gauge whether providers at existing health systems offer rights-based, client-centered quality care that directly contributes to improved treatment outcomes. Community-based organizations and civil society will provide feedback from program beneficiaries to health unit management committees, PLHIV, Ministry of Health, PEPFAR, GF, and other stakeholders.

The eRegister is in use in 157 of the 172 health facilities in Lesotho that provide care for 90% of all people on treatment in the country. At the facility level the eRegister generates a unique ID as part of the registration process. This ID is linked to personal attributes and also has a facility code and serial number. In each person's record there are also fields for their National ID and ART number. At the national level the health information exchange (HIE) on the OpenEMPI client registry system generates a unique ID when the client is registered creating a global ID that matches their attributes.

4.7 Targets by population

The targets for the following three tables have been generated from DATIM:

Table 4.7.1 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY20)	Additional patients required for 80% ART coverage	Target current on ART (APR FY21) *TX_CURR*	Newly initiated (APR FY21) *TX_NEW*	ART Coverage (APR 21)
Attained						
Scale-Up Saturation	335,440	312,999	-	313,045	16,528	93%
Scale-Up Aggressive						
Sustained						
Central Support						
Commodities (if not included in previous categories)						
Total	335440					

Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (date)**	***VMMC_CIRC* (in FY21)**	**Expected Coverage (in FY21)**
Lesotho	Age of Focus: [15-29]	694,686	493,642	20,426	74%
	Total/Average	694,686	493,642	20,426	74%

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate (SNUs) and disease burden**	**Coverage Goal (in FY21)**	**FY21 Target**
AGYW	186,218	62%	114,852
KP_PREV	8,517	77%	6,599
PP_PREV	1,295,301	17%	222,926
TOTAL	1,490,036	23%	344,377

Table 4.7.4 Targets for OVC and Linkages to HIV Services		
Estimated # of Orphans and Vulnerable Children	**Target # of active OVC (FY21Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC***
197,599	92,352	69,491

4.8 Cervical Cancer Program Plans

Cervical cancer is a major public health problem in Lesotho, ranking 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 from cancer among women in Lesotho. The age-standardized incidence rate was 52.1 per 100,000 in 2018. Every year approximately 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% having had a screening test in the past 12 months (LDHS, 2014). WLHIV have a four-five times higher risk of developing cervical cancer compared to HIV negative women.

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. 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. 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 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.

Site-level implementation in COP18 entailed a phased approach at 35 high volume sites that offered "screen and treat" services to 25,584/37,000 (70%) WLHIV aged 25-49 years. Eligible WLHIV are screened within the ART and MNCH clinics using visual inspection with acetic acid (VIA), which is the primary screening method. Treatment for precancerous lesions is offered through the use of cryotherapy/thermo-coagulation and LEEP. During COP18, the PEPFAR Lesotho program established three additional LEEP centers (Queen II, Motebang and Mafeteng Hospitals), making a total of four LEEP centers, including Senkatana. Screen and treat services were enhanced through procurement of equipment and supplies, building on existing national stocks that are provided by the MOH.

During COP20, the PEPFAR Lesotho program will build on these gains to expand cervical cancer screening services to 59,147 WLHIV aged 25-49 years, which reflects 50% of the current on treatment (TX_CURR) target in this age group. The program will expand to sites that account for at least 70% of the WLHIV aged 25-49 years who are on treatment. 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. The PEPFAR Lesotho program will continue to leverage GOL resources to improve treatment uptake by using thermocoagulation. Site, district, and partner-level performance reviews will be conducted through monthly progress reviews, site-level visits for programmatic monitoring, and SIMS visits.

4.9 Viral Load and Early Infant Diagnosis Optimization

PEPFAR will continue providing comprehensive technical support to ensure timely and quality-assured TB/HIV diagnosis and patient monitoring services that will contribute to achieving epidemic control and attaining 95-95-95 targets. The support includes, but is not limited to, specimen transport, referral testing, results delivery, procurement and distribution of laboratory commodities, and continuous quality improvement.

In COP20, the technical support will focus on optimization and integration of both conventional 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, guidance and specific requirements including staff deployment, equipment placement, and VL/EID/TB reagent contracts will be fully implemented and/or strengthened. The implementation of laboratory network optimization and integrated services is expected to improve quality, efficiency and cost-effectiveness.

The program has mapped instruments and laboratory network with capacity and utilization. Specimen transport and laboratory network optimization is already operationalized as of FY20. Lesotho is using 6 Roche, 3 Hologic Panther, 15 mPIMA and 63 GeneXpert (61 GX-IV and 2 GX-VIII) instruments. The POC-EID instruments (15 mPIMA and 14 GeneXpert) that were rolled out separately have now been optimized and integrated across the program to support multipurpose testing services. With full implementation of laboratory network optimization, the unmet need will be addressed with no additional placement of new instruments. The provision of optimized and 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.

Scaling up of Viral Load (VL) monitoring services

By the end of FY20, VL monitoring is expected to cover 95% of eligible PHLIV on ART while in COP20, the coverage will increase to 100%. The strategies to achieve the targets include optimization of platforms, specimen transport, further decentralization of testing services, web-based timely result reporting, routinely monitoring performance, and improving quality of integrated testing services.

To increase the capacity of testing outputs by 25%, low throughput Roche instruments from two VL laboratories have been be replaced with high throughput instruments. In addition, 3 Hologic Panther with high throughput are expected to be operational before April 2020. The terms and conditions for instrument/reagent rental agreement have been revised to monitor performance of the service provider. DBS VL will be also scaled up to improve access to hard-to-reach areas where whole blood specimen collection and transport services are challenging.

The reference and all clinical laboratories will optimize the use of LIS to improve data flow between laboratories and health facilities and strengthen VL dashboard to support data analysis and visualization at the national level. SMS messaging and notification of patients and web-based result transmission (e-reporting) using LIS and DHIS2 will be scaled to all health facilities. This will substantially reduce turnaround time to less than 2 weeks, 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. In implementing POC-VL, guidance, protocols, and specific requirements including staff training, laboratory validation and biosafety are completed. POC VL testing service has already been piloted in five sites. This will be scaled up in additional health facilities where conventional testing services are not accessible and time-sensitive monitoring cannot be provided to PBFW and virally unsuppressed patients. Both GeneXpert and mPIMA platforms will be used for scaling up POC VL testing services.

With VL platform optimization and continued monitoring, PEPFAR Lesotho anticipates achieving 100% VL testing coverage of eligible PLHIV on ART. For VL reagents that include instrument rental and consumables, PEPFAR Lesotho has budgeted US$4,948,600, which is expected to cover 75% of the national need. The remaining cost is anticipated to be covered by GF. About US$627,800 has been allocated to cover specimen transport services, consumables and ancillary equipment. In addition, $250,000 has been allocated for laboratory personnel, training and technical assistance.

Early Infant Diagnosis (EID) Optimization

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. In COP20, PEPFAR Lesotho will continue providing comprehensive support including, procurement and distribution of commodities (cartridges and consumables), specimen transport, testing services, care and support, and QA/QI activities. In addition to the national Reference Lab, 29 health facilities will continue providing EID services. Using a hub and spoke approach, 200 health facilities will access POC EID services, which covers 80% of the country EID tests while the remaining 20% continue to be tested in the national reference laboratory.

In COP20, 95% and 5% EID testing will be provided using POC and conventional instruments, respectively. The implementation of POC EID will substantially improve coverage and all HIV exposed infants presented at MCH will be virologically tested. With DSD, PEPFAR will achieve virologic testing and linkage of care for 100 % of HIV exposed infants under 2 months. The overall turnaround time will be reduced to 1-2 days. Technical support including HR, supervision and M&E 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$536,250 for procurement and distribution of POC EID commodities, training and technical assistance. As part of the laboratory network optimization, the POC-EID platforms will be fully integrated to provide multiple testing services. POC instrument maintenance services will be included in the instrument/reagent rental agreements with the vendors.

PEPFAR Lesotho will continue to support MOH in all 10 districts to ensure that all HIV exposed infants are covered with prophylaxis and they keep up with the EID testing schedules while their parents are advised on the safest feeding options so as to protect them from getting infected during breast-feeding. Lactating mothers and their babies are kept as pairs MBP (Mother-baby-pair) in MNCH and they have the same clinic appointments. In cases where MBP missed the appointment, they will be reminded and tracked back to care to ensure that they are retained in care. Mother-baby-pair cohort analysis will be conducted annually and will evaluate the retention level within the PMTCT program. MBPs will graduate from MNCH to general ART when the baby is 24 months of age.

In Lesotho the EID schedule is aligned with the immunization schedule. Program data shows that the EID coverage within 2 months of birth is 94% with the transmission rate of 1.2% while the remaining proportion of HIV-exposed infants continue to present late for their first virologic test within 2 to 12 months. PEPFAR Lesotho will continue to support MOH to improve EID and follow these infants through the continuum of care until their final PMTCT outcomes are known and prioritize rapid ART initiation to those who are infected. Lesotho MoH will review PMTCT program gaps that result in some infections and strengthen the program processes and procedures to eliminate MTCT. The country has a sufficient supply of LPV/r pellets for children under the age of 3 years.

Optimization of GeneXpert instruments for multi-testing purposes

Lesotho is using GeneXpert technology for diagnosis of presumptive TB cases. There are 63 GeneXpert (61 GX-IV and 2 GX-VIII) instruments that will provide optimized and integrated testing services. In COP20, 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. 80% of the GeneXpert capacity will be dedicated to TB testing while 20% will be dedicated for POC EID and POC VL testing services.

As part of integrated laboratory support, PEPFAR will continue to procure TB lab commodities. In COP20, PEPFAR Lesotho budgeted US$951,500 for TB /GeneXpert cartridge, other TB tests and consumables. About $53,400 has been allocated for sample transport, training and technical assistance. GeneXpert instrument maintenance services will be included in instrument/reagent rental agreements with the vendor. The contract agreement is expected to be completed and implemented before the end FY20. Overall, PEFPAR's support is expected to cover 75% of the national testing demand while the remaining gap will be covered by GF.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Key systems barriers identified through SID 2019, 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, 3) poor data quality to track 95-95-95 achievements for sustained epidemic control and 4) limited technical capacity and coordination of the HIV program.

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

4. HIV and TB program administration

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 COP20. 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, 3) strengthen strategic information to ensure timely, complete, and accurate data management to inform programmatic planning and 4) provide technical assistance to the Ministry of Health for key ART and TB program minimum requirements.

PEPFAR Lesotho is currently investing in all the areas that it can to sustain epidemic control. Once the systems for laboratory, supply chain, health information and HIV/TB programming 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.

5.1 Commodity Security and Supply Chain

Commodity Security and Supply Chain

The State Office of the Investigator General's (OIG) August 2019 report classified supply chain management as the single most important barrier to the HIV response as Lesotho gets closer to epidemic control. OIG identified two general areas of concern regarding supply chain management:

1. Internal Control Challenges: Embassy employees described a weak internal control environment within the Government of Lesotho as a general concern. Specific challenges included poorly written contracts that did not include performance indicators or delivery milestones and the lack of an inventory accountability process at the central and local level. Weak internal controls, in turn, could facilitate waste, fraud or mismanagement of US-Government funded commodities.
2. Organization, Leadership, and Accountability: Embassy employees and a USAID funded study also cited ineffective coordination between the Lesotho Government organizations involved in commodity purchases. Late payments to vendors by the Lesotho Ministry of Finance and lengthy bureaucratic procurement processes were also identified as challenges.

OIG concluded that stockouts and low supplies of first-line ARV drugs and other commodities, even on a temporary basis, present risks to the PEPFAR program. Without a comprehensive understanding of the reasons for supply chain disruptions, the program risked not meeting the PEPFAR performance goals. Moreover, the program may not be able to ensure accountability for US Government funds provided for HIV/AIDS commodities procurement.

Between February 3 to 7, 2020, a joint mission between PEPFAR and the GF visited the Ministry of Finance (MOF), Ministry of Health (MOH) and Ministry of Public Service (MOP) with the objective of carrying out a root-cause-analysis (RCA) and developing a clear action plan to resolve the identified supply chain challenges.

A summary of the resolutions of the OIG recommendations includes the following:

1. The Government of Lesotho (GOL) committing to establishing the Supply Chain Management Directorate (SCMD) with the right compliment of staff.
2. The GHSC-PSM program to provide technical assistance for contract management practice within the SCMD.
3. The GOL to fulfill their pledge for funding 100% of the $31.5 Million (LSL470 Million) ARV budget.
4. The budget line for all commodities to be ring-fenced to a new cost center under the SCMD. The current practice of combining medical commodities and all others in one account called "purchases" doesn't guarantee security and access to the funds.
5. Both PEPFAR and GF have committed to second seven staff for one year to the SCMD in the FY2021, with a clear transition plan for all seven staff to be absorbed into the new MoH staff establishment. The secondment of these staff to the SCMD is in addition to the 12 District Logistics Officers currently supported by both PEPFAR and GF.

In COP20, technical support and capacity building will be provided to the MoH through the SCMD. DHMTs and the NDSO will ensure that there is a fully functional GOL-led HIV commodities and SCM system that can guarantee 100% security for all HIV-related commodities. PEPFAR Lesotho will continue to procure TPT, VMMC commodities, and for the first time PrEP buffer stock for all PEPFAR partners.

The COP20 supply chain management focus will be to ensure that standard operational procedures (SOPs) are developed and implemented to facilitate patient centered services. Furthermore, supply chain activities will support the scale-up and sustainability of differentiated service delivery models including MMS/D and CAGS.

The following are COP20 core activities:

1) Strengthen the collection, management and use of supply chain-related data for enhanced transparency and accountability of commodity ordering, distribution and final mile delivery. 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 within the DHIS II system. In COP20, the focus will be on monitoring that sites are effectively utilizing the data reporting platforms that include HIVST, 3-HP, TLD, DTG and TDF/3TC. In addition, the GHSC-PSM will also continue monitoring adherence to accurate reporting for 90 and 180 days MMD using the new daily tally sheets in dispensaries. The GHSC will also support mentorship programs for all sites having challenges accurately reporting through the new Informed PUSH system. In the short to medium term, the Informed PUSH will serve as the

key HIV commodity consumption information source for laboratory, ARVs, and TPT commodities. The GHSC-PSM will continue to work to ensure that the pharmacy and supply chain modules improve collection, management and analysis of HIV, laboratory, TB, nutrition, family planning and other essential commodities within eRegister. The GHSC-PSM program will also work with the DHMTs to design and collect commodities data for decentralized drug distribution (DDD) pick-up points. The information from DDD pick-up points will need to be linked to the eRegister and DHIS2 reporting platforms.

2) Strategically segment the supply chain to better reach unique patient populations more efficiently via different tailored channels based on their needs (i.e. delivering medicines to more convenient locations and pickup points that strengthen adherence and retention). As Lesotho gets close to epidemic control, the biggest emerging challenge is retaining all stable and suppressed patients on treatment. A root-cause-analysis carried out by EGPAF revealed that most patients who are lost-to-follow-up (LTFU), dropout due to inflexible work (employment) commitments. In order to ensure that the second 95% is achieved and maintained, the DDDs solution will be piloted in COP20 for both urban and rural patients. The GHSC-PSM will support the MoH and DHMTs to develop SOPs to ensure uniform implementation of DDDs. In addition, the GHSC-PSM will support the implementation and capacity building of MOH, DHMTs, sites and pick-up point operators.

3) Make progress towards reducing long-term dependence on donor funding and refocusing technical assistance to support countries assuming increasing responsibility for oversight of the supply chain as the principal stewards for commodity availability and security. The Government of Lesotho has for the past 5 years, shown political will and leadership by funding 70% of the ARV budget. In FYs 2020–2021, the MoF has committed to fund 100% ($11.5 million/M470 million)) towards ARVs. Lesotho still relies on PEPFAR (75%) and GF (25%) for laboratory reagents and supplies. In COP20, a sustainable financing strategy will be formulated to assist the GOL to absorb the laboratory commodity costs. The GOL will be encouraged to consider vendor managed contracts, to negotiate better terms with suppliers (pooled procurement) and to benefit from better terms negotiated by global and regional pooled procurement platforms.

4) Accelerate utilization of private sector capabilities and infrastructure, with near-term focus on warehousing and distribution, for operating the supply chain and for enhanced performance and increased visibility to the point of care. The GHSC-PSM has been working with the National Drug Services Organization (NDSO) for the last four years to improve transport management and efficient deliveries of HIV commodities to the last mile. In FY16, the GHSC-PSM supported the NDSO with transport network optimization technical assistance (TA) whose main objective was to rationalize the transport fleet and find ways of delivering commodities within schedule. Although improvements have been observed, this is one space where the NDSO could benefit from Third Party Logistics (3PL) partners in

COP20. This development would remove one burden from NDSO so they can concentrate on procurement and contract management.

5) Proactively monitor and mitigate procurement and supply chain related risk in COP20. Taking into consideration both PEPFAR and the GF supply chain OIG reports; it becomes imperative that the GOL takes risk mitigation seriously. During the joint root-cause-analysis (RCA) visit, there were recommendations proposed to reform commodity management across the whole Lesotho supply chain pipeline. A couple of items that require emphasizing include:

    1. Timely payment for commodity orders: in FY 2018 – 2019, delays in payment went beyond March 31, 2019, resulting in a shortfall of $9 million in the succeeding financial year (FY 2019 -2020). This situation led to a commodity gap at the end of FY 2019, which had to be covered by GF. The GHSC-PSM will support MOH to design a system for monitoring committed funds and ensuring that vendors are paid on time.
    2. Procurement and cash flow plans: the RCA revealed that the MOH struggles to complete and submit procurement and cash-flow plans to the Ministry of Finance and the GF. Since both the procurement and cash-flow plans are important and required documents by MOH, the GF and other donors, the GHSC-PSM will build the capacity of the SCMD to complete and submit these plans on time.
    3. The GHSC-PSM will support the MOH to put in place a supply chain quality assurance and improvement unit to ensure adherence to quality and performance standards within the supply chain management space.

5.2 Laboratory Service

The key system gaps in laboratory service were identified during site improvement through monitoring system (SIMS), a national assessment, and the sustainability index and dashboard (SID 2019) reports. There is still limited capacity in the expansion of diagnostic and monitoring services and improvement in laboratory systems. Challenges include, but are not limited to, lack of laboratory infrastructure, human resources, and lack of a national accreditation system to sustain quality of services. Based on the gaps identified, major activities with performance indicators and expected outcomes were described. In Table 6, laboratory network optimization, information system, continuous quality improvement, biosafety and waste management activities that are directly aligned with overall sustainable epidemic control priorities are described.

Investment in above-site programs including laboratory is critical to address the current programmatic gap in service delivery and long-term sustainability. Strengthening laboratory systems will improve access to HIV/TB diagnostic and patient monitoring tests and quality of testing services, which will contribute to achieving 95-95-95 targets. The goal of the laboratory system strengthening is to ensure accurate, reliable and timely TB/HIV diagnostic and patient monitoring services are provided. The strategies include 1) optimizing sample referral and

laboratory networks to improve testing coverage and turn around time for viral load, early infant diagnosis, TB and OI diagnosis, 2) improving quality of laboratory services through continuous quality improvement and accreditation of services, and 3) strengthening the laboratory information and M&E system for timely analysis, reporting and decision making.

Optimization of national laboratory networks

In COP20, PEPFAR Lesotho will improve the national laboratory network, optimize and integrate instrument utilization for multiplex testing. This is expected to increase efficacy and effectiveness of laboratory services and improve testing coverage for HIV/TB diagnosis and patient monitoring services. The country has already completed mapping of instruments and laboratory network optimization exercises. With the implementation of optimization and continued monitoring, the COP20 testing targets will be achieved.

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 (2 reference) and site level (18 district, 13 minilabs and all POCT sites) laboratories that support HIV/TB care and treatment services. The support includes, but is not limited to, implementation of quality management systems, human resources, above site and site level training, site supervision, biosafety and waste management activities, equipment maintenance and an inventory management system.

Guidelines and standard operating procedures will be updated for specimen transport, testing, biosafety, waste management, along with preventive and routine maintenance of laboratory equipment. An inventory of standardized equipment platforms will be strengthened. 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 down time 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.

A quality management system with the 12 elements of a quality system will be used as a working framework. Clinical laboratories and POCT sties will be enrolled in proficiency testing (PT) schemes for VL, EID, CD4, TB and other HIV related tests. The laboratories POCT sites will be assessed, and improvement monitored using the WHO AFRO Stepwise Laboratory Quality Improvement Process towards Accreditation (SLIPTA) or the WHO/CDC Stepwise Process for Improving the Quality of HIV-Related Point-of-Care-Testing (SPI-POCT) checklist. The key areas to be reviewed include process control, corrective actions and documentation, safety and management reviews. By the end of COP20, three reference and direct 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 have successfully passed leading to improved performance and overall quality of testing services.

Laboratory information systems and M&E system

The electronic laboratory information system (LIS) will be upgraded to generate quality data and reduce the turnaround time of test 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 the VL/EID dashboard to support data analysis, visualization at national level, and quarterly reporting of patient and test level data. To improve patient care, the current LIS will be integrated with DHIS2 and eRegister.

5.3 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. In COP19, PEPFAR has focused on improving and institutionalizing DQA mechanisms and assessments to improve DHIS2. There is interoperability with the eRegister (currently being scaled up in Lesotho) and DHIS2, to minimize human error and streamline data entry into DHIS2 for reporting. All HTS, care and treatment data is auto reported into DHIS2 for sites that have been certified to transition to a hybrid paper/electronic stage. The alignment of MOH and PEPFAR systems will be a priority in COP20 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, mentoring and strengthening data quality skills among staff.

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 have been developed in Lesotho using OpenMRS and OpenEPMI. The system was set up in 45 facilities in four districts in Lesotho with the HTS, ANC and treatment modules operational by the end of COP18. The design and beginning of a pilot for a health information exchange (HIE) platform was also put in place by the end of COP18. The system is designed to ensure that all HIV clients have unique identifiers and is supported by the Ministry of Health Health Management Information System (HMIS) strategic plan and policy put in place in February 2019.

In COP19, eRegisters are being 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 eRegister system making case-tracking and surveillance possible. A comprehensive eRegister consolidation and expansion plan will lead to the phased implementation of the eRegister to all the 127 sites while monitoring data quality entry and providing technical support for the 45 facilities already implementing eRegisters. An automated DHIS2/eRegister link exists for ease of reporting in the

system. In COP20 the pharmacy module will be implemented, and a lab dashboard will be operationalized. When the OpenMRS community releases the OpenHIE and biometric packages these will be scaled in Lesotho. During COP20 facilities will move from registering clients and achieving data quality (Stage 1) to reporting electronically and minimizing paper documents (Stage 2). Technical support for the country wide system along with mentorship will continue throughout COP20 as the eRegister becomes widely used and depended on.

LePHIA 2020

PEPFAR Lesotho will complete the second survey of the population HIV impact assessment (PHIA) in COP19. The survey began on December 5th and will end on April 8th, 2020 and has included participants 15+ years of age. The LePHIA 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 and 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 and whether people have accessed ARV treatment in South Africa. In COP20 we expect the first results to become available on World AIDS Day, 1 December 2020. Further analysis and report writing will take place through COP20 and will be finalized by September 2021.

5.4 HIV and TB Program Administration

Technical Assistance

Even though good progress has been made to link HIV patients to care and treatment services, there remains a need to provide technical assistance to the MOH HIV and TB programs to build ownership, management, technical leadership, and implementation of national HIV/TB clinical programming. Technical assistance will be provided in COP20 to build capacity within MOH to collect, analyze, and use program data to improve HIV and TB programs. Support will be provided to the government to update national HIV and TB program guidelines, including guidelines to help track the transition to optimized ART regimens for adults and children (TLD transition), TPT scale-up, granular site management, and use of DBS for VL. Technical assistance will also be provided for the coordination of program implementation and program performance monitoring. These activities will enhance the government's ability to effectively implement national HIV/TB clinical programs and increase ART coverage for HIV and TB patients in Lesotho. ART coverage as of FY20 Q1 was 75%. For APR FY20 we must reach ART coverage of 81% and attain and sustain the ART coverage of 90% in FY21 for all.

Critical for the success of the ART program is the implementation of the Lesotho national quality assurance and quality improvement framework to ensure that explicit quality management

practices including quality assurance and quality improvement activities are fully integrated into HIV and TB service delivery.

PEPFAR Lesotho will support the national HIV/TB technical working groups and district health management teams to ensure that CQI efforts are scaled up widely and routinely reviewed to support the monitoring framework. PEPFAR Lesotho will support the MOH's HIV and TB program to identify widespread barriers to and assist DHMTs or facilities to make changes to improve HIV and TB service delivery. CQI activities will be reviewed with the MOH HIV and TB programs on a monthly basis to advance an integrated and effective CQI program and culture for the TB and HIV programs.

Human Resources for Health (HRH)

As Lesotho gets close to reaching epidemic control and attaining the 95x95x95 targets, the human resources for health (HRH) mix must evolve from scale-up to a focus on retention and managing patients lost-to-follow-up. PEPFAR programs in Lesotho have maintained a similar staff compliment from COP15 to date. These staffing patterns will be reviewed to consider alternative service delivery models now being implemented. In COP20, an analysis of HRH working in the PEPFAR response, evolving from finding and initiating patients on treatment to one that retains them, will be completed.

The analysis of HRH will use new data collection tools developed and recommended by OGAC and the HRH technical team. The HRH inventory completed in FY18 in Lesotho was a preliminary look at the workforce in the program. In COP20 the program will collect more detailed information. The inter-agency team, with support from headquarters, will provide overall guidance in this process and will hold monthly and field support visits to ensure that the HRH support is right-sized and a transition plan to the government of Lesotho and other partners will happen at the right time.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

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: partner management, the administration and management burden of the PEPFAR business practices (such as SIMS, POART, COP, and SID), and the space limitations of the Embassy.

As of March 2020, PEPFAR Lesotho will have four vacant positions, all local hires. For State, the candidates for the Local Capacity Specialist position have been selected for interviews. Interviews should begin at the end of March 2020. For USAID, the two vacant local staff positions, Health System Strengthening Specialists and Care and Treatment TB Specialist, were approved in COP19. The PDs and all relevant documentation are with HR for processing and advertisement. They will

be advertised by the end of March. For CDC, the one vacant local hire position is a Senior M&E Specialist. This position will be filled in the second half of 2020.

In COP20, PEPFAR Lesotho is proposing two new local hire positions: one with Peace Corps and one with CDC. For Peace Corps, the current M&E and Small Grants Coordinator is being split into two separate positions. The current staff member will remain the M&E Coordinator and Peace Corps will recruit for a new Small Grants Coordinator to assist with the PEPFAR VAST grants and PCV reporting. The position is currently being developed and hiring should begin once the position is approved. CDC is proposing a local hire Lab Specialist; this position will replace the current USDH Senior Laboratory Advisor position that will become vacant in August 2021. The job is currently being classified with plans to have the recruitment begin in July and the position filled by October.

There are no large proposed changes from COP19 management and operation costs.

APPENDIX A -- Prioritization

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1. attained 90-90-90 by age and sex band to reach 95-95-95 overall

SNU	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) overall*																				Overall TX Coverage
				Treatment Coverage at APR by Age and Sex																				
				<1		1-9		10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Berea	COP 15	Scale-Up Saturation	APR 16	95%	43%	95%	43%	41%	24%	61%	71%	50%	46%	40%	49%	0%	0%	0%	0%	0%	0%	76%	65%	50%
	COP 16	Scale-Up Saturation	APR 17	95%	20%	95%	46%	40%	18%	62%	68%	95%	52%	53%	66%	0%	0%	0%	0%	0%	0%	79%	90%	64%
	COP 17	Scale-Up Saturation	APR 18	95%	85%	95%	89%	56%	27%	89%	89%	89%	89%	89%	89%	0%	0%	0%	0%	0%	0%	85%	89%	87%
	COP 18	Scale-Up Saturation	APR 19	44%	69%	74%	81%	76%	81%	71%	81%	35%	81%	43%	74%	53%	76%	66%	82%	74%	81%	66%	69%	76%
	COP 19	Attained	APR 20	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
	COP 20	Attained	APR 21	94%	94%	94%	93%	90%	96%	93%	####	93%	97%	93%	91%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Butha Buthe	COP 15	Scale-Up Saturation	APR 16	96%	36%	96%	36%	42%	53%	46%	34%	43%	16%	7%	14%	0%	0%	0%	0%	0%	0%	24%	30%	16%
	COP 16	Scale-Up Saturation	APR 17	64%	71%	95%	64%	87%	99%	74%	60%	30%	40%	34%	48%	0%	0%	0%	0%	0%	0%	80%	95%	52%
	COP 17	Scale-Up Saturation	APR 18	9%	5%	9%	5%	5%	5%	41%	41%	36%	27%	20%	29%	0%	0%	0%	0%	0%	0%	50%	55%	29%
	COP 18	Scale-Up Saturation	APR 19	67%	33%	63%	####	####	####	####	84%	42%	72%	29%	70%	36%	67%	50%	73%	65%	84%	74%	84%	111%
	COP 19	Attained	APR 20	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
	COP 20	Attained	APR 21	100%	100%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	94%
Leribe	COP 15	Scale-Up Saturation	APR 16	95%	39%	95%	39%	33%	14%	41%	58%	95%	46%	31%	41%	0%	0%	0%	0%	0%	0%	53%	71%	42%
	COP 16	Scale-Up Saturation	APR 17	95%	95%	95%	58%	62%	24%	66%	76%	73%	92%	47%	57%	0%	0%	0%	0%	0%	0%	75%	95%	60%
	COP 17	Scale-Up Saturation	APR 18	95%	85%	95%	85%	56%	23%	89%	89%	89%	89%	89%	89%	0%	0%	0%	0%	0%	0%	87%	89%	86%
	COP 18	Scale-Up Saturation	APR 19	24%	24%	65%	91%	84%	87%	79%	77%	58%	92%	41%	85%	57%	79%	63%	83%	67%	79%	57%	65%	83%
	COP 19	Attained	APR 20	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
	COP 20	Attained	APR 21	95%	95%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Mafeteng	COP 15	Scale-Up Saturation	APR 16	87%	40%	87%	40%	37%	24%	67%	75%	34%	42%	22%	26%	0%	0%	0%	0%	0%	0%	52%	66%	32%
	COP 16	Scale-Up Saturation	APR 17	95%	40%	95%	60%	61%	49%	71%	80%	26%	39%	33%	41%	0%	0%	0%	0%	0%	0%	74%	90%	46%
	COP 17	Scale-Up Saturation	APR 18	95%	83%	95%	83%	62%	42%	88%	88%	88%	82%	81%	84%	0%	0%	0%	0%	0%	0%	79%	88%	86%
	COP 18	Scale-Up Saturation	APR 19	8%	55%	67%	94%	84%	90%	70%	69%	46%	89%	42%	85%	49%	77%	64%	80%	67%	89%	66%	72%	88%
	COP 19	Attained	APR 20	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
	COP 20	Attained	APR 21	92%	91%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Maseru	COP 15	Scale-Up Saturation	APR 16	36%	13%	36%	13%	46%	27%	20%	34%	25%	14%	9%	15%	0%	0%	0%	0%	0%	0%	14%	19%	14%
	COP 16	Scale-Up Saturation	APR 17	95%	45%	95%	68%	86%	56%	77%	95%	82%	49%	41%	62%	0%	0%	0%	0%	0%	0%	98%	86%	61%
	COP 17	Scale-Up Saturation	APR 18	95%	97%	95%	97%	63%	36%	88%	88%	88%	88%	84%	88%	0%	0%	0%	0%	0%	0%	88%	88%	88%
	COP 18	Scale-Up Saturation	APR 19	44%	40%	63%	76%	90%	92%	89%	89%	57%	90%	88%	####	59%	76%	66%	80%	69%	80%	62%	69%	82%
	COP 19	Attained	APR 20	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
	COP 20	Attained	APR 21	93%	93%	93%	93%	92%	94%	93%	97%	93%	91%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Mohale's Hoek	COP 15	Scale-Up Saturation	APR 16	95%	35%	95%	35%	29%	18%	14%	38%	15%	28%	31%	23%	0%	0%	0%	0%	0%	0%	62%	95%	34%
	COP 16	Scale-Up Saturation	APR 17	95%	70%	95%	58%	61%	59%	47%	79%	30%	44%	34%	43%	0%	0%	0%	0%	0%	0%	88%	95%	50%
	COP 17	Scale-Up Saturation	APR 18	95%	87%	95%	87%	53%	37%	53%	88%	88%	77%	72%	64%	0%	0%	0%	0%	0%	0%	69%	88%	72%
	COP 18	Scale-Up Saturation	APR 19	27%	18%	66%	69%	52%	66%	58%	57%	19%	58%	36%	65%	34%	53%	39%	59%	47%	64%	51%	62%	60%
	COP 19	Attained	APR 20	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
	COP 20	Attained	APR 21	91%	91%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Mokhotlong	COP 15	Scale-Up Saturation	APR 16	52%	19%	52%	11%	28%	13%	9%	11%	6%	3%	1%	2%	0%	0%	0%	0%	0%	0%	2%	3%	3%
	COP 16	Scale-Up Saturation	APR 17	52%	19%	95%	55%	67%	46%	41%	51%	28%	18%	24%	27%	0%	0%	0%	0%	0%	0%	56%	65%	32%
	COP 17	Scale-Up Saturation	APR 18	27%	24%	27%	14%	11%	8%	35%	42%	50%	17%	29%	32%	0%	0%	0%	0%	0%	0%	39%	55%	32%
	COP 18	Scale-Up Saturation	APR 19	43%	50%	59%	85%	75%	60%	55%	62%	17%	53%	23%	44%	32%	53%	50%	65%	54%	70%	51%	68%	75%
	COP 19	Attained	APR 20	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
	COP 20	Attained	APR 21	100%	100%	94%	94%	94%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Qacha's Nek	COP 15	Scale-Up Saturation	APR 16	62%	34%	62%	34%	36%	37%	40%	47%	31%	42%	22%	31%	0%	0%	0%	0%	0%	0%	57%	72%	34%
	COP 16	Scale-Up Saturation	APR 17	16%	17%	95%	52%	64%	62%	46%	66%	42%	55%	22%	38%	0%	0%	0%	0%	0%	0%	76%	95%	43%
	COP 17	Scale-Up Saturation	APR 18	31%	6%	95%	40%	0%	0%	27%	25%	18%	25%	13%	17%	0%	0%	0%	0%	0%	0%	35%	46%	20%
	COP 18	Scale-Up Saturation	APR 19	20%	40%	53%	####	74%	####	70%	65%	21%	54%	16%	58%	34%	56%	41%	61%	55%	75%	60%	74%	89%
	COP 19	Attained	APR 20	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
	COP 20	Attained	APR 21	100%	100%	95%	95%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	94%
Quthing	COP 15	Scale-Up Saturation	APR 16	95%	38%	95%	38%	37%	13%	35%	61%	70%	52%	18%	24%	0%	0%	0%	0%	0%	0%	67%	86%	33%
	COP 16	Scale-Up Saturation	APR 17	95%	28%	89%	32%	29%	15%	37%	57%	58%	41%	18%	26%	0%	0%	0%	0%	0%	0%	55%	78%	31%
	COP 17	Scale-Up Saturation	APR 18	32%	16%	32%	16%	16%	5%	42%	61%	46%	34%	15%	24%	0%	0%	0%	0%	0%	0%	50%	68%	27%
	COP 18	Scale-Up Saturation	APR 19	14%	14%	63%	55%	53%	56%	44%	40%	16%	39%	14%	42%	19%	41%	26%	48%	34%	53%	45%	60%	52%
	COP 19	Attained	APR 20	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
	COP 20	Attained	APR 21	100%	100%	95%	94%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	94%
Thaba Tseka	COP 15	Scale-Up Saturation	APR 16	72%	25%	72%	25%	28%	19%	18%	23%	10%	19%	12%	21%	0%	0%	0%	0%	0%	0%	33%	39%	20%
	COP 16	Scale-Up Saturation	APR 17	24%	63%	88%	45%	50%	26%	34%	34%	22%	35%	25%	40%	0%	0%	0%	0%	0%	0%	61%	76%	39%
	COP 17	Scale-Up Saturation	APR 18	38%	19%	38%	19%	20%	16%	38%	46%	74%	49%	22%	30%	0%	0%	0%	0%	0%	0%	47%	49%	32%
	COP 18	Scale-Up Saturation	APR 19	0%	25%	4%	71%	58%	65%	54%	41%	25%	48%	27%	60%	40%	60%	54%	62%	62%	71%	57%	70%	63%
	COP 19	Attained	APR 20	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
	COP 20	Attained	APR 21	88%	88%	92%	92%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

APPENDIX B – Budget Profile and Resource Projections

B1. COP20 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP20 Budget by Program Area

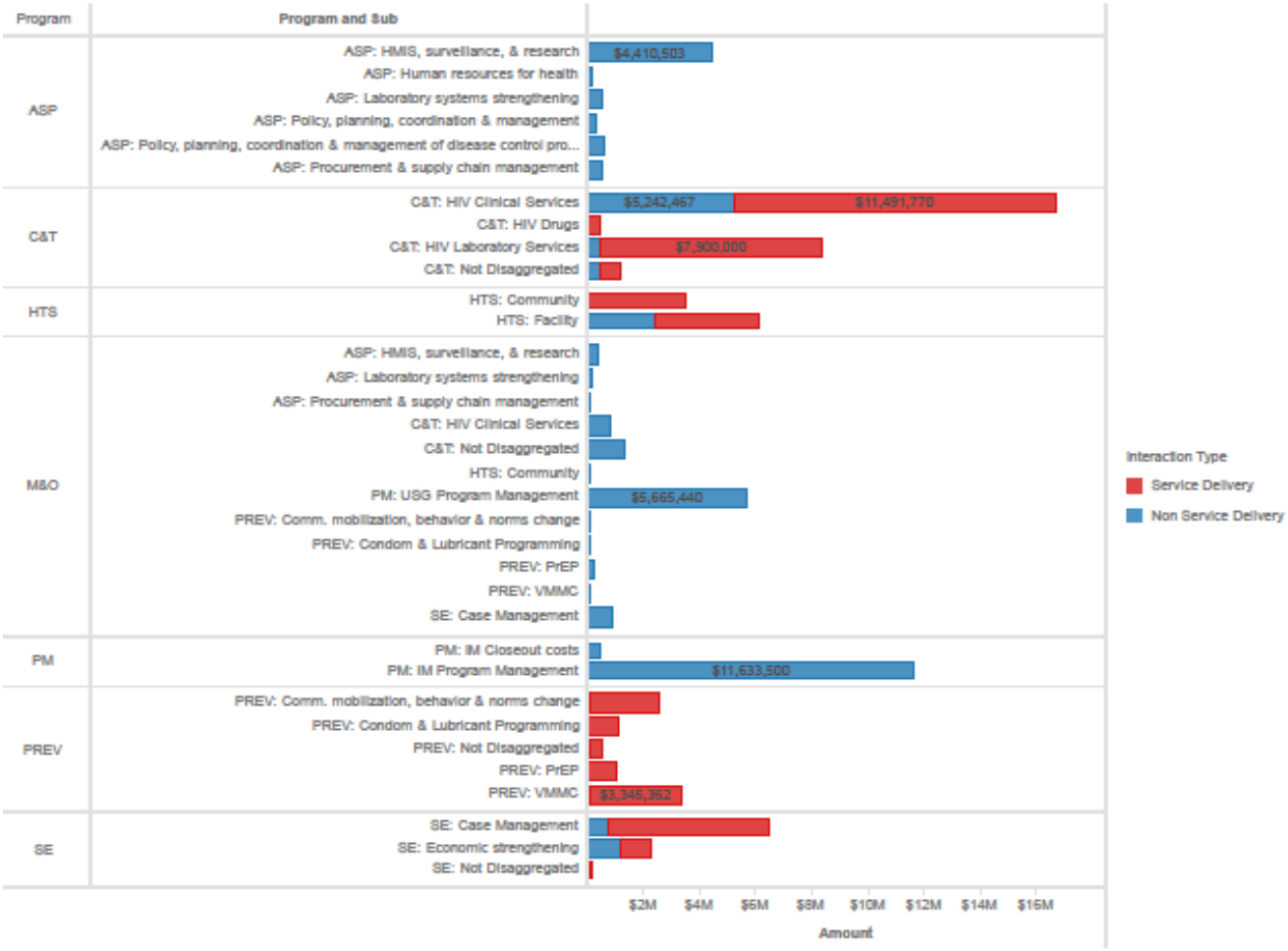


Table B.1.2 COP20 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$3,040,312	**$79,069,953**	**$82,110,265**

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$0
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$0
HVOP	Other Sexual Prevention	$6,570,277
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$4,203,760
HVCT	Counseling and Testing	$11,168,414
HBHC	Adult Care and Support	$0
PDCS	Pediatric Care and Support	$2,764
HKID	Orphans and Vulnerable Children	$11,660,004
HTXS	Adult Treatment	$31,529,046
HTXD	ARV Drugs	$0
PDTX	Pediatric Treatment	$0
HVTB	TB/HIV Care	$5,828,490
HLAB	Lab	$639,148
HVSI	Strategic Information	$1,903,877
OHSS	Health Systems Strengthening	$291,879
HVMS	Management and Operations	$4,790,213
TOTAL		**$79,069,953**

B.2 Resource Projections

Resource projections for COP20 budgeting were done using the COP20 Planning Level Letter, historic expenditures, and COP19 budgets as a baseline. COP20 budgeting used COP18 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 C – Tables and Systems Investments for Section 6.0

Table 6-E tab of the Table 6 and SRE Excel workbook

Table 6-E (Entry of Above Site Programs Activities)								
Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Interventio	Interventio	COP20 Benchmark
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget,	Weak supply chain	COP19	COP22	100%
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Weak supply chain	COP20	COP22	DDD SOPs developed, piloted, and implemented
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget,	Weak supply chain	COP16	COP21	Commodities Long-term Sustainable Financing Strategy developed and implemented
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Weak supply chain	COP20	COP22	Third Party Logistics Strategy developed and implemented
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget,	Weak supply chain	COP16	COP21	The Directorate of Supply Chain Management gazetted and staffed at the central level.
HHS/CDC	Trustees Of Columbia University In The City Of Ne	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Need for SRE Activities	COP18	COP20	Inclusion of recency testing into the national HTS strategy/policy
HHS/CDC	Elizabeth Glaser Pediatric Aids Foundation	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Adults	Surveillance	Need for SRE Activities	COP18	COP20	100% of all newly diagnosed receive testing for recent HIV infection.
HHS/CDC	Elizabeth Glaser Pediatric Aids Foundation	ASP: Policy, planning, coordination & management-	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service	Limited technical capacity and	COP18	COP20	1) Complete transition to TLD; 2) 85% TPT coverage; 3) 80% of the Index testing and APN services; 3)
USAID	Elizabeth Glaser Pediatric Aids Foundation	ASP: Policy, planning, coordination & management-	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service	Limited technical capacity and	COP18	COP20	1) 85% TPT coverage; 2) 80% of the Index testing and APN services; 3) 90% ART coverage by SNU, Sex

APPENDIX D– Minimum Program Requirements

1. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	• National VL platform expanded in Berea and Mohale's Hoek to meet 100% current demand for VL tests • POC/EID testing expanded to cover >80% of DNA/PCR tests for HEI • TB GeneXpert platform adequate to meet national demand • POC/VL testing for Pregnant and Breastfeeding women pilot started in February 2020 and phased roll-out planned to 13 sites by end of September 2020 • FY20Q1 results show 83% coverage of VL testing of patients current on ART • Instrument mapping and laboratory network optimization plan completed	• Expand VL platforms to meet demand for services • Consolidate gains made in COP19 in VL access, testing, and reporting • 100% VL coverage to all patient eligible for VL • Laboratory network optimization implemented and integrated POC testing services provided in 29 laboratories • Online referral and result reporting implemented and VL test turn around time reduced to < 14 days • 100% POC EID coverage with turn around time 1-5 days

2. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.	• Index Testing:
	  • National Roll-out: 10 districts, >300 PEPFAR-supported sites at facility and community
	  • Roll-out in all sub-populations by age and gender
	• HIV Self-testing:
	  • National Roll-out: 10 districts, >300 PEPFAR-supported sites at facility and community
	  • Prioritized sub-populations are men, AGYW, partners of index clients, KP, and partners of PMTCT women
		• Index Testing:
		  • Roll out to all PEPFAR supported sites (>300) community and facility
		  • Monitor coverage and fidelity of implementation
		  • 60% of HTS_TST_POS from index testing
		  • Review of the National tools to integrate IPV screening and monitoring in index texting services, including consent, and reporting of adverse events
		• HIV Self-testing:

		• Prioritized sub-populations are men, AGYW, partners of index clients, KP, and partners of PMTCT women • Strengthen monitoring and reporting
3. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	• National roll out: 10 districts at facility and community levels • PrEP is currently being offered to all HIV-negative clients at elevated risk of HIV acquisition • Revision of the National PrEP Implementation plan	• Consolidate gains in PrEP roll-out to all eligible clients and strengthen retention
4. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary	• Reducing risk for adolescent girls in high HIV-burden areas and for 9-14-year-old girls and boys with regards to primary prevention of sexual violence and HIV. • Providing support and case management for vulnerable children and adolescents living with HIV. • All three services are currently included in the OVC package, for both COP19 and 20. The OVC partner is now present in all 10 districts and is in the process of reducing risks for adolescent girls by expanding services that emphasize primary prevention of sexual violence and HIV into the 5 highlands districts.	• Consolidation of the comprehensive prevention and treatment service package for OVC ages 0-17 years and their household members • Support for OVC eligible for graduation

prevention of sexual violence and HIV.	• Actively facilitating testing for all children at risk of HIV infection.	
5. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.	• National Roll-out: 10 districts, 179 PEPFAR-supported sites • Roll-out in all sub-populations by age and gender	
6. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.	• CQI implemented in all 10 districts • Functional site level QI teams in over 85% sites • Over 200 CQI on-going projects based on clinical cascade data .	• Continue integration of QI/QA in all treatment sites
7. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	• PEPFAR's treatment partners have been disseminating U=U messaging at the health facility level.	• Treatment literacy and U=U messaging integrated in the MOH DSD guidelines
8. Clear evidence of agency progress toward local, indigenous partner prime funding.	• USAID: 3 local/regional recently awarded • CDC: Treatment and laboratory cooperative agreements moved into re-	• USAID: 1 Transition award for one of the local sub-partners to become a prime partner

	compete status, with a new award date of October 1, 2020 for both. In both instances, local applicants are being given preference points. The Notice of Funding Opportunity announcements were published on January 9, 2020.	• On-going capacity building of local IPs and their sub-partners • CDC: Activity mobilization of the new treatment and laboratory awards
9. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	• In recent years, as PEPFAR's budget for Lesotho has increased, the total funding towards the HIV response by the GOL has remained level. Funding from the host government decreased from 40% of the overall HIV budget in 2015 to 30% in 2019 due to increased PEPFAR investments.	• Share of the government's functional and financial responsibilities will be monitored through the biennial completion of the responsibility matrix
10. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	• Since their introduction PEPFAR Lesotho has been reporting the following MER indicators: TX_ML for HIV treatment outcomes; CXCA_SCRN and CXCA_TX for the secondary prevention of cervical cancer; and TB_PREV for the treatment of latent TB infections among people living with HIV/AIDS. • The cervical cancer program has been scaled up to all high volume sites during COP19, including 4 regional LEEP treatment centers.	• Procurement of thermal coagulators and LEEP equipment delayed the expansion of the screen-and-treat services, and this will be scaled up in FY2020.

11. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	• Phased roll-out of Recency testing to all 10 districts. • eRegisters rollout ongoing in 157 sites (the goal is 172 by the end of COP 19). In order to reach full functionality, IPs are currently working on feeding data from eRegisters at individual sites into a national, shared registry of unique identifiers and health records.	• Scale-up of Recency testing • Institutionalization of the eRegister system including expansion of the shared health record

APPENDIX E– Acronyms List

AGYW	Adolescent girls and young women
ANC	Antenatal care
ART	Anti-retroviral therapy
ARV	Antiretroviral
ASLM	African Society for Laboratory Medicine
BBSS	Biological Behavioral Surveillance Study
BRO	Boys Respecting Others
CAG	Community Adherence Group
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control
COP	Country Operational Plan
CQI	Continuous quality improvement
CSO	Civil Society Organizations
DBS	Dried blood spot
DDD	Decentralized drug distribution
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
DSDM	Differentiated Service Delivery Model
DTG	Dolutegravir
EFV	Efavirenz
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
MOF	Ministry of Finance
MOH	Ministry of Health
MOP	Ministry of Public Works
MOSD	Ministry of Social Development
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