

Lesotho Country Operational Plan

COP 2022

Strategic Direction Summary

April 2022



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***Military PSNU data are non-public**

A portion of PEPFAR data relates to foreign military sites, such as bases, barracks, or military hospitals. Data originating at these sites are aggregated to each respective OU's Military PSNU and are non-public. When developing graphics for the SDS, do not include the Military PSNU, which you can find in PSNU dropdowns in Panorama. These services may be funded through a variety of implementing agencies or mechanisms, so the Military PSNU designation is not equivalent to DOD as an implementing agency.

1.0 Vision and Goal Statement

Lesotho's Country Operational Plan (COP) 2022 is the culmination of work from the PEPFAR Lesotho interagency team in collaboration with The Global Fund, the Ministry of Health, and other stakeholders. The LePHIA 2020 demonstrated that Lesotho has achieved the UNAIDS 90-90-90 goals with 90% of people living with HIV (PLHIV) knowing their status; 97% of those who know their status on treatment; and 92% of those on treatment virally suppressed. Furthermore, according to the UNAIDS Spectrum estimates, Lesotho has reached epidemic control – the point at which new HIV infections fall below the number of deaths among persons with HIV. While we celebrate this achievement, we recognize the negative impact COVID-19 has had on the HIV response in Lesotho over the past two years. Nevertheless, LePHIA 2020 showed what the HIV response in Lesotho, with the support of PEPFAR, can achieve. By protecting its gains and ensuring treatment continuity, Lesotho will be able to recover and reach the next set of milestones, the UNAIDS 95-95-95 goals and 10-10-10 targets. With this context, COP22 will focus on maintaining epidemic control through the following three objectives:

- Mitigate COVID-19 impacts on PEPFAR programs
- Achieve UNAIDS 95-95-95 goals and 10-10-10 targets
- Consider strategies for transition and sustainability of the Lesotho HIV response

With COVID-19, many of PEPFAR's programs were either stopped, restructured or scaled-down to reduce the risk of transmission and protect the safety of both PEPFAR-supported staff and clients. Recognizing that many of PEPFAR's programs are also crucial to saving lives and preventing HIV transmission, Lesotho evaluated the risks and benefits and paused or restarted PEPFAR program activities as the COVID situation warranted. First and foremost, PEPFAR ensured that PLHIV were able to continue their treatment by scaling up multi-month dispensing and implementing a variety of ART delivery programs.

In COP22, PEPFAR Lesotho will aim to reach the UNAIDS 95-95-95 goals and increase investments in support of the UNAIDS 10-10-10 targets. There are still subpopulations, such as children 1-4 years old, young people, and men, who do not know their status and who are not on treatment. We will aim to target our interventions for case identification, utilizing methods such as index testing and HIV self-testing. To maintain at least 90% of PLHIV on ART, we will ensure continuity of treatment through client-centered services by continuing to scale up activities such as multi-month dispensing; decentralized drug delivery; virtual case management for tracking of those who missed appointments or have had interruptions in treatment; "return to care" package of services; and offering enrollment of 90% of children living with HIV (CLHIV) into the orphans and vulnerable children (OVC) program. In COP22 we will continue prevention programming for adolescent girls and young women (AGYW) through DREAMS; wrap-around services for OVC; and prevention programming for key populations. We will maintain voluntary medical male circumcision (VMMC) and pre-exposure prophylaxis (PrEP) programs. To decrease morbidity and mortality, we will scale up the package of services for those with advanced HIV disease (AHD); intensify TB case-identification; continue to scale up TB preventive therapy for PLHIV; and continue cervical cancer screening and secondary prevention. Finally, we will maintain our programs for sustainable systems and invest in laboratories, health information (i.e., eRegisters), supply chain, human resources for health, and building the capacity of local partners. Through ongoing investments in organizational capacity building of civil society organizations, implementation of social norms change work and a more holistic integration of GBV prevention and response for HIV social protection, HIV prevention and treatment programs, PEPFAR Lesotho will contribute to the achievement of the UNAIDS 10-10-10 targets.

In COP22, Lesotho will consider strategies for transition of the PEPFAR program to a more sustainable model. As one of six countries in the “Sustaining the Impact” initiative, we will work with the Government of Lesotho, Civil Society, Global Fund, and other stakeholders to identify opportunities for and challenges to sustainability.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Lesotho has a total population of 2,090,482 people, 51% of whom are women and 31% of whom are under the age of 15 and 15% overall under the age of 5.¹ 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 0.527² and a Gross National Income (GNI) per capita of \$3,151.³ Seventy-two percent of the population live in rural areas.

In 2022, the Lesotho Estimates Group determined that, due to the large number of Basotho accessing HIV services outside of Lesotho, the de facto population of 1,868,395, based on the 2016 Census, was the most appropriate for national estimates. The number of people living with HIV was 281,693, and the number of deaths related to HIV was 4,521. These updated numbers have been incorporated into the population-level estimates in the UNAIDS Spectrum model along with the 2020 Lesotho Population Based HIV/AIDS Impact Assessment (LePHIA) HIV prevalence and incidence and country 2020 program data. This model forms the basis for PEPFAR planning and is aligned with the LePHIA2020 results showing that Lesotho has achieved 90-97-92 for those 15 years and older. Prevalence among men and women ≥ 15 years of age was 22.7% in 2020. Prevalence varied from 18.8% in Butha Buthe to 24.0% in Mafeteng and from 17.8% in males to 27.4% in females.

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 COP22 with Prevention of Mother-to-Child Transmission (PMTCT), HIV testing, and HIV care and treatment. Voluntary medical male circumcision (VMMC) services will be supported jointly by PEPFAR Lesotho and Global Fund (GF), with services provided in the five lowland districts (Leribe, Berea, Maseru, Mafeteng, Mohale’s Hoek) by PEPFAR and in the five highland districts (Butha Buthe, Mokhotlong, Thaba Tseka, Qacha’s Nek, and Quthing) by GF. Key population (KP) activities will focus in Maseru and Leribe urban centers that border South Africa, where female sex workers (FSW) and men who have sex with men (MSM) are concentrated.¹

Lesotho was ranked second highest in the world for HIV prevalence and highest in incidence among people 15-59 years through 2019.⁴ The most recent estimated prevalence among people 15-59 years is 22.7%. However, HIV incidence has declined from 1.9% identified in the 2014 Demographic and Health Survey (DHS) to 1.1% in the 2016/2017 LePHIA and most recently to 0.5% in the 2020 LePHIA.

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 and in 2020 for pediatric patients. During COP22, Lesotho will continue to scale up index testing in health care facilities,

¹ Lesotho Population Projections 2016-2036, 2020

² UNDP, <http://hdr.undp.org/en/data>, 2019

³ World Bank, <http://data.worldbank.org/country/lesotho>, 2019

⁴ UNAIDS, <http://aidsinfo.usaids.org/2019>

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 COP22, Lesotho will consolidate and enhance the eRegister program and health information exchange in 178 facilities supported by PEPFAR with 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 maintaining 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. In COP22 the policy for electronic data usage will be finalized.

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 95-95-95 and 10-10-10 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 | 1,868,395 | 100 | 299,642 | 16 | 302,975 | 16.2 | 200,855 | 10.7 | 199,752 | 10.7 | 461,930 | 24.7 | 403,241 | 21.6 | 2021, Spectrum (derived from 2016 Census de facto population) |
| HIV Prevalence (%) | | 22.7 | | 2.6 | | 1.5 | | 8.5 | | 2.5 | | 27.4 | | 17.8 | 2020, LePHIA (25+ is 15+) Total prevalence refers to 15+ |
| AIDS Deaths (per year) | 4,521 | | --- | | --- | | --- | | --- | | --- | | --- | | 2021, Spectrum |
| # PLHIV | 281,693 | | 4,096 | | 4,175 | | 13,361 | | 7,828 | | 155,594 | | 96,639 | | 2021, Spectrum |
| Incidence Rate (Yr) | | 0.45 | | --- | | --- | | 0.34 | | 0.33 | | 0.64 | | 0.28 | 2020, LePHIA (25+ is 15+) |
| New Infections (Yr) | 5,000 | | | | | | | | | | | | | | 2020, LePHIA |
| Annual births (Total Fertility Rate [TFR] 2.7%) | 41,118 | | | | | | | | | | | | | | 2021, Spectrum |
| % of Pregnant Women with at least one ANC visit | --- | 91.3 | --- | --- | | | --- | 89.6 | | | --- | 91 | | | 2018, MICS |
| Pregnant women needing ARVs | 8,644 | --- | | | | | | | | | | | | | 2021, Spectrum |
| Orphans (maternal, paternal, double) | 176,810 | | --- | | --- | | --- | | --- | | --- | | --- | | 2021, Spectrum |
| Notified TB cases (Yr) | 4,549 | | 120 | | 112 | | 164 | | 175 | | 1,280 | | 2,698 | | MoH DHIS2 Annual Results |
| % of TB cases that are HIV infected | 2,438 | 53.6 | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | MoH DHIS2 Annual Results |
| % of Males Circumcised | 216,513 | --- | | | 94,419 | 43.6 | | | 80,027 | 37 | | | 42,067 | 19.4 | 2022, Program Data Q1 |
| Estimated Population Size of MSM* | 10,408 | | | | | | | | | | | | | | 2021, National Estimates |
| MSM HIV Prevalence | | 26.1 | | | | | | | | | | | | | 2021, National Estimates |
| Estimated Population Size of FSW | 13,912 | | | | | | | | | | | | | | 2021, National Estimates |
| FSW HIV Prevalence (%) | | 48.54 | | | | | --- | --- | | | --- | --- | | | 2021, National Estimates |

| | | | | | | | | | | | | | | |
|---|-------|------|--|--|--|--|--|--|--|--|--|--|--|--------------------|
| Estimated Population Size of PWID | | | | | | | | | | | | | | |
| PWID HIV Prevalence | | | | | | | | | | | | | | |
| Estimated Size of Priority Populations (Prisoners) | 2,600 | | | | | | | | | | | | | 2014, UNAIDS Atlas |
| Prisoners HIV Prevalence (%) | | 31.4 | | | | | | | | | | | | 2014, UNAIDS Atlas |
| Estimated Size of Priority Populations Prevalence (specify) | | | | | | | | | | | | | | |

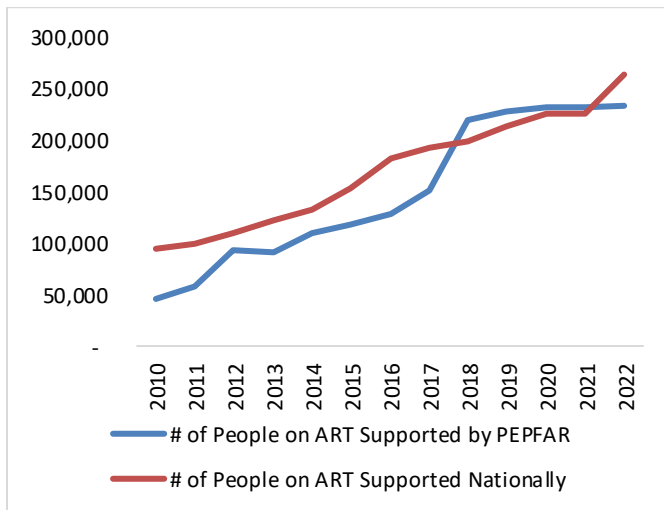
Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression

| 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 | | On ART | ART Coverage (%) | Viral Suppression (%) | Tested for HIV | Diagnosed HIV Positive | Initiated on ART |
| | (#) | (%) | (#) | PLHIV diagnosed (#) | (#) | | | (#) | (#) | (#) |
| Total population | 1,868,395 | 15.08 | 281,693 | 263,719 | 232,437 | 88.1 | 87.5 | 195,486 | 13,121 | 14,486 |
| Population <15 years | 602,617 | 1.37 | 8,271 | 6,420 | 6,240 | 97.2 | 82.6 | 16,798 | 188 | 301 |
| Men 15-24 years | 199,752 | 3.92 | 7,828 | 6,211 | 4,599 | 74 | 68.5 | 10,071 | 297 | 274 |
| Men 25+ years | 403,241 | 23.97 | 96,639 | 92,923 | 76,528 | 82.4 | 85.6 | 27,228 | 4,477 | 4,880 |
| Women 15-24 years | 200,855 | 6.65 | 13,361 | 13,044 | 10,329 | 79.2 | 82.1 | 71,745 | 2,339 | 2,309 |
| Women 25+ years | 461,930 | 33.68 | 155,594 | 145,121 | 134,741 | 92.8 | 89.9 | 68,568 | 5,818 | 6,721 |
| | | | | | | | | | | |
| MSM | 10,408 | 26.10 | 2,716 | 1,294 | 210 | 16% | 84% | 4,314 | 219 | 122 |
| FSW | 13,912 | 48.54 | 6,753 | 3,543 | 626 | 18% | 92% | 2,763 | 220 | 302 |

| | | | | | | | | | | |
|------------------------|---|---|---|---|-----|---|-----|---|---|----|
| | | | | | | | | | | |
| PWID | - | - | - | - | 1 | - | - | 0 | 0 | 0 |
| Priority Pop (specify) | - | - | - | - | 323 | - | 99% | 0 | 0 | 34 |

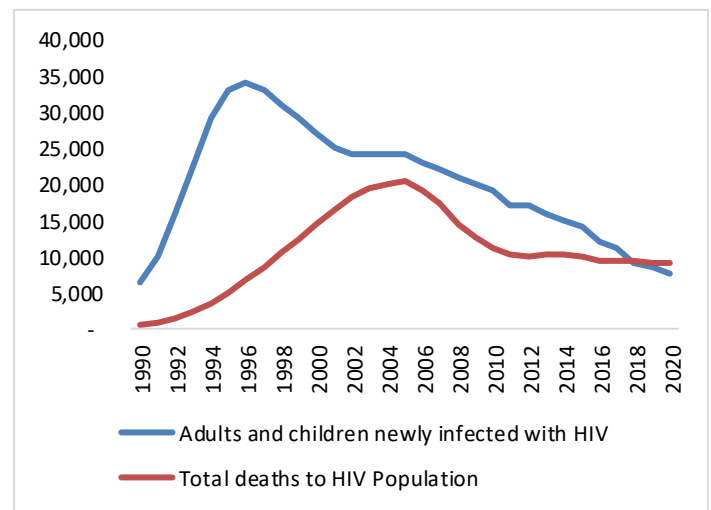
Source: Lesotho national estimates and PEPFAR MER data

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



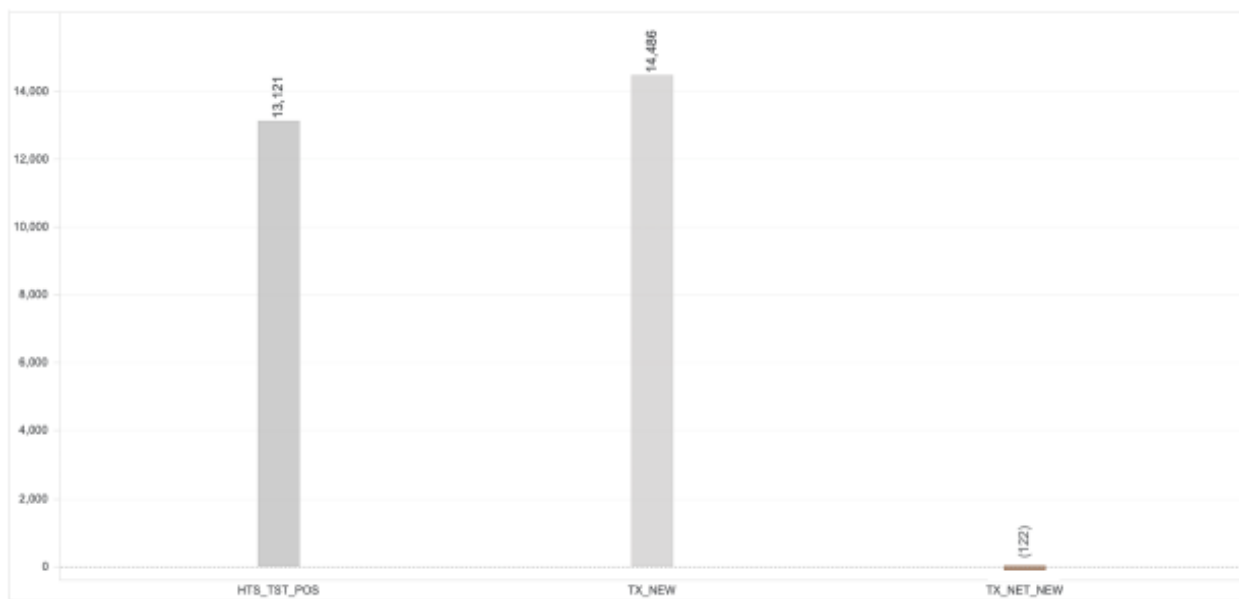
Source: PEPFAR MER data, Spectrum estimates

Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV, 1990-2020



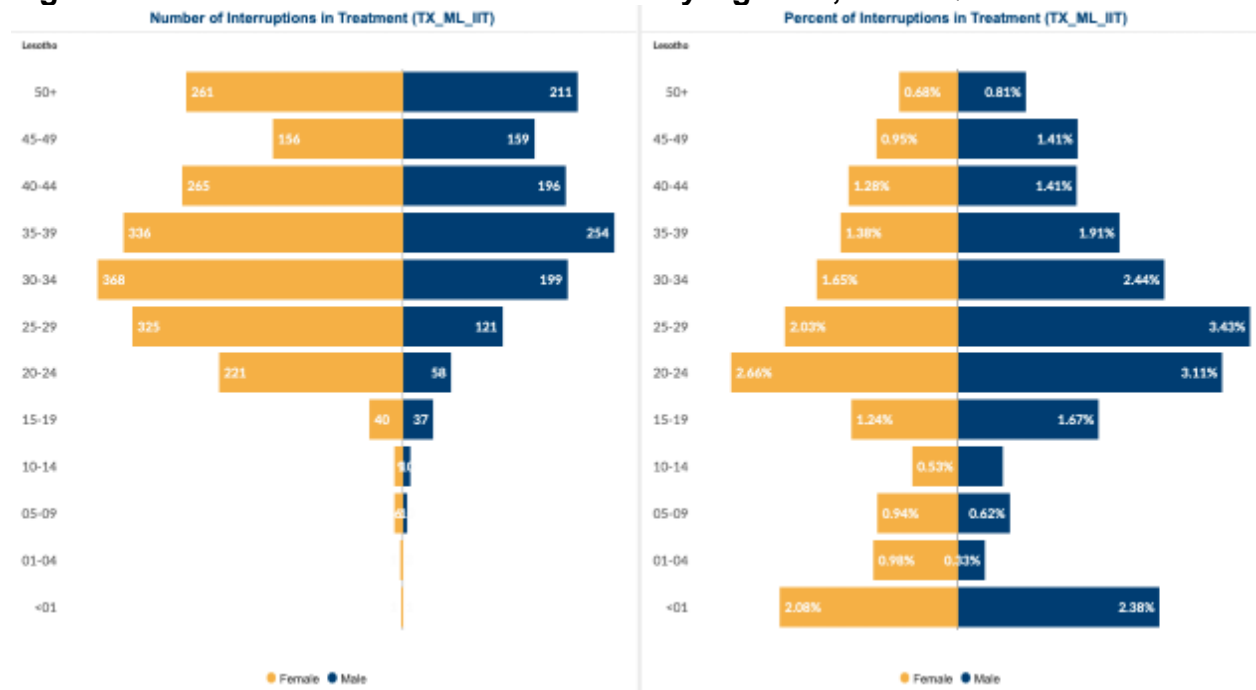
Source: UNAIDS and Spectrum estimates

Figure 2.1.5 Assessment of ART program growth in FY21



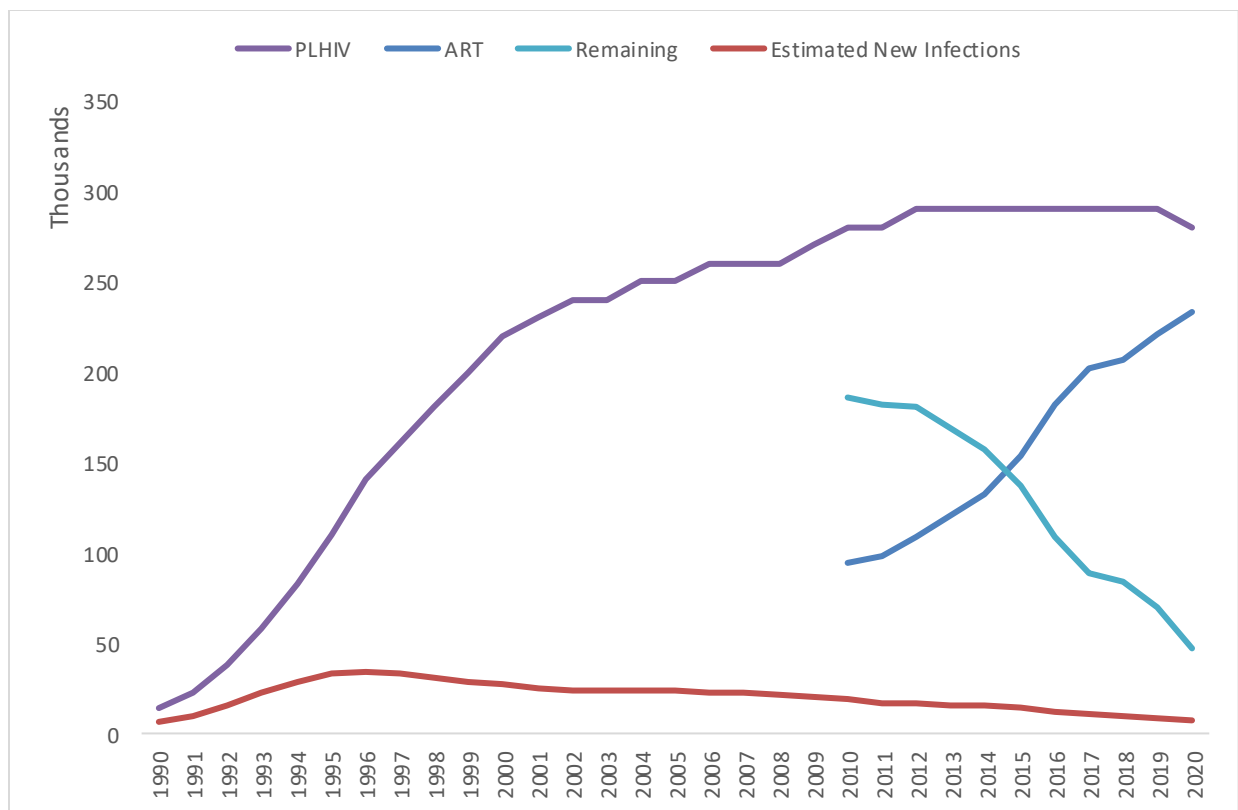
Source: PEPFAR MER data

Figure 2.1.6 Clients Gained/Lost from ART by Age/Sex, FY21 Q4



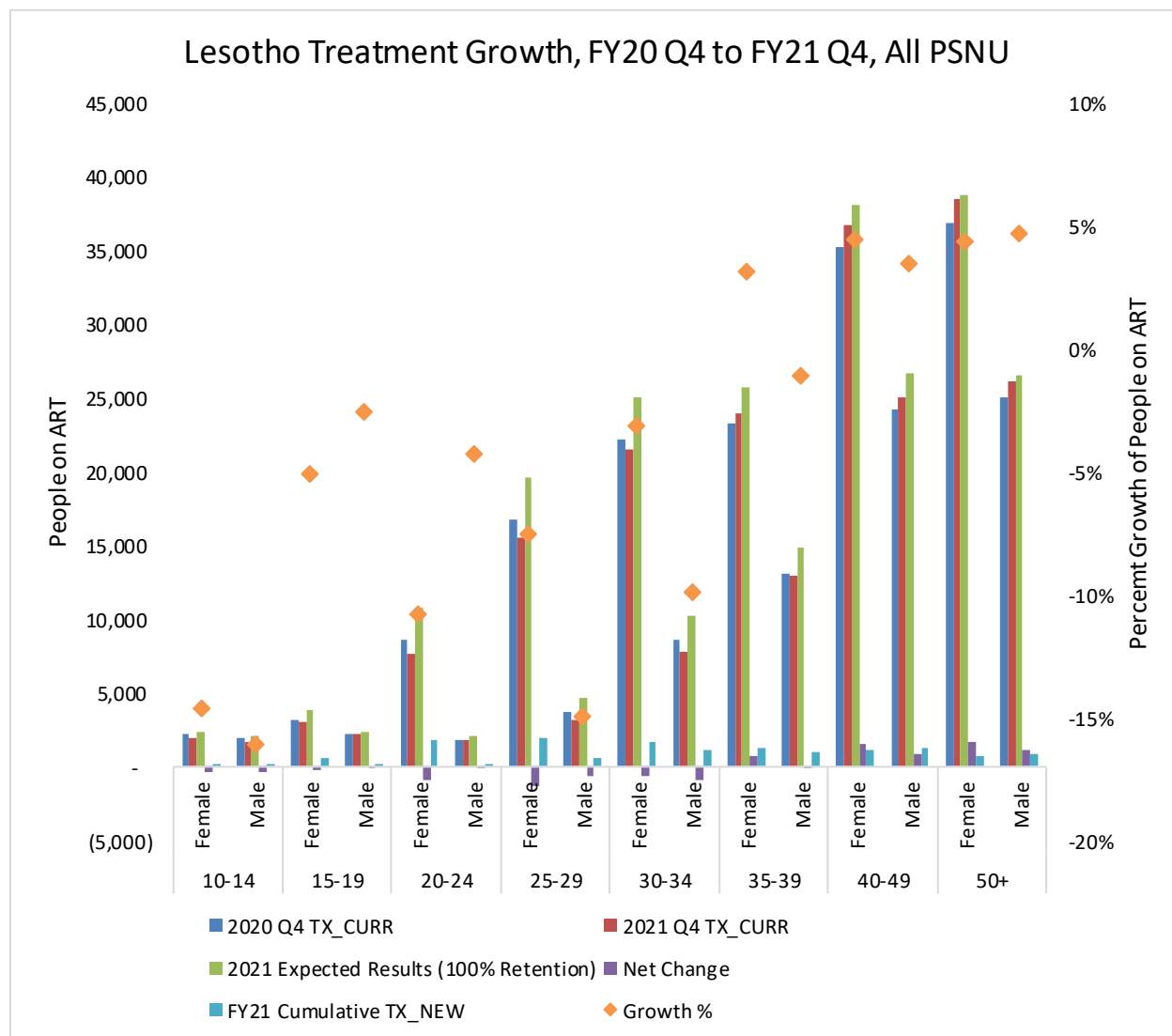
Source: PEPFAR MER data

Figure 2.1.7 Epidemiologic Trends and Program Response for Lesotho



Source: UNAIDS 2021 Estimates

Figure 2.1.8 Net change in HIV treatment by sex and age bands 2020 Q4 to 2021 Q4



Source: PEPFAR MER PSNUxIM dataset

2.2 New Activities and Areas of Focus for COP22, Including Focus on Client ART Continuity

2.2.1: Treatment Program Growth and Continuity of Treatment

The COP22 goal for the second 95 is to achieve and maintain 90 percent treatment coverage in all ages and sexes to improve quality of life and health outcomes for all PLHIV active on antiretroviral therapy (ART). The APR21 results show the gains of 99% ART optimization with high viral suppression rates of 98% for those active in care. Furthermore, 14,486 ART-naive PLHIV were initiated on treatment; however, the low continuity of treatment proxy rate of 94% significantly affects the overall treatment growth rate at -0.1% and annual NET_NEW of -122. The treatment net growth is affected by high attrition men and women aged 15-34 years accounting for >90% of the clinical cascade attritions, and attritions significantly increased during periods of COVID-19 lockdowns that resulted in cross-border and inter-district travel restrictions. Mortality rates remained low at 0.5% in the general population, although adults aged 50+ years had a higher mortality rate compared to the general population. Interruption in treatment (IIT) volumes

are highest in those who have been on ART for ≥ 3 months, but cohort analysis shows a higher percentage of IIT in those who are new on ART for < 3 months, children, adolescents, youth, and young adults. With this foundation, a dedicated focus on addressing attrition and return to care will help achieve the overall goal of increasing viral suppression of clients in PEPFAR-supported sites.

To achieve and maintain treatment goals, the program will examine and address causes of attrition. Client feedback analyses indicate that 80% of missed appointments and interruption in treatment are due to working in South Africa (16%), local work (14%), site documentation errors (12%), temporary travel (10%), feeling cured/healthy (8%), forgetting (6%), transportation challenges (6%), self-transfers (4%), wrong addresses (4%), and school (3%). A programmatic root cause analysis identified service delivery, provider- and systems-related barriers that included sub-optimal ARV ordering to meet the demand for DSD services, incomplete documentation, and triangulation of data across multiple clinical cascade registers, sub-optimal use of e-registers and shared health records, negative provider attitudes at re-engagement in care, and frequent staff rotations impacting understanding of the PEPFAR and MOH reporting requirements.

During COP22, HIV treatment program growth and continuity of treatment will be fostered through four strategic priorities:

1. Bridging the HIV treatment gap in sub-populations with the highest unmet need for ART through improved test-and-treat for ART-naïve patients, improving re-engagement in care for those who have disengaged from care, and expanding early retention support within the first six months of ART initiation or re-engagement in care.
2. Strengthening facility- and community-based differentiated service delivery models (DSD) models to improve continuity of treatment and prevent interruption in treatment.
3. Strengthen provision of quality people-centered services and integrate treatment & viral load literacy in all service outlets at facility and community levels to prevent interruption in treatment (IIT); and
4. Avert morbidity and mortality among PLHIV through multi-disease programming for TB/HIV, advanced HIV Disease, cervical cancer prevention, non-communicable diseases, and mental health screening and management.

The sections below provide details on key COP22 programming pivots to improve treatment growth and continuity of treatment for adults and children on ART.

COP22 program shift for enhanced site level support to improve ART re-engagement to care and optimal retention in care

The Spectrum 2022 and LePHIA 2020 results show at least 16,000 Basotho know their HIV status but are not active on treatment. A greater focus on the cycle of interruption in treatment and re-engagement in care (CIRA), in addition to ART initiation, will be a major focus for COP22 in order to achieve optimal treatment growth trends in all sub-populations. Re-engagement services will be focused and expanded in sites that account for 80% of the interruption in treatment volumes and sites with $> 2\%$ IIT rates per cohort on ART (i.e., RTT Surge sites). The core service package in these Return to Treatment (RTT) Surge sites will be aligned to the duration on ART, DSD model preference, and migratory patterns of clients on ART. The figure below provides a summary of the core service package based on duration on ART or migrant status:

Clinical case management plan (Clients on ART for <6m i.e., TX-naïve/re-engaged in care):

1. Active Tx Case Management
2. Universal enhanced adherence counseling (in-person & virtual)
3. Separate clinician visit from ART refills
4. Develop DSD plan in ≤ 3 months on ART
5. Tailored treatment demand creation
6. Tailored welcome-back package at re-engagement in care
7. AHD screening if IIT for ≥ 12 months and/or enrolment in to viremic clinics
8. Train on Motivational Interview and use of disclosure kit



ART continuation package (Clients on ART for 6+ months):

1. MMD at 95% (with 6m MMD at 85%) coverage
2. Expand decentralized drug delivery: Community ART Groups, Community ART Delivery, Collect-&-Go e-lockers, pharmacy pick-up points, border clinics, factory clinics, tertiary clinics, moonlight clinics.
3. Enhance client support networks: Peer/PSG clubs, O4Z, Specialized clinics
4. Universal enhanced adherence counseling (in-person and virtual)
5. Customer care & motivational interview training for reengagement
6. Active patient tracking
7. Transition support for adolescents and youth
8. Active management of viremia or treatment failure

Migrants COT Service Package

- ART Initiation or re-engagement in care
 - Able to return to site within 2 weeks: ARVs for 2 weeks at initiation then 6m MMD for subsequent visits
 - Unable to return to site within 2 weeks: 3M MMD at initiation then 6m MMD refill at subsequent visits
- Already on ART: 6M MMD refills
- Quality of Care package for migrants:
 - Virtual EAC at day 7, 14, 30 and then monthly
 - VL and AHD screening and management if re-engaged in care after 12+ months of IIT
 - Decentralized drug delivery
 - Update telephone contacts (Lesotho and RSA) at each clinic visit
 - U=U Treatment literacy

Strengthening site level systems to improve documentation

Interventions to address continuity of treatment at specific sites or districts will be guided by the nationally led quality improvement framework. This will build on the current “ART documentation surge”, e-register, and HIE roll-out to reduce documentation issues resulting in inaccurate counts. This has already demonstrated reduction in the net losses for both females and males. The PEPFAR Lesotho program will address the fourth barrier to COT through improving documentation systems in the supported sites. During COP22, the e-register used by the clinical partners will include, but is not limited to:

- a. SMS appointment reminders through linkage of CommCare and e-register
- b. Monitoring clinic appointment schedules to enable fast-tracking pharmacy refills, viral load sample collection, EAC, and treatment case management.
- c. Generation of missed appointments, defaulters, interruption in treatment, and transfer-out reports to inform tracking efforts.
- d. Identification of clients eligible for the Clinical Case Management Plan i.e., newly diagnosed, newly re-engaged back to care, viremic, advanced HIV disease, new opportunistic infection, pregnant/breastfeeding.
- e. Utilization of the Shared Health Record for data triangulation to reconcile patient data from DDD models, self-transfers, and visiting clients
- f. Reports for the COP22 MER/MOH indicators and the minimum programming requirements for the 95-95-95 clinical cascade and averting morbidity & mortality.
- g. Granular site level data analyses and Root Cause Analyses (RCA) to identify barriers to continuity of treatment, VL testing and sustained viral suppression rates and development of targeted remedial plans.

Sustaining the gains of the second and third 95s

Despite challenges of the COVID-19 pandemic, the PEPFAR Lesotho program will continue to consolidate the following gains that will foster continuity of treatment:

- **Strong policy framework** that is aligned to WHO and PEPFAR guidelines including same-day or rapid ART initiation for all PLHIV irrespective of CD4 status.
- **Consolidate intra- and inter-facility linkages to ART** using treatment Case Managers and strengthening the facility-community linkages either through active escort or integrated outreach.
- **Provision of optimized treatment regimens** that have fewer side effects, lower resistance thresholds, and more success in improving viral suppression rates. COP22 will focus on pediatric DTG transition in eligible children.
- **Expanding multi-month scripting and dispensing in all DSD models**, especially 6-month MMD coverage to 85%. The program will continue to maintain MMD for visiting and clients that are transferring out.
- **Active treatment Case Management** utilizing professional counselors, community focal persons, mentor mothers, youth ambassadors, and male peers for active tracking, treatment literacy, and assisted disclosure.
- **Active tracking efforts** will entail CommCare appointment reminders, rapid tracking within 24 hours of a missed appointment, elicitation of phone contacts (local and/or RSA), IIT tracking with fidelity of at least three times for re-engagement back to care; and institutionalizing data triangulation and updating client ART cards, tracking tools, registers, and eRegister systems.
- **Facility Collaborative Quality Improvement (CQI)**: PEPFAR partners will continuously refine interventions to address emerging reasons for attrition for various target populations using a CQI approach, root cause analysis, and community-led monitoring (CLM) results. PEPFAR Lesotho will ensure that all CQI initiatives are focused on promoting people-centered health care. Promising interventions will be

reviewed during monthly meetings and POART meetings with key stakeholders and considered for scale-up.

- **HRH Optimization:** The PEPFAR Lesotho program will consolidate the gains of the current HRH optimization approach to improve continuity of treatment, sustain viral suppression rates, and foster provision of people-centered care by all health care providers. The FY21 HRH inventory report will continue to be utilized to address barriers in the cycle for interruption in treatment and return to care (CIRA), capacity building of providers on people-centered care, and development of a phased PEPFAR HRH transition plan in collaboration with MOH and other HIV/AIDS stakeholders.

People-centered continuity of treatment interventions are covered in section 4.2 of the SDS.

2.3 Investment Profile

In Lesotho, the Government of Lesotho, Global Fund, and the United States Government via PEPFAR primarily fund the HIV response. PEPFAR Lesotho's budget has decreased over the past several years, from \$94 million in COP19 to \$75 million for COP22.

Historically, the Government of Lesotho has maintained their commitment to the HIV response, especially the procurement of ARVs. Currently, the Government of Lesotho procures approximately three quarters of the country's ARVs, with Global Fund assisting with the remaining gap.

Table 2.3.1 Investment Profile for HIV Programs⁵

| Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022 | | | | | | |
|---|----------------------|----------------|-------------|------------|---------------|-----------|
| | Total | Domestic Gov't | Global Fund | PEPFAR | Other Funders | Trend |
| | \$ | % | % | % | % | 2018-2022 |
| Care and Treatment | \$81,839,601 | 59% | 8% | 32% | 0% | |
| <i>HIV Care and Clinical Services</i> | \$68,381,173 | 64% | 10% | 26% | 0% | |
| <i>Laboratory Services incl. Treatment Monitoring</i> | \$11,547,949 | 38% | 0% | 61% | 0% | |
| <i>Care and Treatment (Not Disaggregated)</i> | \$1,910,478 | 0% | 0% | 100% | 0% | |
| HIV Testing Services | \$14,429,632 | 19% | 18% | 62% | 0% | |
| <i>Facility-Based Testing</i> | \$6,825,927 | 0% | 13% | 87% | 0% | |
| <i>Community-Based Testing</i> | \$3,864,085 | 0% | 28% | 72% | 0% | |
| <i>HIV Testing Services (Not Disaggregated)</i> | \$3,739,620 | 75% | 17% | 8% | 0% | |
| Prevention | \$22,099,032 | 36% | 14% | 50% | 0% | |
| <i>Community mobilization, behavior and norms change</i> | \$2,791,321 | 0% | 47% | 53% | 0% | |
| <i>Voluntary Medical Male Circumcision</i> | \$3,142,625 | 0% | 3% | 97% | 0% | |
| <i>Pre-Exposure Prophylaxis</i> | \$1,743,178 | 0% | 0% | 100% | 0% | |
| <i>Condom and Lubricant Programming</i> | \$1,046,746 | 0% | 14% | 86% | 0% | |
| <i>Opioid Substitution Therapy</i> | \$0 | | | | | |
| <i>Primary Prevention of HIV & Sexual Violence</i> | \$2,361,020 | 0% | 17% | 83% | 0% | |
| <i>Prevention (Not Disaggregated)</i> | \$11,014,142 | 73% | 10% | 17% | 0% | |
| Socio-economic (incl. OVC) | \$9,179,788 | 0% | 12% | 88% | 0% | |
| <i>Case Management</i> | \$3,780,495 | 0% | 0% | 100% | 0% | |
| <i>Economic Strengthening</i> | \$3,172,795 | 0% | 0% | 100% | 0% | |
| <i>Education Assistance</i> | \$1,000,000 | 0% | 0% | 100% | 0% | |
| <i>Psychosocial Support</i> | \$0 | | | | | |
| <i>Legal, Human Rights, and Protection</i> | \$0 | | | | | |
| <i>Socio-economic (Not Disaggregated)</i> | \$1,226,498 | 0% | 87% | 13% | 0% | |
| Above Site Programs | \$13,498,328 | 18% | 36% | 47% | 0% | |
| <i>HRH Systems</i> | \$3,325,855 | 0% | 90% | 10% | 0% | |
| <i>Institutional Prevention</i> | \$0 | | | | | |
| <i>Procurement and Supply Chain Management</i> | \$792,615 | 0% | 37% | 63% | 0% | |
| <i>Health Mgmt Info Systems, Surveillance, and Research</i> | \$4,833,189 | 0% | 23% | 77% | 0% | |
| <i>Laboratory Systems Strengthening</i> | \$937,014 | 0% | 6% | 94% | 0% | |
| <i>Public Financial Management Strengthening</i> | \$20,236 | 0% | 100% | 0% | 0% | |
| <i>Policy, Planning, Coordination and Management of Disease Ctrl Programs</i> | \$857,021 | 0% | 0% | 100% | 0% | |
| <i>Laws, Regulations and Policy Environment</i> | \$1,000 | 0% | 0% | 100% | 0% | |
| <i>Above Site Programs (Not Disaggregated)</i> | \$2,731,398 | 87% | 13% | 0% | 0% | |
| Program Management | \$14,051,174 | 0% | 19% | 81% | 0% | |
| <i>Implementation Level</i> | \$14,051,174 | 0% | 19% | 81% | 0% | |
| Total (incl. Commodities) | \$156,091,777 | 40% | 13% | 46% | 0% | |
| Commodities Only | \$15,545,384 | 0% | 54% | 46% | 0% | |
| % of Total Budget | 10% | | | | | |

Source: HIV Resource Alignment; Note: Domestic Gov't and Other Funders data included where available. Aggregated Domestic Gov't data has been included where disaggregation is not available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

⁵ Note that PEPFAR was unable to verify historical or current budget allocations for HIV programming from the domestic government for this years' investment profile, which feeds directly into Table 2.3.1.

Table 2.3.2 Investment Profile for HIV Commodities⁶

| | Total | Domestic Gov't | Global Fund | PEPFAR | Other Funders | Trend |
|--|---------------------|----------------|-------------|------------|---------------|-----------|
| | \$ | % | % | % | % | 2018-2022 |
| Antiretroviral Drugs | \$2,626,016 | 0% | 80% | 20% | 0% | |
| Laboratory Supplies and Reagents | \$7,159,374 | 0% | 28% | 72% | 0% | |
| CD4 | \$113,770 | 0% | 0% | 100% | 0% | |
| Viral Load | \$3,788,079 | 0% | 0% | 100% | 0% | |
| Other Laboratory Supplies and Reagents | \$3,257,524 | 0% | 61% | 39% | 0% | |
| Laboratory (Not Disaggregated) | \$0 | | | | | |
| Medicines | \$312,042 | 0% | 100% | 0% | 0% | |
| Essential Medicines | \$35,675 | 0% | 100% | 0% | 0% | |
| Tuberculosis Medicines | \$0 | | | | | |
| Other Medicines | \$276,367 | 0% | 100% | 0% | 0% | |
| Consumables | \$2,848,818 | 0% | 79% | 21% | 0% | |
| Condoms and Lubricants | \$352,761 | 0% | 51% | 49% | 0% | |
| Rapid Test Kits | \$2,236,335 | 0% | 93% | 7% | 0% | |
| VMMC Kits and Supplies | \$259,722 | 0% | 0% | 100% | 0% | |
| Other Consumables | \$0 | | | | | |
| Health Equipment | \$88,123 | 0% | 100% | 0% | 0% | |
| Health Equipment | \$0 | | | | | |
| Service and Maintenance | \$88,123 | 0% | 100% | 0% | 0% | |
| PSM Costs | \$2,511,011 | 0% | 67% | 33% | 0% | |
| Total Commodities Only | \$15,545,384 | 0% | 54% | 46% | 0% | |

Source: HIV Resource Alignment; Note: Domestic Gov't and Other Funders data included where available. Aggregated Domestic Gov't data has been included where disaggregation is not available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

| Funding Source | Total USG Non-PEPFAR Resources | Non-PEPFAR Resources Co-Funding PEPFAR IMs | # Co-Funded IMs | PEPFAR COP Co-Funding Contribution | Objectives |
|----------------|--------------------------------|--|-----------------|------------------------------------|--|
| Global VAX | \$10,684,272 | \$8,859,272 | 9 | 0 | Support COVID vaccine service delivery; supply chain logistics; human resources; monitoring & evaluation; pharmacovigilance; and communication, advocacy, and demand creation. |
| Peace Corps | \$1,514,300 | \$0 | 0 | 0 | Achieving the Peace Corps mission. |
| Total | \$12,198,572 | \$8,859,272 | 9 | 0 | |

2.4 National Sustainability Profile Update

PEPFAR Lesotho completed the Sustainability Index Dashboard (SID) in 2021 to assist with identifying areas of weakness that are critical to the HIV response. Among the 17 sustainability elements, two scored dark green (“sustainable and requires no additional investment at this time”), three scored light green (“approaching sustainability and requires little or no investment”), 12 scored yellow (“emerging sustainability and needs some investment”), and none scored red (“unsustainable and requires significant investment”). There were no marked changes since the SID was completed in 2019.

⁶ Note that PEPFAR was unable to verify historical or current budget allocations for HIV programming from the domestic government for this years’ investment profile, which feeds directly into Table 2.3.2.

In COP22, PEPFAR Lesotho will continue to focus above-site investments in commodity security and supply chain, laboratory systems, HIV recency testing, human resources for health and information systems to address vulnerabilities in these areas as the program transitions to a more sustainable model.

PEPFAR and GF continue to be the two largest external donors to the national HIV response in Lesotho. The Government of Lesotho has continued its commitment to cover the costs of ARVs for the treatment program. The transition to greater financial responsibility on the part of the Government of Lesotho has been negatively affected by the COVID-19 pandemic's impact on the economy. Increased focus on linkages with other donors that support health and social protection in COP22 will help expand sustainability platforms and integration of PEPFAR programs into broader Government of Lesotho activities as we work towards sustainability planning.

PEPFAR Lesotho will increasingly work with and implement activities through indigenous partners to build local capacity, increase program sustainability, and ensure epidemic control. PEPFAR agencies have taken steps to increase funding towards local, indigenous prime partners. USAID has awarded cooperative agreements to local organizations such as Baylor and m2m and will continue to support technical and organizational capacity development of local partners to prepare more of these organizations for a prime role. CDC will provide preference points to local applicants as part of any Notice of Funding Opportunities. CDC will continue to incorporate health system strengthening activities for the MOH in all awards to develop local capacity and work with all partners to ensure that their organizations in Lesotho are led by Lesotho citizens.

2.5 Alignment of PEPFAR investments geographically to disease burden

From 2016 to 2020, HIV prevalence in Lesotho decreased from 25.6% (LePHIA 2016/2017) to 23.5% (LePHIA 2020) among persons 15-59 years of age. According to LePHIA 2020, prevalence among those 15+ years of age ranged from 18.8% in Butha-Butha to 24.0% in Mafeteng. The absolute number of PLHIV is highest in the lowland districts of Berea, Leribe, Mafeteng, Maseru, and Mohale's Hoek where approximately three-quarters of the population resides. Incidence among persons 15-59 years decreased from 1.1% in the 2016/2017 LePHIA to 0.5% in the 2020 LePHIA. COVID More data is needed to determine how COVID-19 affected HIV prevalence and incidence rates.

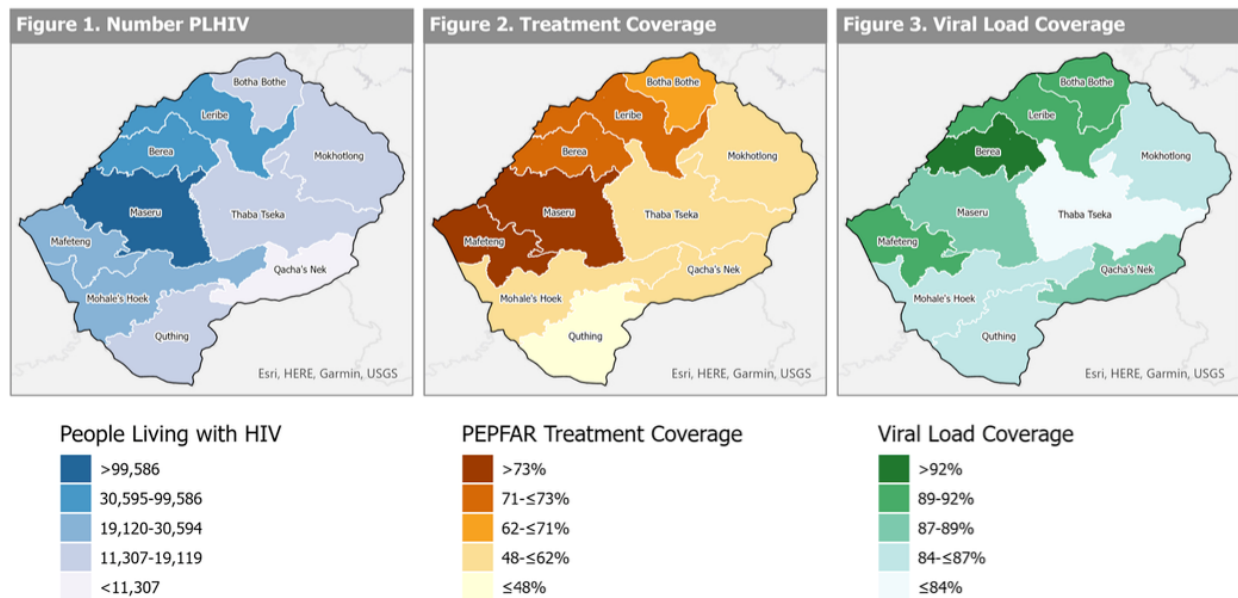
PEPFAR currently provides HIV treatment services in all ten districts of Lesotho including approximately 207 health facilities. This encompasses most all health clinics and hospitals owned by MOH and CHAL as well as a few private and correctional facilities. OVC programs are implemented in all 10 districts. Some PEPFAR prevention programs are limited to certain districts. For example, the DREAMS program is in 4 districts (Berea, Mafeteng, Maseru and Mohale's Hoek) and the VMMC program is in 5 districts (Berea, Leribe, Maseru, Mafeteng and Mohale's Hoek). When this occurs, GF attempts to support similar activities in the remaining districts.

There are no major geographic shifts in PEPFAR programming planned in COP22.

Figure 2.5.1



PEPFAR Lesotho: People Living with HIV (PLHIV), Treatment Coverage, and Viral Load Coverage by District



Source: PEPFAR Panorama, 2021

Created: 3/22/2022

2.6 Stakeholder Engagement

Representatives from the MOH, civil society organizations, Global Fund, National AIDS Commission (NAC), United Nations agencies, faith-based organizations, PEPFAR implementing partners, and others participated in a three-day, virtual stakeholders’ meeting for COP22 on February 1-3, 2022.

Prior to these meetings, the COP22 guidance and Planning Level Letter, along with other documents (2021 Sustainability Index Dashboard and Responsibility Matrix; COP21 SDS and Approval Memo) and Panorama Spotlight were shared with stakeholders. Over 100 people participated in the meeting. There was a healthy dialogue both verbally and in the chat feature. Stakeholders were supportive of focusing on the 95-95-95 and 10-10-10 goals and beginning the plans for transitioning to a sustainable model. CSOs advocated for additional support for and attention to: joint program design; mainstreaming structural interventions into all PEPFAR programming; capacity building; and community-led monitoring (CLM) and more funding for local partners. While all the CSO recommendations cannot be incorporated into PEPFAR programming, their input and insight are valued.

A separate virtual meeting was held with CSO on February 4 in which they presented their priorities for COP22. In general, the CSO supported the priorities as outlined in the Planning Level Letter. As was discussed at the stakeholders meeting, they desired to see additional funding for structural interventions, capacity building, CLM and local partner funding.

Representatives from the MOH, CSO, GF, NAC, UNAIDS and other groups participated in the three-day, COP22 virtual planning meeting on March 8-10, 2022. Approximately 80-90 participants contributed to effective discussion on the objectives and strategic priorities for COP22. Much of

the discussion focused on issues raised by representatives from the international CSO. There was a focus on key populations, structural interventions, and human rights. Drafts of the various COP tools (DataPack, FAST, etc.) were shared for review by participants. The questions and answers from the daily discussion, both verbal and in the chat feature were also posted, as were taped recordings of the meeting.

The draft COP22 strategic direction summary was distributed to all stakeholders prior to submission on April 14, 2022.

2.7 Stigma and Discrimination

UNAIDS recommends implementation of 10,10,10 to address barriers that impede full realization of the benefits for HIV prevention, care and treatment interventions by all populations that need them. The People Living with HIV Stigma and discrimination index 2.0 draft report (June 2021) indicates that Lesotho still has a lot of stigma within the HIV prevention and care and treatment programs. Overall, 7.5% of the people reported stigma and discrimination with 12.9% of respondents reporting disclosure of their HIV status to their family members without their consent.

Among the key populations 49.1%, 24%, 16.7%, and 42.6% of the transgender people, MSM, female sex workers and bisexual people reported having experienced stigma respectively. To address this, all organizations that offer KP services will be assessed with the KP competence framework tool. Gaps identified will be addressed accordingly. Additionally, the CLM assessment tool will be revised to incorporate KP specific information that picks out stigma and discrimination, and the implementing partners will address the gaps. If resources are available, other structural barriers will be addressed such as engaging and training health workers and law enforcement officers on prevention stigma and discrimination and supporting advocacy interventions to finalize the counter domestic violence bill/ gender framework, harmonization bill, and ensuring the policy is inclusive of and relevant to same-sex couples; LGBTIQ people; sex workers; people living with disabilities.

Among PLHIV, 4.3% of people not on treatment fear that their partner, friends, or others would know that they are on treatment. Additionally, 48.8% of participants reported treatment disruption due to fear of being identified with HIV treatment, not being ready to deal with HIV infection, myths about treatment, use of herbs purported to cure HIV. Overall, 4.4% of participants reported bad treatment in their interaction with health care workers. To address stigma and discrimination within HIV care and treatment to engender behavior change, in COP22, Lesotho will 1) train the clinical health care workers on the human rights, stigma and discrimination free service delivery, 2) educate the patients about their rights and ensure that at all HIV care and treatment sites, the patients' rights charter is displayed to remind the beneficiaries of their rights during clinical service uptake, 3) ensure that all health care workers have signed the code of conduct to offer stigma and discrimination free services and oath of confidentiality to ensure that patients consent to HIV care and treatment services, all the health care workers maintain privacy and confidentiality on patients information, 4) optimize utilization of the health facility boards, suggestion boxes or exit interviews as feedback mechanisms on HIV care and treatment services provided at health facilities, 5) use of mentor mother model (peer to peer) to offer PMTCT services in order to advocate and provide psychosocial support to other HIV positive mothers who are enrolling into the PMTCT program and nominating the stigma and discrimination focal person at health facilities to oversee that activities addressing stigma and discrimination at health facilities are implemented.

In the military sites, the following interventions will be implemented; 1) conduct step down training for stigma and discrimination to the military personnel, 2) disseminate the new code of conduct to

all the military officers and troops, 3) dissemination of the new health policy to all the military officers and troops, and 4) integration of HIV and primary health services.

To ensure that there is articulation of a remuneration standard for peer outreach workers/navigators, to ensure decent work and fair pay is provided, PEPFAR will continue to engage the MOH HIV TWG to develop and standardize terms for engaging peers and outreach worker. As PEPFAR we work towards standardization of payment rates across all implementing partners.

3.0 Geographic and Population Prioritization

Beginning in COP18, nine of the ten districts of Lesotho became “scale-up saturation” districts, with Mafeteng as the only attained district. In COP20, Berea, Butha-Buthe, and Leribe were designated as attained districts with overall treatment coverage above 90%. The overall treatment coverage by the end of fiscal year 21 for the Scale-up Saturation districts ranged from as low as 74% treatment coverage in Quthing to a high of 88% in Maseru; and the remaining districts in ascending order are Thaba-Tseka (79%), Mohale’s Hoek (80%), Mokhotlong (84%), and Qacha’s Nek (86%), Projected, in Table 3.1 (above/below), two additional districts (i.e., Maseru and Qacha’s Nek) reached attained status in COP21.

Voluntary medical male circumcision (VMMC) services will be synergized between PEPFAR Lesotho and Global Fund (GF), with services provided in the five lowland districts by PEPFAR Lesotho and in the five highland districts by GF. The ART coverage among 15-29 year-old males in the lowland districts were above 80%, except in males 25-29 year-olds in Leribe at 61%. In the highland districts, the treatment coverage was above 80% in Butha-Buthe, Mokhotlong, and Qacha’s Nek. However, Quthing and Thaba-Tseka’s treatment coverage among 20-24 and 25-29 year-olds ranged from 53%-58%, and slightly higher in 15-19 year-olds at 75%.

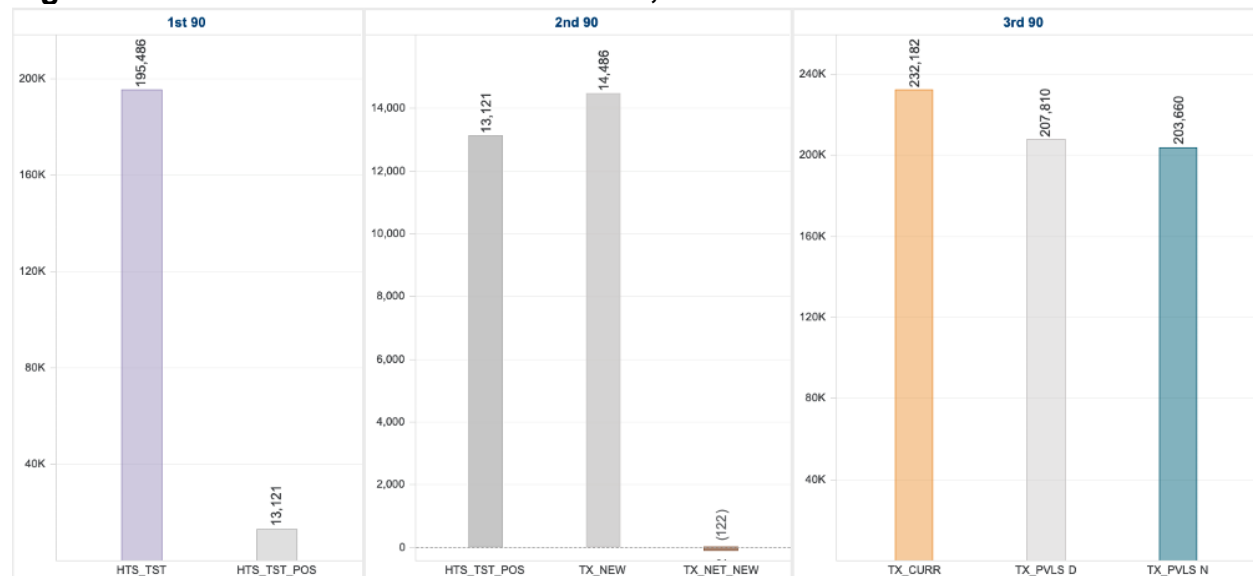
Table 3.1 Current Status of ART saturation

| Table 3.1 Current Status of ART saturation | | | | |
|---|---|--------------------------------|------------------------------|------------------------------|
| Prioritization Area | Total PLHIV/% of all PLHIV for COP22 | # Current on ART (FY21) | # of SNU COP21 (FY22) | # of SNU COP22 (FY23) |
| Attained | 178,561 | 150,808 | 6 | 6 |
| Scale-up Saturation | 103,132 | 79,839 | 4 | 4 |
| 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 |

Source: 2022 Spectrum and PEPFAR program data

4.0 Client-Centered Program Activities for Epidemic Control

Figure 4.0.1 Overview of 95/95/95 Cascade, FY21



Source: PEPFAR MER data

4.1 Finding people with undiagnosed HIV and getting them started on treatment

Lesotho is one of the few PEPFAR-supported countries that have achieved the UNAIDS 90-90-90 targets for the year 2020. According to the LePHIA survey 2020, 90% of people living with HIV in Lesotho were reported to know their HIV status, of these 97% were on treatment, and 92% of those on treatment were virally suppressed. While this is a commendable achievement, the program continues to aim for 95-95-95 by 2025 in all measures of geographic region, age, and sex to fully control the epidemic.

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.

In FY23 the PEPFAR Lesotho program's goal is to provide HTS to 183,127 adults and children to identify 10,274 new people living with HIV and link 95% to care and treatment services; resulting in an aggregate positivity rate of 6% (6.5% for adults, while the yield for children will be 1.2%).

Although Lesotho is no exception to the negative impact of the COVID-19 pandemic on HIV testing efforts in the last 2 years, the FY21 HIV case finding approaches reflected a pivot in HTS programming to evolve with the country's changing epidemic. Due to the COVID-19 pandemic, community index tracking has not been optimally implemented in FY21 while HIVST was scaled up to ensure that people can learn their status despite limited health facility access. In COP22, the program will therefore continue to scale up and strengthen tracking of index contacts outside the facilities and ensure that HIVST is fully integrated to reach as many index contacts as possible while supporting the normalization of facility-based services for HTS. The program will also

implement client-centered HIV testing approaches to find the missing populations and link them to treatment. The Lesotho PHIA (LePHIA 2020) and APR data confirms that gaps remain in treatment coverage for children, adolescents, and young men.

In COP22, out of the total 10,274 new positives, 397 (3.9%) are children 0-9 years old; 59% of whom will be reached through index testing modality through active tracking at facility and community levels, and strong collaboration with the OVC programs. The OVC partners will liaise with the clinical partners and ensure that all orphans and vulnerable children have a valid HIV status and are indexed appropriately on establishing the parental HIV status. While 37% will be identified through other PITC, children will be routinely screened at all facility entry points. Strong supervision of site level staff along with district health management staff will ensure that all HIV exposed infants are followed up and have final HIV status outcomes appropriately documented. Young children of index clients who are not able to come to the health facilities will be provided with Assisted HIV self-testing in the community by trained village health workers and actively linked with facility confirmatory testing if screened positive.

Adolescents 10-19 years of age are another group that require differentiated service delivery approaches for effective case finding in FY23 and beyond. While index testing remains one of the key approaches to find adolescents 10-19 and will be scaled up with fidelity among this target group, HIVST also has great potential to reach this target audience. The program aims to fully leverage social networks, ICT/digital/social media platforms to reach young people in urban settings and community structures and other media to reach young people in rural settings. Ensuring youth-centered services from targeted messaging, peer-led mobilization, self-screening and HIVST with linkages to client-centered confirmatory services from HIVST is key to ensuring youth access and utilize the services. The program will also use strategic partnerships with tertiary institutions and religious and faith groups in the targeted messaging and HIVST for young people. A youth friendly Facebook and/or Instagram page that is linked with a WhatsApp number will be developed to target young people with a self-risk screening tool and HIVST promotion, including distribution points and results reporting. However, in remote areas where ICT may be a challenge, village health care workers will be engaged for community demand creation and demand driven distribution of HIVST. The program will also introduce social network strategies (SNS) among the young people to help refer and test members of the same social groups, and risk profiles. A total of 885 (8.6% of total cases) adolescents 10-19 newly identified positive are expected in COP22, 268 boys and 617 girls. About 25% of these cases are expected to come from index testing while 27% will come from other PITC, ANC (for girls) and TB as the main channels.

In COP22, focus will also be placed on young men 20-35 years to close the identification, treatment, and viral suppression gap in this group. 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.

However, men's poor health seeking behaviors present another barrier to facility-based access to service. The recency testing data is evidence that fewer (11-19%) newly identified men present with recent HIV infection compared to women (11-29%). It is therefore imperative that the program

implements strategies that are likely to mobilize and reach men with services. As such, the PEPFAR Lesotho HTS program will continue to support existing male friendly clinics and extended working hours to accommodate young working men who are not able to make normal working hours to the facilities. The three key aspects for male programming namely: time, place and privacy, are essential to improved uptake of services. Targeted workplace outreaches for messaging and HIVST distribution to male dominated workplaces will be implemented in a routine and needs-based approach. Index testing will also be strengthened, and a conducive, non-coercive environment created for safe elicitation and testing of sexual partners for all persons newly tested positive at all entry points. The program will use supportive client-centered approaches to enhance testing of partners such as assisted partner notification, flexible testing hours, and client-preferred testing venues. Social network strategies may be integrated in index testing for male case finding as a pilot of the approach in community index testing platforms.

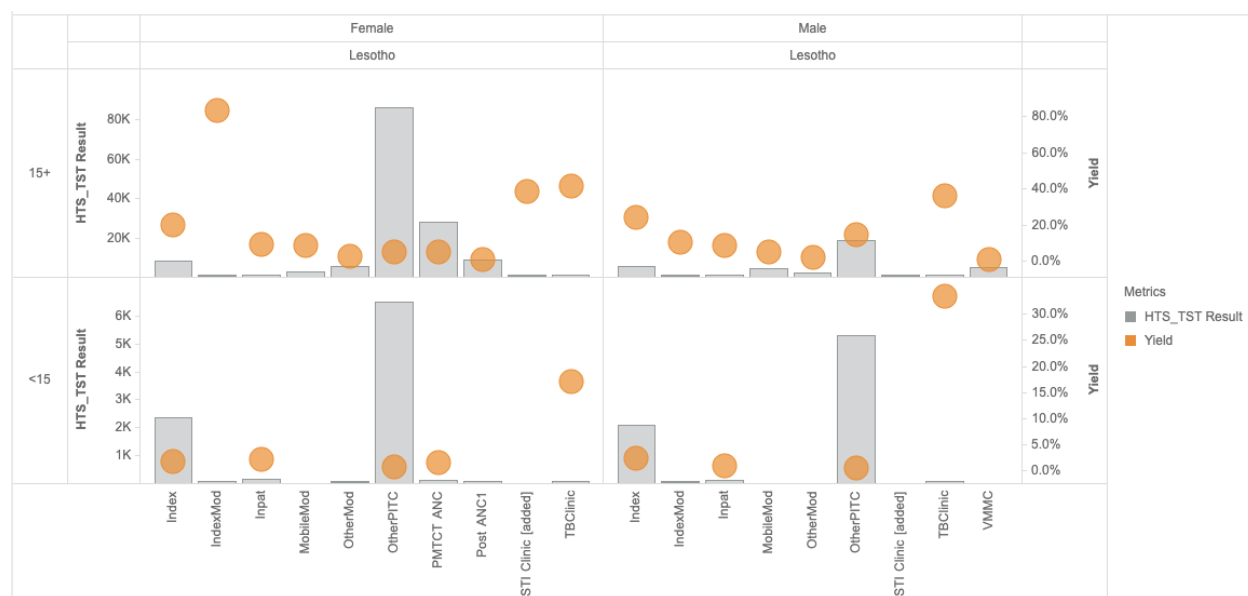
HIVST distribution will be targeted towards this target group through integration with index testing (secondary distribution), distribution through religious & social groups, online platforms, & workplaces, linked with convenient client-centered confirmatory services from HIVST.

Nuanced programming to ensure non-discriminatory and stigma-free HIV services for key populations will be prioritized. The PEPFAR Lesotho program continues to have a KP specific program while working with the Ministry of Health to ensure that the public health system creates a KP friendly environment. The KP program will continue to provide KP-friendly integrated services (condoms, lubricants, HIVST packs) in designated KP hot locations and/or service points. The program will scale up and strengthen social network & index testing strategies, peer/partner delivered HIVST, and leverage social media platforms for demand creation and messaging. Continued and sustained use of the online platforms for self-risk assessment and access to KP friendly testing service through drop-in centers and hotspots outreaches will remain critical in reaching 95-95-95 and 10-10-10 targets and maintaining epidemic control among the key populations.

The program has been using a risk screening tool coupled with HIVST to ensure highly targeted case finding; and this will continue to be implemented for all populations at all testing points. Testing volumes by site will be routinely monitored to ensure an increase in the positivity yield and decrease in the volume of testing numbers. All HTS partners will continue to participate in monthly progress meetings to monitor trends and ensure scale and fidelity of these case finding approaches. Program monitoring will be strengthened at site level through SIMS, program monitoring visits, and community led monitoring to identify performance issues, adherence to minimum standards, and target relevant interventions to poor performing sites, and use best practices from the highest performing sites across the program.

Figure 4.1.1 shows testing volume and yield by modality and age/sex disaggregation for FY21. The bulk of HIV tests for adults came from Other PITC with an average positivity of 7%, followed by PMTCT and index testing. Similarly for children, PITC contributed the highest number of tests at 0.7% yield followed by index with a 2% yield. The program continues to strengthen the use of the risk screening tool and offer HIVST for low-risk groups to ensure targeted case finding in all modalities, especially in PITC.

Figure 4.1.1 Testing Volume and Yield by Modality and Age/Sex, FY21



Source: PEPFAR MER data

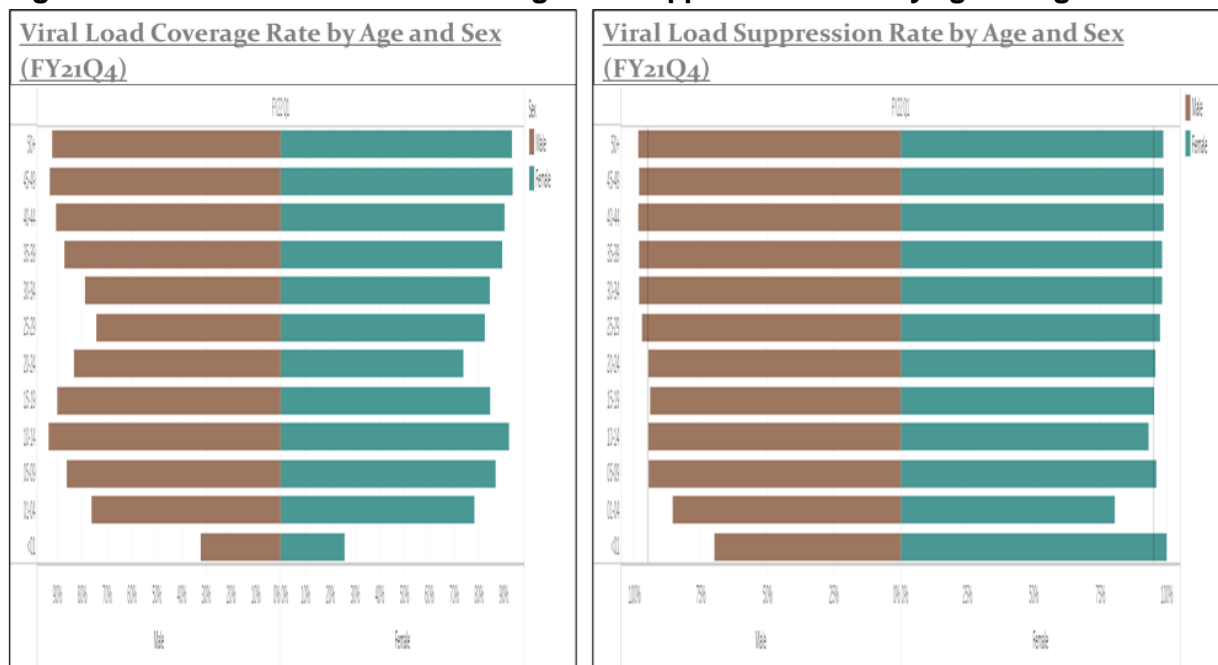
In FY23, the PEPFAR Lesotho program will therefore make the following pivots in the case identification strategy to enhance case finding for underserved age and sex populations:

- Strengthen targeted peer-led demand creation and mobilization efforts for increase uptake
- Strengthen the use of local community structures in HIVST distribution and contact tracing
- Ensure safety, ethics and appropriate client safeguarding policies and practices in the index testing program
- Scale up index testing and partner notification services prioritizing new positives and viremic clients to ensure an adult positivity of at least 20% and increasing contribution of this modality to OU case finding
- Integrate HIV self-testing in all testing modalities, especially index testing to reach undiagnosed male sexual partners and Children living with HIV
- Strengthen 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
- Use recency testing data to inform community outreaches, HIVST distribution and integration into index testing efforts
- Support and collaborate with key stakeholders to promote community education and U=U messaging to increase acceptability for index testing and partner notification services

4.2 Ensuring viral suppression and ART continuity

The COP22 treatment goal is to attain at least 86% population viral load suppression rates in all sub-populations to reduce HIV transmission, improve health and wellbeing of PLHIV, and improve overall quality of life. To attain this treatment goal, the PEPFAR Lesotho program will intensify efforts to provide people-centered care to bridge three main gaps along the continuum of care i.e., the continuity of treatment (COT) gap, viral load testing gap, and viral suppression gaps.

Figure 4.2.1 FY21Q4 viral load coverage and suppression rates by age and gender



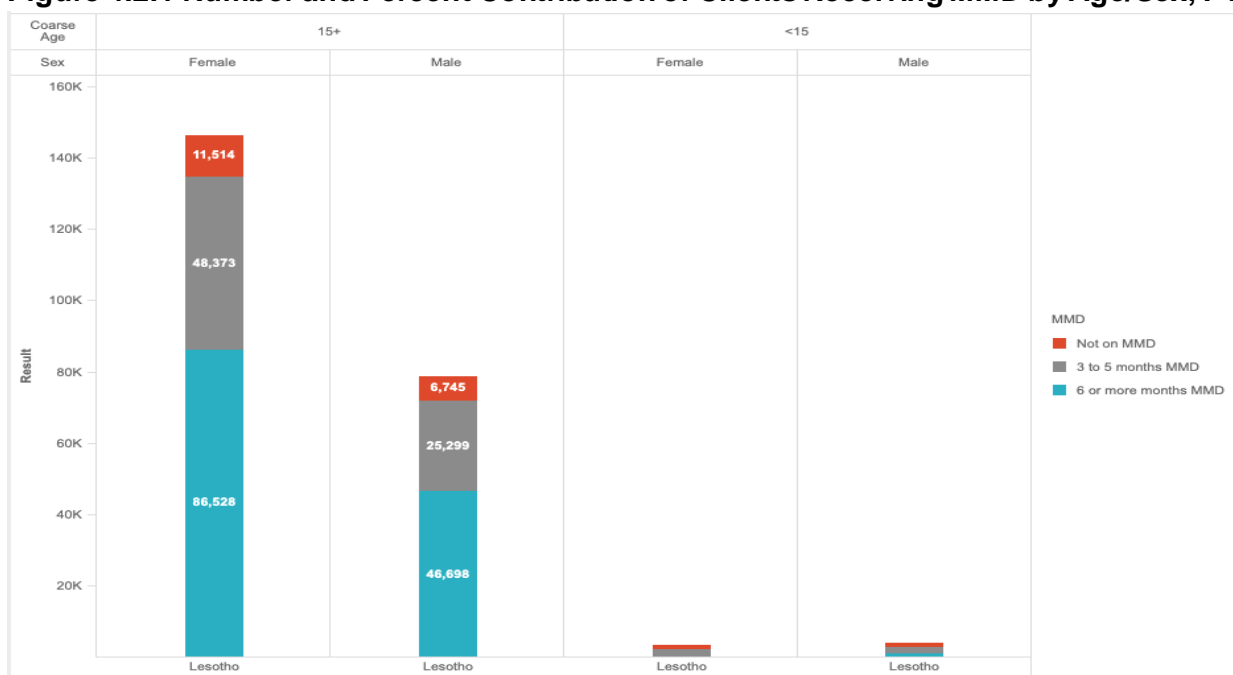
Source: PEPFAR MER data

Although APR21Q4 results show that 98% of patients active in care are virally suppressed and 99% are on optimized ART regimens, the program is still at 73% population viral suppression rates. Population viral load suppression rates are lower in children, adolescents, and men largely attributed to lower viral load testing coverage, sub-optimal pediatric ART regimens, low psychosocial/peer support networks, and high stigma and discrimination that affects health seeking behavior. The APR2021 results show that continuity of treatment is a major gap that will affect attainment of the population viral load suppression rates due to the high attrition rates along the HIV clinical care cascade. In terms of numbers, treatment losses are highest among those aged 15-34 years, and cohort analysis shows the higher proportions of children <15 years, men, and those on ART for <6 months are exit the clinical cascade is high. Population viral suppression rates are further affected by suboptimal viral load coverage, low demand creation, and low treatment & viral load literacy levels. Viral load coverage is lower in children, adolescents, men, and the highland districts of Thaba Tseka, Quthing, and Mokhotlong.

During COP22, viral suppression and treatment continuity interventions will be people-centered, focusing on sub-populations with the highest attrition & mortality rates, and the lowest viral load coverage and suppression levels. This will be attained through direct service delivery support to promote enhanced treatment case management based on duration on ART, migration status, viral load status, and multi-disease management to avert morbidity and mortality.

PEPFAR Lesotho direct service delivery support at site level is limited to health units that have at least 200 PLHIV on ART and a few specialized clinics that offer services for KP, prisoners, and tertiary institutions (see Figure 4.2.1 below). The COP22 site level support for improved retention will continue to focus on these clinics. Site volume analysis shows that 169 (82%) sites account for 95% of the total FY21Q4 treatment results and these will be prioritized for scaling up the core client-centered viral suppression and continuity of treatment service package that includes bridging treatment gaps in the ART-naïve and re-engaged clients, differentiated care, integration of collaborative quality improvement to address site-level clinical cascade gaps, averting mortality rates, and enhanced treatment case management (see section 2.2 above).

Figure 4.2.1 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY21



Source: PEPFAR MER data

The sections below provide core COP22 viral suppression and treatment continuity priorities for different sub-populations that include newly initiated, re-engaged in care, 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 2022 recommend Test-and-Treat for all people living with HIV irrespective of CD4 cell counts. During COP22, the PEPFAR Lesotho program will focus on providing same-day or rapid 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 with linkage navigators, mentor mothers, village health workers, 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 ART refills. All newly initiated clients will receive efficacious ART regimens including DTG-based regimens, including DTG 10mg dispersible tablets.

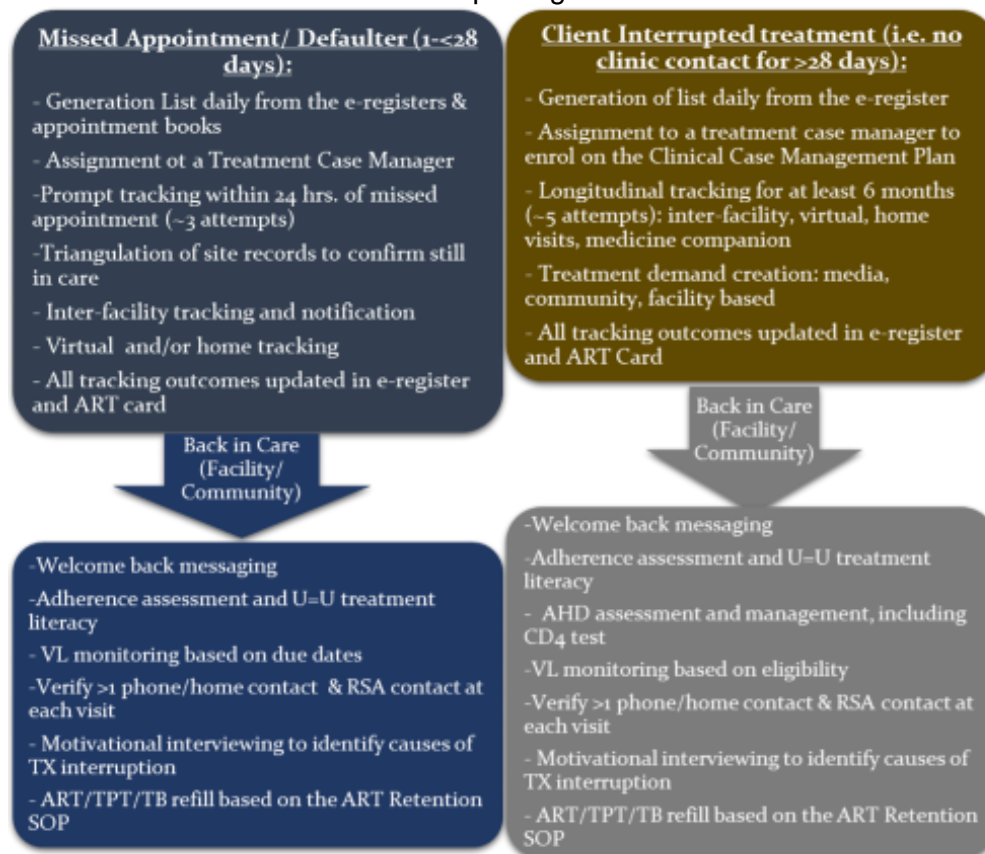
The Clinical Case Management Plan will be utilized to improve early retention in care and will entail mapping of Treatment Case Managers to all newly initiated clients to provide one-on-one longitudinal support (in-person and/or virtual) during the first six months on ART. The minimum service package will entail: treatment literacy pre- and post-ART initiation, universal enhanced adherence counseling (in-person & virtual) (at day 7, 14, 28, and then monthly), separate clinician visits from ART refills, development of a DSD plan within the first 3 months on ART, tailored treatment demand creation at facility and community levels, including use of mass media and social media, AHD screening and management, and training of providers on motivational interviewing and use of the disclosure kit. All newly initiated clients will be supported to identify medicine companions at community level who can support in medicine pick-up if they are unable to attend the clinic. Adherence assessments will be conducted at each clinic visit and enhanced adherence counseling will be offered to those who are at risk of interruption in treatment. Active

community tracking will be strengthened prioritizing those who are not ready for same-day ART initiation. Patients with advanced HIV disease will be screened to rule out Cryptococcal Meningitis or TB Meningitis to enable rapid ART initiation.

4.2.2. Re-engagement back to care

The COP22 strategic focus for treatment growth is to increase re-engagement into care services, in addition to enrolling new patients on ART. Targeted demand creation will be expanded at facility and community levels to increase knowledge on the benefits of ART, service package at re-engagement, and available support systems to improve continuity of treatment especially in the first 6 months after ART initiation.

Active community tracking will be scaled up, prioritizing high-medium volume ART sites to attain at least 90% tracking coverage of all missed appointments, defaulters, and those who have disengaged from care for >28 days. At least three tracking attempts will be undertaken per client, including phone call, home visits, and contacts with the medicine companions. The figure below provides the return-to-care minimum service package:



The Clinical Case Management Plan will be utilized to improve early retention in care by Treatment Case Managers that include professional counselors, lay counselors, mentor mothers, youth ambassadors, peers, and linkage to community OVC Case Managers. The Treatment Case Managers will be assigned to all re-engaged clients to provide one-on-one longitudinal support (face-to-face and/or virtual) during the first six months of re-engagement back in care. The minimum service package will entail: treatment literacy at re-engagement and subsequent contacts, universal enhanced adherence counseling (face-to-face & virtual) (at day 7, 14, 28, and then monthly), separate clinician visits from ART refills, MMD refills based on the retention SOP, enrollment in DSD based on client preference (e.g. Community ART delivery, facility-based MMD, Collect-&-Go e-lockers, pharmacy pick-up points, etc.), and screening and management of AHD,

opportunistic infection, mental health, & non-communicable diseases. Tailored treatment demand creation at facility and community levels will be scaled up, including use of mass media and social media. Capacity building of health care providers at facility and community levels on motivational interviewing and use of the disclosure kit will also be undertaken. At re-engagement and subsequent clinic visits, the telephone contacts of the client and their medicine companions will be updated, including developing plans for medicine pick-up by the medicine companion if the client is unable to attend the clinic. Adherence assessments and enhanced adherence counseling will be offered at each clinic visit. SMS appointment reminders and active community tracking will be provided to improve retention rates.

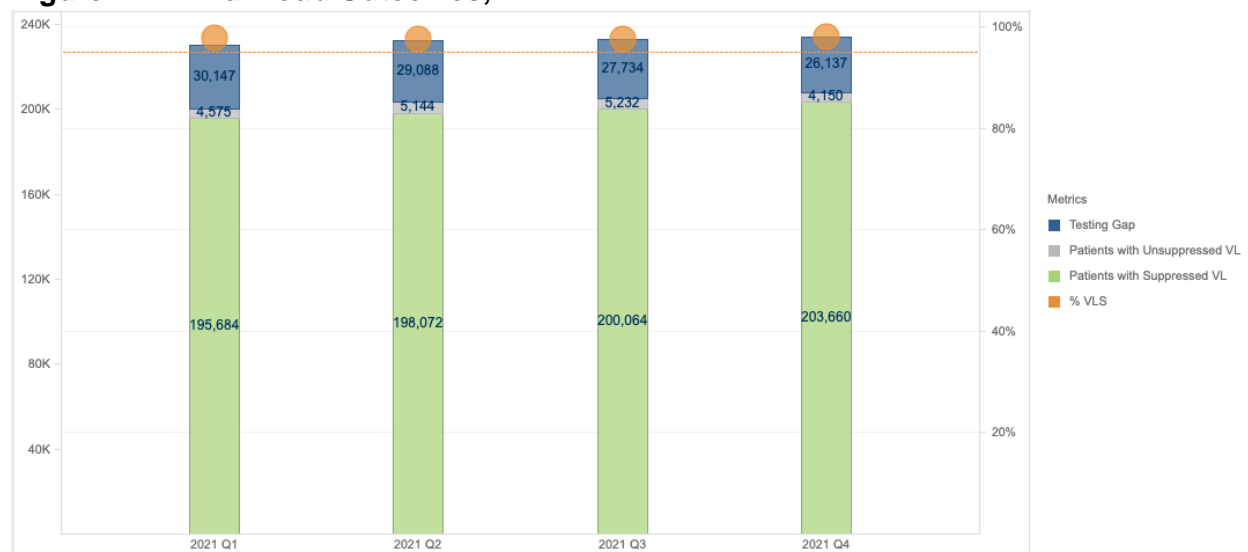
4.2.3 Unsuppressed or viremic PLHIV

The FY21Q4 results show that 2% PLHIV active on ART are not virally suppressed and their viral suppression levels increase with age. During COP22, 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 viremic PLHIV, including provision of enhanced adherence counseling that will screen for mental health challenges, repeat viral load monitoring, ensuring timely evaluation for second line if no improvement.

Treatment Case Managers will be allocated to each viremic client to provide ongoing virtual and face-to-face 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 to the clinic early to start enhanced adherence counseling.

Professional counselors will be trained on the provision of age and developmentally appropriate enhanced adherence counseling, including caregivers of viremic infants and 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.

Figure 4.2.2 Viral Load Outcomes, FY21



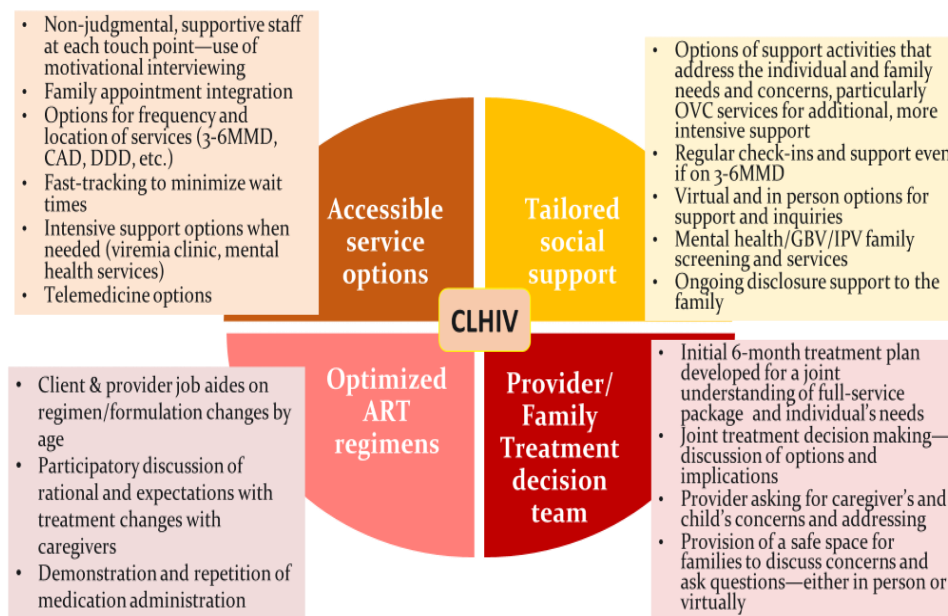
Source: PEPFAR MER data

The sections below provide core COP22 viral suppression and treatment continuity priorities for different sub-populations that include newly initiated, re-engaged in care, viremic/unsuppressed, children and adolescents living with HIV, and stable adult women and men.

4.2.4. Children and adolescents

PEPFAR Lesotho will support the MOH to achieve 90% treatment coverage for CLHIV and ALHIV, initiate more efficacious ART regimens including pediatric DTG 10mg DT, and ensure viral suppression and retention in care. As of APR 21, program data shows lower viral load coverage and suppression rates for children and adolescents, especially those under five years of age. During COP22, Point-of-care viral load (POC-VL) testing will be scaled up to address the unmet need for viral load testing among children and adolescents. In addition, VL testing will be integrated in all DSD models including weekend clinics, adolescent corners, MNCH service delivery sites, and community support group activities.

Continuity of pediatric treatment will continue to be a major focus during COP22 to attain optimal population viral suppression rates and improved treatment outcomes. Clinically stable CLHIV and ALHIV will be enrolled into differentiated service delivery including facility based MMD and CAGs to support continuity of treatment. During COP22, the benchmark for C/ALHIV in MMD coverage is set at 80%, up from 75% in COP21 and 65% in COP20. Family-centered care services will be implemented in sites that account for at least 80% of children on ART. Integration of and linkage to broader essential child survival interventions will form a part of family-centered care for C/ALHIV services. The figure below summarizes the family-centered elements for children living with HIV.

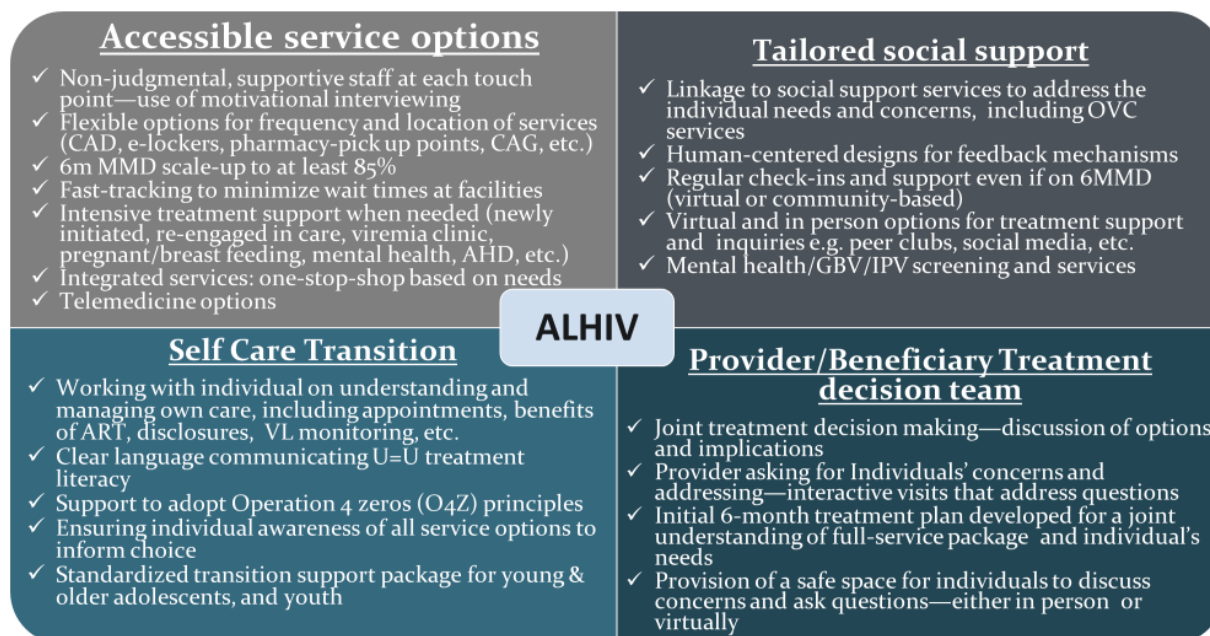


Children who are under the age of 10, their caregivers, and older children who are not able to enroll into teen clubs/ Operation four Zero (O4Z) will continue to have their age-appropriate psychosocial support groups which will meet on a monthly and quarterly basis. During the PSS group meetings children 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.

The ANC sentinel survey in 2018 revealed that adolescent girls aged 15-19 years account for 22% of ANC attendees, while those aged 20 -24 represent 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, pregnancy prevention and family planning, STIs and TB and incorporate Operation four Zero (O4Z) into the already existing psychosocial support group (PSG) clubs and make children and adolescents more self-resilient and responsible for their own health. The human centered design approach will be utilized to improve feedback from adolescents and young people on how services can be improved to address their unmet needs and improve access and adherence. The figure below provides a summary of people-centered services for adolescents living with HIV (ALHIV).



Lesotho MOH with PEPFAR support will continue to coordinate clinical and supply chain implementing partners to ensure that the health facilities: employ good inventory management practices; do not run out of recommended efficacious ART regimens and other essential medicines needed for care and support; 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.

4.2.5. Adult women 15+ years on ART

The LePHIA 2020 results show women have a higher HIV disease burden. The APR21 results show the treatment growth rates for adult females is 0.6% with a Net New of 854, and continuity of treatment rate of 95%, which is attributed to high attrition rates. Despite challenges in continuity of treatment, the program has continued to increase access to viral load testing with 89% VL coverage rates at FY21Q4 and 98% viral suppression rates. MMD coverage among adult females aged 15+ years is high at 92%, with 59% on 6-month MMD. (see table 4.2.5).

| Table 4.2.5 MMD coverage for adult females ages 15+ | |
|---|--------------------------------|
| ARV Dispensing quantity | FY20Q4 Adult females receiving |
| ARV Dispensing Quantity - 3 to 5 months | 87,562 (58%) |
| ARV Dispensing Quantity - 6 or more months | 36,015 (24%) |
| ARV Dispensing Quantity - Less than 3 months | 21,582 (14%) |

Although the program has sustained high viral load coverage at 89% and virologic suppression rates of 98% among adult women, continuity of treatment is a persistent barrier to attaining population viral suppression rates. Women aged 25-39 years have the highest volume of treatment interruption. Figure 4.2.5. ii. provides the LePHIA 2020 ART coverage and treatment gap in adult women. Major barriers of continuity of treatment persist that are related to the impacts of the COVID-19 pandemic, 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 violence/gender-based violence, stigma, and discrimination). In addition, continuity of treatment is also affected among the women of working age who travel for work and live outside of Lesotho for an extended period. According to LePHIA 2017, 17.8% of women reported that they live outside of Lesotho, including 4.8% who live outside of the country for one month or more, and over 58.9% travel outside of the country due to work, mainly in the Republic of South Africa.

During COP22, the program will use a person-centered approach to address barriers for continuity of treatment and sustained viral suppression rates among adult females, (with special attention to ages 15–34-year-olds), to greater than 98% and ensure that net losses do not account for more than 1% of the treatment program. Focus interventions that will achieve and maintain epidemic control in adult women aged 15+ years include:

- i. **ART Optimization:*** The program will continue to implement the revised national treatment policy guidelines on the provision of optimized ART regimens, including DTG for women of reproductive age for sustained virologic suppression, reduce morbidity and mortality, and reduced risk of HIV transmission).
- ii. **Multi-Month scripting and dispensing:*** The program will continue to build on the current gains to integrate MMD uptake in all service outlets including ART clinic, TB clinic, MNCH entry points, and community-based decentralized drug delivery modes. Overall MMD coverage in adult women will be at 95% and 6-month MMD coverage at 85%. The program will continue to align MMD refills with facility or community viral load sample collection to avoid any testing interruption due to COVID-19 and other factors.
- iii. **Differentiated service delivery models*** to reduce frequency of clinic visits, long clinic waiting times, and risk of interruption in treatment will be scaled up through the provision of facility-based MMD, community ART delivery, Community ART Groups (CAGs), Collect-&

Go/BonoloMeds e-lockers, pharmacy pick-up points (PUPs), and peer-supported drug delivery using mentor mothers to attain at least 95% overall MMD coverage in adult WLHIV, and 85% 6-month MMD coverage. 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 U=U treatment literacy and address any knowledge gaps on treatment benefits. Clinic appointments for stable adult WLHIV will be reduced to at least two 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-track viral load testing and return of results. Granular site level data, CLM, and collaborative quality improvement (CQI) will be utilized to bridge gaps in differentiated service delivery models for all adult WLHIV, including those newly initiated on ART, re re-engaged back in to care, viremic, pregnant/breastfeeding, and stable on ART.

- iv. Active Tracking to prevent treatment interruptions:** Community-facility tracking for all missed appointments, defaulters, transfer-outs, and interruption in treatment will be strengthened to enhance linkage back to care. Treatment Case Managers that include Lay Counselors, community 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, e-register, and ART cards.
- v. Address socio-cultural barriers to treatment continuity and sustained viral suppression:** These will be addressed through the provision routine intimate partner violence (IPV)/gender-based violence (GBV) screening in all service outlets (e.g., ART Clinic, MNCH, 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 demand creation for MMD uptake.
- vi. Integrated reproductive child health services:** PMTCT, ART, voluntary & informed choice FP, and EID services will be provided to all adult women of reproductive age to reduce any retention barriers related to clinic transitions for the women or their children/infants. 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, neonatal or child health care needs of end users. Point-of-care viral load monitoring for PBFW will be provided to ensure 100% coverage of eligible women based on national guidelines.
- vii. HRH Optimization for person-centered health care services:** Treatment case management to meet the unique needs of women will be strengthened through availability of critical cadres of staff in critical clinical cascade areas. Mentor mothers, youth ambassadors, OVC Case Managers, and DREAMS Ambassadors will continue to be utilized to provide adherence, retention, and treatment U=U literacy support at facility and community levels. Multi-skilling of health care providers at facility and community levels through training and mentorship on women-centered services will be strengthened.

4.2.6. Adult men 15+ years on ART

The APR21 results show the treatment growth rates for adult Males (15+ years) is 0.4% with a Net New of 302, and continuity of treatment rate of 94%, which is attributed to high attrition rates. Despite challenges in continuity of treatment, the program has continued to increase access to viral load testing with 89% VL coverage rates at FY21Q4 and 98% viral suppression rates. MMD coverage among adult Males aged 15+ years is high at 92%, with 59% on 6-month MMD. (see table 4.2.6.1).

| Table 4.2.6.1 MMD coverage for adult males ages 15+ | |
|---|------------------------------|
| ARV Dispensing quantity | FY20Q4 Adult males receiving |
| ARV Dispensing Quantity - 3 to 5 months | 45,116 (55%) |
| ARV Dispensing Quantity - 6 or more months | 22,580 (27%) |
| ARV Dispensing Quantity - Less than 3 months | 11,333 (14%) |

Community partners conducted a root-cause analysis for interruption in treatment and found 80% of them 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 reasons for defaulting).

Programmatic data and the 2022 UNAIDS Spectrum estimates highlight the needs for innovative ways to target males aged 20-34 who are being missed by the program to return to care as well as to identify undiagnosed HIV infected males. Continuity of treatment among this age group is key to achieve and sustain epidemic control and reduce new infections.

During COP22, PEPFAR Lesotho aims to improve access to male-friendly health care services to increase continuity of treatment and sustaining viral suppression rates among adult males, (with special attention to ages 15-34-year-olds), to greater than 98% and ensure that net losses do not account for more than 1% of the treatment program. Focus interventions that will achieve and maintain epidemic control in adult men include:

- i. **ART Optimization:** The program will continue to implement the revised national treatment policy guidelines on the provision of optimized ART regimens, including DTG for all newly diagnosed men, those already established on ART, and management of treatment failure.
- ii. **Multi Month scripting and dispensing (MMD):** PEPFAR Lesotho will continue to leverage on the gains of MMD scale to achieve >95% overall coverage and at least 85% 6-month MMD coverage. PEPFAR Lesotho will continue to track MMD Scale-up by age and sex in all service outlets including male clinics, adolescent corners, ART clinics, and other community based decentralized drug delivery models e.g., border mobile clinics, Collect-&-Go e-lockers and pharmacy pick-up points. 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. The program will continue to align MMD refills with facility or community viral load sample collection to avoid any testing interruption due to COVID-19 and other factors.
- iii. **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 40 Men clinics are active and sites that do not

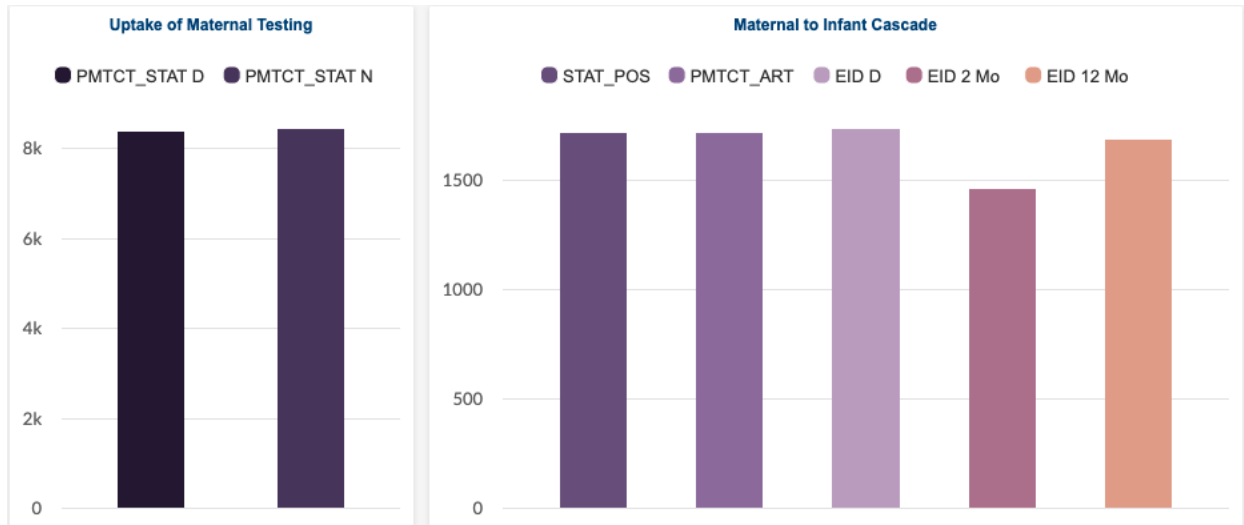
have adequate space for dedicated clinics have been trained on the provision of male-friendly health care, prioritizing high and medium volume sites. PEPFAR partners will continue to provide training and supportive supervision in conjunction with MOH staff to all facilities to ensure that providers are sensitized to provide adult male 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.

- iv. **CAG Enrollment:** The program will continue to scale-up enrollment of adult men in Community ART Groups (CAGS) 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.
- v. **HRH Optimization:** 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.

| Table 4.2.6.2 COP22 retention strategies aligned to the MenStar Approach and Framework | | | | |
|---|---|--|---|---|
| Descriptor | Who are they | Key Health care need | Key Emotional need | COP22 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 Expands Men’s Clinics at high impact sites. HRH optimization/re-allocate Expert men clients) Treatment literacy Messaging |
| Interruption in treatment | Interruption in treatment, 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 85% for adult males |

4.3 Prevention, specifically detailing programs for priority programming:

Figure 4.3.1 PMTCT Cascade



Source: PEPFAR MER data

HTS

The WHO recommends integration of HTS into HIV clinical and social service delivery entry points. These include: community-based HIV prevention programs, such as VMMC and PrEP initiation, monitoring, ongoing testing services for negative partners of discordant couples, OVC programs, KP programs, DREAMS programs, and ANC and post-ANC services. This strategy serves as a gateway into HIV care and treatment. PEPFAR Lesotho will continue to offer community-based testing that is coordinated with laboratories to ensure correct results that leads to immediate linkage to appropriate HIV prevention, care, and treatment services. Through coordination with MOH, HTS adequate stock of HIV testing kits will be available to all prevention programs. HTS is part of the minimum package of services for VMMC and PEPFAR Lesotho will continue to offer it based on the HIV risk profile and as an opt out service. Males within the VMMC program who test HIV negative and are at significant risk of HIV infection are offered PrEP in addition to VMMC and other prevention services. People identified through VMMC as HIV positive will be linked to ART and then offered VMMC after at least 3 months on ART. HTS, including HIVST, will continue to be offered as part of PrEP following the national guideline for PrEP initiation and continuation. The negative partner in a sero-different relationship will be offered HTS and counseled on PrEP at least annually and on request at community or facility levels. HTS will continue to be offered as part of the OVC services based on the HIV risk profile and on request. For AGYW, HTS will be offered as part of the DREAMS core package and with convenience at community and facility levels. HTS will be offered to AGYWs, in addition to facility-based testing, HIVST kits will be readily available to AGYW through community-based distribution, private pharmacies and e-lockers, and those who test positive with HIVST, will be linked to nearby centers for confirmatory HTS. HTS is already part of the KP and PMTCT programs. For PBFW, the PMTCT program will continue to provide opt-out HIV testing to all pregnant women at their first antenatal clinic visit (ANC1) with rapid initiation of lifelong antiretroviral treatment (ART). Women who test negative at ANC1 will be offered retesting during their third trimester/late in pregnancy or in labor/delivery. HIV retesting will continue for postpartum women who previously tested HIV negative. In addition, integration of maternal retesting in family planning (FP) settings will be strengthened, since many women routinely access these services during the postpartum period. The MOH will be supported to forecast the HIV test kits to prevent stock of commodities.

The OVC/DREAMS implementing partner will coordinate with other clinical partners to facilitate targeting and referrals for HTS and treatment. All beneficiaries in the OVC program are referred and completely linked for HTS. OVC and DREAMS programming are both implemented in four districts; OVCs needing DREAMS services will be referred for such services, which helps to foster synergies.

DREAMS

In COP22, the DREAMS initiative will continue its implementation in the four priority districts of Maseru, Berea (Historic DREAMS districts), Mafeteng and Mohale's Hoek (expansion districts from COP 20). The historic DREAMS districts have shown significant achievement towards reaching 70% saturation. For the districts and age bands that have reached saturation targets, maintenance packages will be conceptualized and implemented to ensure DREAMS program continuity, integration into government health and social protection systems and structures, core package provision and epidemic control. The DREAMS initiative will strengthen the clinical package at both facility and community levels to ensure that all girls continue to receive the clinical and non-clinical services needed, e.g., HTS, PrEP, FP, STI screening, GBV Prevention and post GBV care, economic strengthening and more.

DREAMS will continue to use the vulnerability criteria and risk assessment tool ensuring that those enrolled in DREAMS are AGYWS at highest risk for HIV acquisition. During COP22, PEPFAR Lesotho will undertake a size estimate of vulnerable AGYWs in Lesotho to better plan for and adapt programming based on changes that might have occurred during the Covid 19 pandemic. DREAMS targets those individuals that have multiple sexual partners, experience(d) violence, have sexually transmitted diseases, absent or irregular condom use, transactional sex, are out of school, or experienced orphanhood. AGYWs are enrolled in DREAMS through multiple entry points, including health facilities and community care points, factories, schools, and tertiary education centers. Following the risk assessment, AGYW are offered the full DREAMS prevention services as indicated including pre-exposure prophylaxis (PrEP). Community service providers will be equipped to provide PrEP, family planning and contraceptive mix, and STI screening.

In COP22, the DREAMS program will scale-up robust socio-economic strengthening activities and initiation of an education subsidy intervention. The enhanced economic strengthening approach will prepare the AGYW for employment through gender sensitive and 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.

Through DREAMS, PrEP services will be scaled up among AGYW ages 15-24 in Maseru, Berea, Mafeteng and Mohale's Hoek. 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. Furthermore, the PrEP service will be integrated into safe spaces to ensure that DREAMS beneficiaries have access to PrEP services. PrEP targets for AGYW will grow by 30%; AGYW will make up 57% of all new PrEP clients in the country. In COP22, PEPFAR aims to provide PrEP to 31,808 new people which represents about a 30% increase from the COP21 target. Similarly, PrEP targets for AGYW will grow by 30%; AGYW will make up 57% of all new PrEP clients in the country.

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.

PEPFAR Lesotho will manage partners and provide opportunities for improved collaboration through coordinated DREAMS and OVC meetings, DREAMS monthly coordinating meeting with IPs, monthly targeted supportive supervision sessions, monthly Site Improvement through Monitoring System (SIMS) visits (if travel is permitted given the COVID situation and Quarterly Data Quality Assessments). These monthly and quarterly check-ins will also create platforms to share program experiences, identify programmatic bottlenecks, and map out strategies for collaboration and linkages. Creative approaches to these monitoring needs will be devised as needed during the COVID pandemic.

OVC

The OVC_SERV target for COP 22 is 95,426. The rationale for setting the target was to consider how many CLHIV in high volume sites need to be enrolled into the OVC program. At FY 21 QTR 4 the program was at 67% of enrollment. To create space for new CLHIV enrollees, the program implemented a case plan achievement readiness assessment (CPARA) for all households who were not assessed in FY21. A total of 18,377 HHs were assessed. A total of 38% of the households met eight benchmarks and were thus considered ready for graduation. As these families graduate, space will be created to support new enrollees, and to provide any services need for others to enable their graduation. Due to the flatlined budget the OU planned around the same target with the CPARA serving as a source to indicate how many more CLHIV should be enrolled to reach the PEPFAR Lesotho target of 90% enrollment. The OVC Prevention intervention for boys and girls 10-14 years old has increased its target by 10%. This includes the four DREAMS Districts.

For children under 2 years old who experienced interruption to treatment in PMTCT and CLHIV already on treatment, the OVC program had already forged linkages with clinical partners (e.g., MOUs, bi-directional referral protocols, shared confidentiality, case conferencing and joint case identification) to enhance follow up at the household level for adherence and retention. For child survivors of sexual and other forms of violence against children, the OVC program will provide trauma counselling through an evidence-based curriculum (Trauma Informed Cognitive Behavioral 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 positive FSWs will be enrolled in the OVC program and provided with on-going home visits. In addition, the OVC program will continue to provide Social Workers at the highest volume sites to help strengthen the bi-directional linkages between the OVC IPs and Clinical IPs to ensure enrollment of CLHIV into the OVC program and tracking of clinical outcomes for CLHIV enrolled in the OVC program, while developing HRH sustainability plans for this cadre.

The caregivers of OVCs who are found positive will be linked with other OVC services such as psychological support (mental health), 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 and better connections for 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, AGYWs and their male partners.

Primary prevention of HIV and sexual violence among 10-14 year olds

Early adolescence is a unique period of challenge and opportunity for positive development. The preventative programming will provide evidence-based social norms change and violence and HIV prevention interventions to the wider community of at-risk girls and boys during the critical window between ages 10-14 in high burden areas where poverty and violence are endemic. Because this group is “at risk” but does not have known risk exposure, the OVC Preventive program approach is different from the Comprehensive Program both in intensity and long evity. The focus for this group is evidence-based programming that prevents sexual violence, delays sexual debut, and prevents HIV. OVC and DREAMS will continue to implement the OGAC-approved HIV and violence prevention curricula - Parenting for Lifelong Health and Coaching Boys into Men.

PrEP

In COP22, PEPFAR aims to provide PrEP to 31,808 new people which represents about a 30% increase from the COP21 target. Similarly, PrEP targets for AGYW will grow by 30%; AGYW will make up 57% of all new PrEP clients in the country. Targets for FSW and MSM will also be increased by at least 20%. To scale up PrEP for PBFW, targets will be assigned to implementing mechanisms so that deliberate efforts are focused on this population. Step down training on integration of PrEP in eMTCT services has been completed in all 10 districts. The GOL has earmarked PrEP as a key intervention of a multi-pronged HIV prevention package and committed to procuring PrEP commodities for end-users 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.

COP 22 will focus on improving the demand for PrEP across all eligible populations. PEPFAR Lesotho will aim to normalize PrEP through:

- Ensuring differentiated and decentralized PrEP service delivery: multi-month PrEP dispensing across community and facility locations; PrEP in private sector BonoloMeds e-lockers & pharmacy); expand access to PrEP in community (such as in drop-in centers, community pick-up points, mobile clinics).
- Strengthening integration of PrEP at all available entry points at the health unit: MNCH/ANC, FP, STI, HTS, VMMC, primary care, men’s clinics. Target truck drivers at border clinics and their parking stations.
- Developing demand creation: targeted messaging and materials for AGYW, FSW, MSM, truck drivers, health care workers/providers, community members and other stakeholders will be availed at sites and distributed in the community

Family planning services and PrEP for PBFW will be integrated as part of the minimum package of PrEP service delivery. In line with the revised National ART guidelines, Event-Driven PrEP for MSM and MMD will be scaled up to improve PrEP continuation among end users. Step-down training of health care providers has been completed to facilitate the provision of PrEP service delivery to all high-volume health centers. In addition, the program will leverage 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. When available, Lesotho will scale up new biomedical prevention interventions including DVR and CAB-LA as options for eligible clients.

Partner performance will be tracked through weekly review reports and mandatory quarterly performance presentations to PEPFAR. Use of programmatic data to identify gaps along PrEP pathway - from testing negative, to screening, eligibility, offer, initiation, and continuation will be

strengthened. Technical assistance for robust data and service quality will involve conducting SIMS, DQA, EQA, and CQI on a regular basis, as well as training and mentorship of site-based M&E officers on data management and use.

Pregnant and Breastfeeding Women and their Babies

The government of Lesotho through the Ministry of Health with PEPFAR support continues to implement the comprehensive package of PMTCT services which follows the cascade from the first ANC visit through labor and delivery until the child is 24 months old. The follow-up includes screening and testing for HIV, rapid ART initiation for those who test HIV positive, and linkage to broader relevant MNCH services and interventions. The main goal of the PMTCT program is to achieve virtual elimination of mother-to child transmission of HIV. So far, the country has done well in terms of reducing vertical transmission of HIV. Since the adoption and roll-out of the test and treat policy in 2016, program data shows that about 80% of HIV infected women in ANC come with already known HIV positive status and are already on ART with the majority being virally suppressed. While on the other hand, the ANC sentinel survey 2018 results show a decline in positivity rate in ANC from 27.9% in 2016 to 22.8 % in 2018.

The first ANC visit remains high at 95% with 76% of pregnant women having 4 ANC visits by the end of their gestation. HIV testing uptake remains high at 99% with a high ART coverage of 99% in ANC for HIV positive pregnant women. Women who test HIV negative during their first ANC are followed and retested every 3 months in line with the retesting algorithm to rule out a possibility of zero conversion before labor and delivery and ensure that those who are infected are initiated on ART and are virally suppressed. The Lesotho Ministry of Health through PEPFAR support has re-enforced integration of oral PrEP-Exposure Prophylaxis (PrEP) for women who test HIV negative at a substantial risk of HIV infection. In COP21 GBV and Mental health services have been incorporated into the eMTCT program. During FY22, 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 among PBFW from 37% in APR19 to >95% in APR 22. Lesotho Ministry of Health has rolled-out POC VL testing for pregnant and breast-feeding women and their HIV infected babies to improve a turnaround time of viral load results and improve timely management of patients who are not virally suppressed. The country has adopted new EMTCT guidelines to include baseline VL testing for newly diagnosed PBFW and every 3 months during pregnancy and breastfeeding until cessation of breastfeeding. Dual Syphilis/HIV testing at first ANC and at 36 weeks gestational age is utilized and facilitates identification and management of women with syphilis or newborns with congenital syphilis. Adherence to treatment will be monitored at every ANC visit. The country has adopted the WHO recommendations for TLD-based regimens and PBFW are included as a group eligible for TLD. PBFW are also included in DSD models of care and they are eligible for MMD.

Children and Adolescents

In FY22, PEPFAR Lesotho will continue to support the MOH in all 10 districts to ensure that all HIV exposed infants are covered with prophylaxis which will be determined by level of risk for infants. High risk HEI will receive enhanced prophylaxis (AZT+ NVP) for the first 6 weeks and ensure that they keep up with the EID testing schedules while their parents are advised on the safer feeding options to protect them from getting infected during breast-feeding. All high-risk HIV exposed infants will be offered the first DNA PCR test at birth and immediate treatment if tested HIV positive. Lactating mothers and their babies will continue to be 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 (EPI). The Lesotho Ministry of Health with PEPFAR support has decentralized POC EID which covers 80% of the country's EID tests while the remaining 20% continue to be tested through the conventional method. PEPFAR Lesotho will continue to support MoH to improve on the 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.

Retaining children and adolescents on treatment and ensuring viral suppression

PEPFAR Lesotho will continue to support MoH to achieve >95% treatment coverage for HIV infected children and adolescents and they will be initiated on more efficacious ART regimens for their age and be monitored closely to ensure they are virally suppressed and retained in care. As of APR 21, program data shows low viral suppression rate and coverage for children and adolescents. Lesotho will continue to roll-out VL DBS and POC VL testing which will be used mainly to address the unmet need for viral load coverage among children and adolescents. Pediatric ART optimization will be fast tracked, the country intends to have all eligible children on DTG based regimen by APR 22.

Children and adolescents who are clinically stable will continue to be enrolled into differentiated service delivery models of care such as MMD, CAGs and person-centered service package that may be convenient for them and encourage treatment continuity and provision of safe space which enables free open communication between adolescents and their services providers and amongst adolescents themselves. The ANC sentinel survey (2018) revealed that adolescent girls aged 15-19 years account for 22% of ANC attendees, while those aged 20 -24 represent 33% of pregnant women in ANC. Therefore, PEPFAR Lesotho will continue to support MoH to scale-up adolescent friendly health corners and evaluate their effectiveness. Adolescent health corners will be strengthened to support prevention and screening for HIV, STIs and TB and incorporate Operation 4 Zero (O4Z) 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 the consignment of pDTG arrives in the country.

Children under the age of 10 and those who are not able to enroll into teen clubs/ O4Z will continue to have their age appropriate psychosocial (PSS) support groups which will meet on a monthly and quarterly basis. These children in districts where the OVC program operates will be referred from the clinic to the OVC program. 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 treatment continuity 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 Treatment literacy and 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 treatment

continuity. Children who experience challenges with adherence and viral suppression will be linked to the OVC program for continued support at community level.

Key Populations

In Lesotho, HIV-related policies and laws do not specifically address groups at high risk, such as KP. Existing legislation currently provides no protection from discrimination based on gender, sexual identity or gender identity. Epidemiological data on KPs in Lesotho are either unavailable or remain incomplete. The FSW and MSM size estimates are 2.5% and 2.0% respectively of the female and male populations aged 15 – 49 years. According to the results of the 2018 Integrated Biobehavioral Survey (IBBS), FSW and MSM in Lesotho have an increased burden of HIV, as compared to other adults of reproductive age. 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. The statistics around male sex workers and non-heteronormative sexual identities is largely missing.

PEPFAR Lesotho will continue to provide HIV prevention, care and treatment interventions for KPs. As per the COP guidance, we will scale up new case identification through various channels that include HIV Self Testing, the Enhanced Peer Outreach Approach, and use of digital platforms such QuickRes to reach previously unidentified people. The target for KP_PREV will be doubled from 6,599 to 13,294.

To strengthen HIV prevention among KP, PrEP will be scaled up with an approximately 20% increase in the PrEP_NEW target. Additionally, new biomedical interventions such DVR and CAB-LA will be provided to KP when available. PrEP will also be delivered through private pharmacies and e-lockers as a way of improving access. MOH included event driven PrEP for MSM in the revised national ART guidelines. DSD will be implemented for initiation, refill and continuation of PrEP and ART.

PEPFAR has identified nine minimum requirements aimed at strengthening KP programs. In COP22, PEPFAR Lesotho will implement the requirements for KP programming as follows:

KP Minimum Program Requirement #1: Document the trajectory of KP budget and expenditures over the prior two COP cycles utilizing PEPFAR financial classification system.

The table below presents KP budgets and expenditures. Since FY20, the KP budgetary allocation has increased from 0.5% to 1.4%. The reduction in expenditure between FY20 and FY21 was due to the disruption in program implementation occasioned by the COVID-19 pandemic, during which period program implementation was initially suspended.

| | 2020 | 2021 | 2022 |
|-------------------------------------|--------------|--------------|--------------|
| PEPFAR Expenditure | \$71,220,309 | \$67,544,064 | --- |
| KP Spend | \$882,363 | \$565,365 | --- |
| KP Spend as % of Total | 1.2% | 0.8% | --- |
| Total PEPFAR Planned Funding | \$94,037,156 | \$86,958,430 | \$78,681,000 |
| KP Budget | \$504,042 | \$1,323,662 | \$1,122,818 |
| KP Budget as % of Total | 0.5% | 1.5% | 1.4% |

KP Minimum Program Requirement #2: Greater commitment to regular and safe key population size estimation exercises.

Lesotho last conducted an IBBS in 2018. The IBBS was conducted in the districts of Maseru, Mafeteng, Leribe and Butha-Buthe. The Global Fund has indicated that they will support an IBBS in Lesotho. Whereas the geographical scope is not known at the moment, preliminary plans from GF indicate that it will be in districts that have previously not had an IBBS.

KP Minimum Program Requirement #3: Establishment of an independent PEPFAR-funded KP community consortium if it does not already exist, in collaboration with diverse stakeholders.

There is an already existing consortium for KP in Lesotho. Efforts will be made to add KP organizations to CLM activities.

KP Minimum Program Requirement #4: All implementing partners and their staff will be required to sign and abide to a code of conduct regarding ethical, non-discriminatory service provision for key populations.

PEPFAR Lesotho sees this as an important opportunity to amplify our long-standing nondiscrimination requirements as reflected both in agency principles and policies that all beneficiaries should be able to participate in PEPFAR programs without discrimination. This includes expanding rights and opportunities for marginalized and vulnerable groups including lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals. All IPs will be required to implement ethical, non-discriminatory services for KP in line with their approved work plans and the terms of their award. PEPFAR Lesotho is designing a new KP award expected to start in COP22. We will use this opportunity to integrate requirements that address this requirement.

KP Minimum Program Requirement #5: Community-led Monitoring activities must include provision for distinct participation and leadership of key populations.

The existing CLM tools do not include KP-specific information. To involve KP in CLM activities in COP22 PEPFAR Lesotho will engage local KP organizations to participate in the revision of the CLM tool, participate in CLM assessments, and dissemination of CLM findings as critical stakeholders.

KP Minimum Program Requirement #6: Provision of integrated KP-competent public and private service delivery that provides the opportunity for person-centered prevention, care, and treatment for the multitude of issues affecting key populations.

The People's Matrix, a Lesotho based KP organization together with other KP organizations in the region developed "A Framework Tool and Process Guide for Participatory Assessment of KP-Competence". PEPFAR Lesotho is supporting the process of piloting the tool which will be followed by refinement and then full assessment of all KP-focused organizations in Lesotho.

KP Minimum Program Requirement #7: Each country that serves key populations will submit, as part of its formal COP submission, a table that details how the country's key populations program will ensure a comprehensive, integrated service package, guided by WHO guidelines, for each key population group

The table below shows the current scope of services by geography and KP type.

| District | Technical Area | FSW | MSM | Prisoners | PWID | TG |
|---------------|----------------|-----|-----|-----------|------|----|
| Berea | Prevention | X | X | | X | |
| | Testing | X | X | X | | |
| | PrEP | X | X | | | |
| | Treatment | X | X | X | | |
| | Viral Load | X | X | X | | |
| Leribe | Prevention | X | X | | | |
| | Testing | X | X | X | | X |
| | PrEP | X | X | X | | X |
| | Treatment | X | X | X | | X |
| | Viral Load | X | X | X | | X |
| Mafeteng | Testing | X | X | | | |
| | PrEP | X | X | | | X |
| | Treatment | X | X | | | |
| | Viral Load | X | X | | | |
| | Testing | | X | | | |
| Maseru | Prevention | X | X | | | X |
| | Testing | X | X | X | | X |
| | PrEP | X | X | X | | X |
| | Treatment | X | X | X | X | X |
| | Viral Load | X | X | X | X | |
| Mohale's Hoek | Testing | X | X | X | | |
| | PrEP | X | X | X | X | X |
| | Treatment | X | X | X | | |
| | Viral Load | X | X | X | | |
| Mokhotlong | PrEP | X | | | | |
| Qacha's Nek | PrEP | | X | | | |
| | Treatment | | | X | | |
| | Viral Load | | | X | | |
| Quthing | PrEP | | X | | | X |
| | Treatment | | | X | | |

Note: Based on FY21 MER indicators from all PEPFAR partners and KP disaggregated results

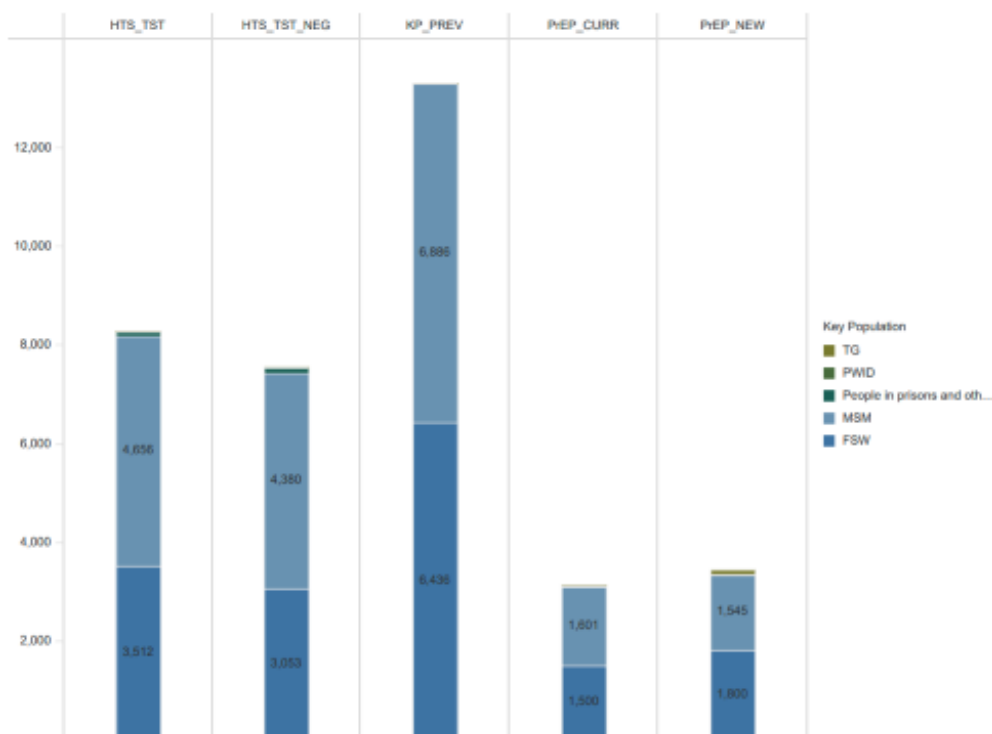
KP Minimum Program Requirement #8: Development of risk mitigation and continuity plans to ensure the safety and security for KP clients and organizations and related data in the event of political upheaval and/or violence directed at key populations.

Lesotho will aim to implement the EpiC Violence Response System Toolkit to mitigate safety and security concerns for KP. The toolkit 1) builds core knowledge among implementers and KP communities, 2) creates networks to ensure key populations' access to health, psychosocial support, and legal services, 3) builds an understanding about violence against key populations and existing efforts to address it, 4) creates systems to provide opportunities for disclosure and respond to violence, including crisis response, 5) promotes accountability to prevent violence, and 6) documents and monitors KP led organizations are already receiving organizational capacity development that involves data management and security systems.

KP Minimum Program Requirement #9: Articulation of a remuneration standard for peer outreach workers/navigators, to ensure decent work and fair pay is provided.

PEPFAR Lesotho already remunerates peer outreach workers/navigators. However, disparities in pay exist across PEPFAR supported implementing partners and with other non-PEPFAR partners who have peer outreach workers /navigators. Through the MOH HIV TWG we will work towards harmonization of pay across PEPFAR and with other non-PEPFAR organizations to standardize rates.

Figure 4.3.2 Prevention Continuum by Key Population Group



Source: PEPFAR MER data

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. 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.

The focus for COP22 remains making progress towards 80% saturation in the age cohort of 15 – 29 year in the five districts of Berea, Maseru, Leribe, Mafeteng, and Mohale's Hoek. There is no updated information in the Decision Makers Program Planning 2.0 (DMPPT) for subnational coverage, however, overall, the country stands at between 55% to 57% coverage in the age pivot of 15 – 29 years. PEPFAR Lesotho will implement the new technical considerations for VMMC that include delaying VMMC for people who test HIV positive until they complete at least a month on ART and are clinically stable to undergo VMMC. Telephonic follow up for eligible men when physical follow up is not possible.

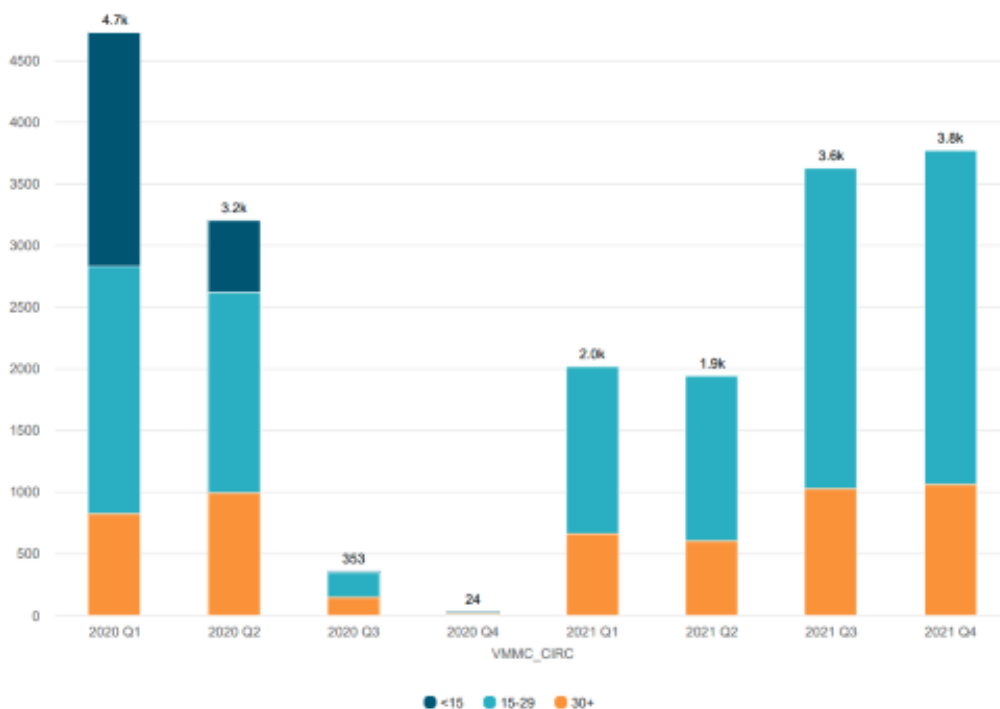
The VMMC program continues to face interruptions occasioned by COVID-19, however, mitigations have been identified and will be scaled to prevent complete program closure during spikes for COVID-19. Having recovered from the implementation interruption in FY20 where only 28% was achieved, in FY 21, the country achieved 59% of the annual target largely due to successfully pivoting the implementation within the COVID-19 setting. 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 for male initiates who prefer to anonymously access medical circumcision for fear of community discrimination. PEPFAR will coordinate with Global Fund to improve performance and quality of VMMC across the entire country.

New demand creation strategies will be implemented in COP22 through leveraging on the COVID-19 vaccination Risk Communication and Community Engagement team that is implemented by the same partner that offer VMMC, retraining, branding and better remuneration of VMMC mobilisers, appropriately branding the VMMC services, and retraining all VMMC staff on demand creation. In FY22, sub-granting and technical assistance to Christian Health Association of Lesotho and Private Clinics was initiated and will be further scaled up to increase access to services and include referrals from HIV testing sites and men's clinics. 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, 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. In FY22, an EQA was conducted, and a gap identified. Building on the findings from the EQA, the recommendations have been scaled up to all the VMMC supported sites and this will continue in COP22 to assure the quality of the program. 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 high-frequency reporting 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.

As a measure to sustain the program, the program will transition to use of re-usable VMMC kits, revise and update the VMMC training curriculum and strengthen MOH's capacity to conduct quality assessments. A new demand creation strategy tailored to the COVID-19 context and current level of saturation will be developed to guide implementation.

Figure 4.3.3 VMMC Quarterly Trends by Age, FY20 - FY21



Source: PEPFAR MER data

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

TB Preventive Therapy Scale-Up and TB Case Finding

Lesotho aims to end TB among PLHIV 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 TB among PLHIV by

up to 89%. In September 2019, Lesotho MOH's National TB Program (NTP) released new guidance on the treatment of latent TB based on WHO guidance. Historically, Lesotho has used six months of isoniazid (6H), but the updated WHO guidelines endorsed the use of three months of weekly rifapentine and isoniazid (3HP) for adults and 12 weeks of rifampicin and isoniazid (3RH) for those <15 years of age.

In the past, Lesotho faced challenges including insufficient stock of INH, poor healthcare worker attitude, and other barriers that negatively impacted TPT scale-up. In COP18, PEPFAR Lesotho conducted patient chart reviews that estimated TPT coverage at 50%. The MOH has obtained adequate stocks of INH and PEPFAR implementing partners began a surge to ensure TPT was provided for all eligible patients currently enrolled in care. This resulted in 192,879 adults and children currently on ART completing TPT, a cumulative TPT coverage of 84% as of December 31, 2021. PEPFAR Lesotho expects to reach 90% TPT coverage in COP21 and sustain TPT coverage above 90% from COP22 onwards by ensuring that all newly diagnosed HIV-positive individuals are initiated on TPT.

During COP21, PEPFAR Lesotho will support the implementation of the 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 the 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 ensure that MOH data collection tools and eRegisters capture TPT initiation and completion. PEPFAR partners will continue to support targeted site level training for health care workers and TPT specific job aides to support implementation. PEPFAR partners will ensure that at entry in care and subsequent clinical interactions, all patients are screened for TB symptoms before initiation and during TPT. This will be captured in the TB detection register or the eRegisters.

The MOH recognized the dynamic and unpredictable nature of the COVID-19 pandemic and issued guidance to health facilities to ensure minimal service interruption in terms of TPT delivery in FY21. To ensure client-centered approaches, the MOH recommended TPT delivery through DSD models. This recommendation facilitated dispensing of multi-month supplies that allowed PLHIV who had already started a TPT course to complete it without returning to the health facility. Virtual patient follow-up was provided to support adherence and monitor adverse events.

Lesotho has one of the world's most severe epidemics of tuberculosis (TB) and HIV, with an estimated TB incidence of 650 per 100,000 population (14,000 incident TB cases, including 8,200 estimated to be TB and HIV co-infected). Current TB incidence estimates are supported by Lesotho's first TB prevalence survey that was completed in 2020. The TB prevalence survey confirmed a TB prevalence of 581 per 100,000 and identified key gaps in case identification. PEPFAR Lesotho will ensure that its investments at site, district and central levels address identified gaps including sub-optimal TB screening, underdiagnosis among children, major leakages across the TB diagnostic cascade, and poor TB treatment outcomes.

During COP22, PEPFAR Lesotho will continue to support the NTPs efforts for active TB case finding support of (i) intensified TB case finding among all PLHIV screened at every encounter using the new 2021 WHO recommendations on TB screening that include the 4-symptom screening tool combined with chest X-ray and other WHO recommended rapid diagnostics. Screening will cover key service points and community settings to reach OVC and KP services. PEPFAR Lesotho will continue to support dual TB/COVID-19 screening; (ii) PEPFAR partners will ensure optimized TB/HIV care and treatment using urine based lipoarabinomannan (LF-LAM)

assays, ensuring the prompt start of TB treatment and ART, and ensuring completion of treatment.

As Lesotho reaches epidemic control, some of the lay HTS counselors have been repurposed for TB contact tracing and documenting the TB detection cascade at facilities 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 addition, PEPFAR Lesotho will provide TB diagnostics support including CXR subsidies, GeneXpert cartridges, DST reagents and LF-LAM. PEPFAR resources will also support TB diagnostics optimization, TB strategic information for TB (operational research, TB indicators, TB score card), guidelines revisions, job aides, and continuous quality improvement initiatives. PEPFAR supported partners will ensure that infection prevention and control measures (IPC) are implemented at all facilities and community settings.

Recency Testing

In COP18, Lesotho integrated recent infection testing into routine HIV services at pilot sites in Leribe to establish a surveillance system of newly identified cases to monitor epidemiological trends. Detecting recent HIV infections among newly diagnosed individuals is a high priority activity that will support HIV epidemic control.

The COVID-19 pandemic severely impacted implementation of recency testing resulting in the pause of all site-level activities for approximately 18 months. With an improving pandemic situation and increasing COVID-19 vaccination coverage, recency activities were resumed in the initial sites in Leribe in November 2021.

In COP21 PEPFAR Lesotho is conducting a rapid geographic expansion of recent infection testing among new diagnosed HIV persons aged 15 and above. We aim to reach 100 facilities in the ten districts. This will achieve national coverage by the end of COP21. During COP22 implementation, we will continue geographic expansion within each district by adding additional HTS sites.

In COP21, PEPFAR Lesotho integrated viral load (VL) results into the recent infection testing algorithm (RITA) to improve the classification of recency status of individuals with a positive test for recent infection (RTRI).

Recent infection surveillance implementation is a collaborative effort including PEPFAR HIV testing 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.

Implementation of Advanced HIV Disease Programming

The LEPHIA 2020 shows that the burden of advanced HIV disease among newly identified HIV positive individuals is still significant as 14 % participants who were unaware of their HIV positive status had a CD4 less than 200 cells/ μ L. This is most marked among males at 18% compared to females at 11%. In COP 22, PEPFAR Lesotho continued to be committed to reducing mortality for PLHIV by providing differentiated service delivery for patients with advanced HIV disease (AHD).

The study “Implementation and Evaluation Differentiated HIV Care and Treatment for People with Advanced HIV Disease in Lesotho” conducted in two district hospitals, Berea Government Hospital and Motebang Hospital during FY19/20 has guided Lesotho in the at the strengthening of 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 with 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 TPT as indicated; (d) systematic screening for CrAg; and (e) intensive follow-up.

In COP20/21 there had been successes in AHD implementation which include: 1) revitalization of AHD services in all hospitals despite the COVID 19, 2) AHD manual and related tools were completed, printed and distributed for use, 3) routinised MOH led AHD specific supportive supervision, 4) availability of AHD commodities (laboratory and pharmaceuticals), 5) multidisciplinary clinical providers had been trained on the recommended package of care for PLHIV with AHD, 6) AHD patient visit schedules were adjusted in accordance with the pandemic situation (multi month dispensing for ART, TPT, virtual patient adherence support and follow ups and patient centered approaches during the pandemic. However, critical gaps identified that will be addressed in COP21/COP2022 include suboptimal AHD package implementation at some sites especially for pediatrics and non-suppressed patients and stock out or expiries or underutilization of AHD commodities (TB-LAM, CrAG).

For COP20/COP21 PEPFAR Lesotho leveraged other investments from MOH, the Clinton Health Access Initiative (CHAI) and GF to implement the WHO recommended AHD package. PEPFAR Lesotho will specifically supported training of multidisciplinary health care workers on the MOH's AHD manual, mentorship of health care workers in implementation of the AHD package as prescribed in the Lesotho/WHO AHD guidelines, and dissemination of AHD manual and related job aides such as the algorithm for providing a package of care for people with AHD. To manage risk of AHD in children, PEPFAR Lesotho is also providing support to the pediatric case finding and ensure that all children < 5years are started or transitioned to more optimized/effective regimens. Additionally, PEPFAR support for AHD diagnostic commodities like CD4, CrAg, Xpert cartridges, TB-LAM which are aimed at addressing the gaps in the AHD clinical cascade.

In COP2022 PEPFAR will provide intensified support to ensure adherence to the AHD package based on WHO and MOH AHD guidance. PEPFAR will support the expansion of AHD management package to the 54 additional lower health facilities using a hub spoke model including continuous quality improvement activities for AHD. This support focuses on the theme to STOP AIDS which in brief includes (1) Screening for opportunistic infections like TB, cryptococcal meningitis, (2) Treat all opportunistic infections like TB and cryptococcal meningitis (3) Optimize ART which focuses on rapid initiation of optimized ART regimens for both Children and Adults and (4) Prevent opportunistic infections through provision of TB Preventive Therapy, fluconazole and cotrimoxazole for all eligible PLHIV.

The COP2022 Advanced HIV Disease priorities will include:

- Training clinical providers (multidisciplinary cadres) on the WHO recommended package of care for PLHIV with advanced disease including the Lesotho AHD Manual and related job aides. This will also include incorporation of the pediatric AHD package outlined in the July 2020 WHO brief, key considerations will include screening for malnutrition, screening for cryptococcal disease for those aged 10 years and above and ensuring routine vaccinations.

- Ensure availability of related lab commodities including CD4 reagents, Cryptococcal antigen testing, LFLAM test (urine-based TB test), Xpert MTB/RIF Ultra and ensuring Optimization of Lab equipment/platforms across the country.
- PEPFAR Lesotho provides resources to pilot the WHO-prequalified Omega Diagnostics VISITECT CD4 Advanced Disease test, a rapid, semi-quantitative lateral flow assay that differentiates CD4 values above and below 200 cells/mm. In addition, PEPFAR will continue strengthening specimen referral and result reporting network linking facilities to CD4 testing service to improve AHD identification.
- Ensure availability of necessary pharmaceutical commodities in collaboration with key players like MOH, Global Fund and CHAI) These commodities include TPT(INH/3HP), Fluconazole, Flucytosine, liposomal Amphotericin, etc.
- Patient follow-up and monitoring through a standardized visit schedule (First visit, Week 2 Month 1, Month 3, Month 5, Month 6 (milestone VL Sample collection) and patient centered approaches
- Utilize ECHO platforms to manage AHD patients at lower health units and build capacity (hub and spoke AHD DSD model).

PEPFAR Lesotho will continue to 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 health systems investments like optimization of CD4 testing instruments including 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.

HIV Drug Resistant Surveillance

The LePHIA 2016-17 estimated the transmitted resistance to ARVS in Lesotho at 11.4% with most mutations conferring resistance to non-nucleoside reverse transcriptase inhibitors (NNRTIs). During COP18, PEPFAR Lesotho supported an HIV Drug Resistance survey through a 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% in 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 resistance among individuals on ART with viral load \geq 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 be available before the end of COP20.

Lesotho has scaled up the DTG-based regimen to all eligible adults and children above 35kg. Greater than 98% of the eligible patients currently on ART have been fully transitioned to DTG-

based regimen. In COP21, Lesotho has prioritized the scale up of pediatric DTG-based regimens to all eligible children weighing >3kg, with the pediatric DTG 10mg dispersible tablets provided as a new formulation in this fiscal year. In COP2022, the country is expected to complete transition to the optimized children friendly regimen. DTG has a high barrier to HIV drug resistance (HIVDR) and therefore virological failure among ART naive patients is very rare. Lesotho is using TLD for both first- and second-line regimen. PEPFAR Lesotho will no longer support conducting NNRTI based regimen surveillance, as Lesotho has already established the prevalence and pattern of NNRTI related HIVDR. Lesotho is implementing HIV recency testing that includes viral load (VL) testing, as part of a recent infection testing algorithm (RITA), samples from recency may be considered for pre-treatment resistance.

PEPFAR-supported HIVDR surveillance activities will mainly focus on patients failing on TLD. PEPFAR Lesotho will collaborate with the MOH, National Reference Laboratory (NRL) to establish systems and applicable procedures for ongoing HIV Drug Resistance surveillance. This may include (i) use of remnant samples routinely collected for patient care, (ii) Use of Cyclical Acquired Drug Resistance (CADRE) by obtaining samples and minimum epi data from Lesotho's viral load testing platforms.

4.5 Additional Program Priorities

National policies and programmatic impacts

During FY21 and FY22, the MOH has rolled out new policy guidelines for: (i) the Prevention of Mother-to-child transmission of HIV (PMTCT); (ii) HIV prevention and treatment guidelines; (iii) Advanced HIV Disease guidelines. The national training of trainers on the new policies has been completed and district and site level training for the PMTCT and AHD has already started. The ART guidelines step-down trainings are scheduled to start in April 2022. All three policies align to the COP22 minimum programming requirements for case identification, care & treatment, laboratory optimization, averting mortality, and promotion of people-centered care.

The new edition of the National ART guidelines emphasizes delivery of quality, non-judgmental, people-centered HIV service throughout the country. Implementation is expected to enable Lesotho to reach the strategic goal of Ending AIDS, Ending Inequalities by 2030.

Index Testing

In COP22, index testing will continue to be scaled up with standard index testing SOPs, training of providers, and supportive supervisions on a routine quarterly basis. Sites will have monthly index testing plans for outreach and routine tracking collaborations with other community partners and programs where available. The collaboration for community tracking of index testing shall be guided by signing of standard data sharing agreements by facility and community entities working together on contact tracing.

All providers will receive refresher trainings on safe and ethical index testing services, including assessing, and responding to potential and actual intimate partner violence among the index clients; sites will have up-to-date referral directory for their clients for services they may need because of receiving index testing services (mental, legal, social, etc.). Community education and mobilization through U=U messaging will continue to be scaled up through various communication channels to encourage partners to access HIV testing services and increase uptake of index testing. Sites will be assessed on an annual basis to ensure that the minimum program requirements for index testing services are maintained. Sites that do not meet these minimum requirements shall receive intensive support to develop remedial action plans to address the

gaps. The PEPFAR-supported community led monitoring (CLM) activity will be leveraged to ensure that facilities are held accountable for the provision of high quality, safe and ethical services overall.

Management of implementing partners

PEPFAR Lesotho utilizes several strategies to manage its implementing partners and ensure alignment with PEPFAR program strategy and monitor partner performance. In addition to agency-specific management oversight by activity managers and program officers, PEPFAR Lesotho hosts routine meetings on at least a monthly basis. These meetings provide an opportunity to disseminate key information to all implementing partners, receive feedback and share best practices. PEPFAR Lesotho intends to implement SIMS in COP22 pending COVID-19 guidance. Additionally, quarterly POARTs allow the PEPFAR Team to track performance. Community-led monitoring will offer an additional stream of data to assess patient satisfaction and quality of care.

Community Led Monitoring

As part of advancing towards a people-centered service approach, Community Led Monitoring (CLM) remains critical and relevant for COP22. CLM facilitates receiving input from recipients of HIV services in a routine and systematic manner to help unpack issues affecting access and utilization of quality HIV services, while at same time strengthening the capacity of communities. CLM helps PEPFAR and health institutions to identify persistent problems, challenges, and barriers to effective service and client outcomes at the site level to formulate workable solutions that overcome these barriers and ensure people have access to quality services.

In COP21, PEPFAR Lesotho provided \$250,000 of funding for the development and implementation of CLM. Currently, CLM is set to cover nine districts across Lesotho and 160 health facilities. Beginning in July of 2021, PEPFAR engaged 10 Civil Society (CSOs) who are mostly Community Based Organizations (CBOs) and one local NGO to lead the implementation of CLM. Global Health Access Initiative (GHAI), is responsible for coordinating the overall implementation of CLM, as well as strengthening the capacity of the 10 local CSOs. The capacity building package includes technical training on the principles and practices of CLM, data collection, analysis and reporting, advocacy, and customized organizational development. CLM has experienced programmatic delays due to COVID-19 programmatic restrictions and continues to await concurrence from the Ministry of Health.

In COP22, PEPFAR Lesotho will continue to fund CLM at \$250,000. PEPFAR Lesotho will coordinate closely with The Global Fund, which also intends to implement CLM in FY23. The geographic scope of PEPFAR-supported CLM activities will be reviewed to avoid duplication of efforts. PEPFAR intends to continue to support the 10 CSOs with capacity building support. CSOs will collect data quarterly using a tool that has been harmonized with the Global Fund's CLM program to ensure alignment and support the ability to track critical HIV program indicators. CLM findings will be triangulated with PEPFAR data streams (such as MER reporting and SIMS), as well as other partners engaged in CLM. The findings will be shared periodically with relevant stakeholders, including the Ministry of Health, CSOs and community members.

To advance involvement of Key Populations into CLM activities, PEPFAR Lesotho intends to engage local KP organizations to obtain feedback on approaches that may be employed for the next phase of CLM. PEPFAR Lesotho will then harmonize the CLM tool to ensure relevant KP-specific issues are covered. Additionally, key population groups will be included as critical stakeholders during the dissemination of CLM findings.

4.6 Commodities

In an effort to achieve sustained epidemic control, it is critical to maintain an uninterrupted supply of quality assured commodities including ARVs, Rapid Test Kits (RTK's), Early Infant Diagnosis (EID) products, viral load, condoms and TLD commodities. In addition, TPT, VMMC and PrEP commodities remain vital to ensure that patients don't contract TB and new HIV infections are averted

In FY23, PEPFAR Lesotho will spend \$6,007,545 to support procurement of laboratory commodities, RTKs (Recency), condoms and lubricants, VMMC kits, and ARVs for PrEP. PEPFAR has allocated sufficient funds for laboratory commodities to cover 75% of the country's need for VL monitoring, EID, and TB diagnosis in the 10 districts. GF will also support 25% of laboratory commodities required by the country to cover all sites in the 10 districts of Lesotho. ARVs and Rapid diagnostic Test Kits (RTKs) will be funded by GF and MOH.

PEPFAR, through the GHSC-PSM 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 and to transition this functionality systematically over to the FOL. The GHSC-PSM project teams are well positioned with their quantification tools (Pipeline and QuantiMed) to complete the needed analysis to fill in supply plans for all HIV and AIDS tracer commodities.

The Government of Lesotho has committed funding to meet 75% of the country's needs for ARV commodities and the GF has committed 25%, therefore leaving no gaps for the procurement of ARVs. Similarly, for RTKs, VL and EID (POC and conventional), there is no gap between the number of tests needed by the country in COP22 and the amount committed by GF and PEPFAR. Generally, there are no commodity concerns related to possible stock-outs due to projected funding gaps.

In FY21, PEPFAR supported implementation of Service Level Agreements (SLA) with VL and EID lab commodities through reagent lease agreement between the GOL and vendors (Roche and Hologic) using the global pricing. In FY22, PEPFAR supported the review of the SLA to determine and reduce the bottle necks encountered during implementation. This significantly reduced stock outs and machine breakdown and led to a scale up of POC VL/EID in facilities to increase our VL coverage and turnaround times thereby allowing us better patient management.

The GHSC-PSM program has provided technical assistance for contract management practice within the SCMD to enhance commodity contract performance using key performance indicators (KPIs). However, COVID 19 undermined some of these efforts by lengthening the lead-times for commodity procurement resulting in some stock outs and expiries. In COP22, the plan is for GHSC PSM to continue to monitor inclusion of KPIs or delivery milestones and accountability processes both at the central and local level and to expand the POC VL/EID to other health facilities to increase VL and EID coverage and decrease total cost per test.

In preparation for eventual transition of supply chain functionalities to the government of Lesotho, PEPFAR Lesotho through the Promoting Quality of Medicines activity will help the GOL to address targeted gaps identified through the implementation of the WHO Global Benchmarking Tool in 2018 and reflected in the ensuing institutional development plan.

PEPFAR Lesotho will continue to coordinate with GF, UNPFA and MOH to ensure that there is an adequate budget and supply for Condoms and Lubricants for commodity security across all

the 10 districts in Lesotho for COP22. Availability of male condoms remain impacted by COVID-19 restrictions and increased lead times as with other commodities. There have been some stock outs of male condoms at the national level, but the situation is now normalizing.

| Table 4.6.2 FY 2021/2022 Commodities Budget for MOH, PEPFAR & Global Fund | | | | |
|--|---------------------|--------------------|--------------------|---------------------|
| Commodity | MOH | Global Fund | PEPFAR | Totals |
| ARVs-Adult + Pediatric | \$21,323,150 | \$5,618,328 | \$0 | \$26,941,478 |
| ARVs for PrEP | \$114,256 | \$0 | \$0 | \$114,256 |
| HIV Test Kits | \$46,970 | \$931,723 | \$57,200 | \$1,035,893 |
| Condoms and lubes | \$0 | \$114,088 | \$185,390 | \$299,478 |
| Self-Testing Kits | \$108,780 | \$290,679 | \$0 | \$399,459 |
| TPT Commodities | \$728,659 | \$510,855 | \$0 | \$1,239,514 |
| Laboratory commodities | \$1,315,773 | \$2,393,844 | \$5,566,580 | \$9,276,197 |
| VMMC kits | \$0 | \$61,965 | \$198,375 | \$260,340 |
| Essential Medicines & Supplies | \$7,466,031 | \$0 | \$0 | \$7,466,031 |
| Grand Total | \$31,103,619 | \$9,921,482 | \$6,007,545 | \$47,032,646 |

The DSD provided by the district logistics officers (DLOs) has had an impact on commodity visibility including integrating COVID 19 commodities and consumables in the GoL Supply Chain Management (SCM). The COVID 19 requisition orders move swiftly from the site level through to DHMTs to the central medical stores through the Informed PUSH system. In COP22, PEPFAR through GHSC-PSM will continue to support COVID commodities management including COVID commodity procurement, vaccine wastage, and storage, generating stock status reports and forecasting exercises. Another achievement is the successful transition of the DLOs to the MoH SCMD. GHSC - PSM will keep four Regional Logistics Coordinators to continue overseeing and supporting the roles of the DLOs in COP22.

4.6.1 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.

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. The MOH has shown political commitment and transitioned approximately 224,592 of PLHIV in Lesotho from all legacy regimens to TLD as at end of Q4 FY21.

The MOH has also revised the regimens for pediatrics in August 2021 to include DTG 10mg for children >20 kg as the preferred 1st line treatment. The MOH has received first consignments of DTG10mg for the planned transition in Q3 of FY22. Currently, health care workers are going through training for quality implementation of the DTG 10mg transition. The plan is to conduct a

phased approach starting with peds newly initiated on treatment and those that have high viral load. By September FY21, the plan is to have transitioned all peds to DTG 10 mg.

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 2021 to 2022 budgets and for COP22, PEPFAR will continue to support this activity.

4.7 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 challenges. These meetings provide an opportunity to discuss collaboration among donors, examine PEPFAR priorities, and ensure alignment with the GOL strategic framework.

The quarterly POART stakeholder meetings have been 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.

Prior to the COVID-19 pandemic, PEPFAR and UNAIDS co-chaired the monthly HIV Development Partner meeting. This forum allowed 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 the Oversight Committee for GF. PEPFAR participation ensures there is joint planning and program coordination between the two largest donors to the national HIV response.

PEPFAR Lesotho holds monthly meetings with the IP that allow the team to track progress between quarterly reporting periods and improve data quality by allowing questions and concerns to be flagged. These IP 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 IP meetings also provide an opportunity for the activity managers to provide technical assistance and guidance to IP to improve their implementation of programmatic activities. The agency activity managers have near daily interactions with partners by phone and email. In-person meetings with IP have largely been suspended due to the COVID-19 pandemic.

PEPFAR Lesotho is working closely with the new, local partners. Training and capacity building support in the areas of technical programming and organizational capacity are being provided. 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. CDC has implemented a system requiring quarterly spend plans and expenditure reports from their partners to help determine where activities have been delayed or changed due to COVID-19. This system also allows activity managers to provide inputs to IP on where alternative strategies can be implemented to ensure partners are still able to achieve their program objectives and targets.

SIMS is a key component of PEPFAR Lesotho program monitoring. Prior to the COVID-19 pandemic, SIMS assessments were done monthly and all sites were visited at least once a year. There were also quarterly DQA to ensure that site level data were complete and accurate. In

combination with SIMS, PEPFAR Lesotho conducted routine site monitoring visits to take a more comprehensive look at challenges, help identify best practices, and address gaps in the clinical cascade. Beginning in March 2020, SIMS, DQA and most site visits were suspended. As the Omicron wave recedes, we plan to resume these activities in FY22 Q3.

All high-level COP planning is done as an interagency team. Except for the Peace Corps and Treasury, PEPFAR Lesotho staff are all located in one building on the Embassy compound. The PEPFAR program will continue to support inter-partner collaborative efforts to strengthen key health system-related interventions that are critical to bridging programmatic gaps. Specifically:

- The clinic-laboratory interface will provide opportunities to review whether site level demand for VL, EID, and TB/GeneXpert services align with the national testing capacity, turn-around time of results, and ensure 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 in case of stock-outs or delayed commodity ordering.
- PEPFAR Lesotho will continue to support the MOH in the roll-out of eRegisters, the health information exchange and unique identifiers.

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 services for men).

Once MOH concurrence is obtained, we plan to begin implementation of community-led monitoring. We will collaborate with GF and UNICEF so that all CLM efforts are aligned.

4.8 Targets by population

Standard Table 4.8.1

| Table 4.8.1 ART Targets by Prioritization for Epidemic Control | | | | | | |
|--|----------------|------------------------------------|---|--|-----------------------------------|-----------------------|
| Prioritization Area | Total PLHIV | Expected current on ART (APR FY22) | Additional patients required for 80% ART coverage | Target current on ART (APR FY23) TX_CURR | Newly initiated (APR FY23) TX_NEW | ART Coverage (APR 23) |
| Attained | 178,561 | 162,286 | 0 | 161,585 | 8,270 | 93% |
| Scale-Up Saturation | 103,132 | 91,733 | 0 | 94,601 | 6,174 | 94% |
| Scale-Up Aggressive | | | | | | |
| Sustained | | | | | | |
| Central Support | | | | | | |
| Commodities (if not included in previous categories) | | | | | | |
| Total | 281,693 | 254,019 | 0 | 256,186 | 14,444 | 94% |

Standard Table 4.8.2

| Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts | | | | | |
|--|----------------------|---------------------------------|-------------------------|---------------------|-----------------------------|
| SNU | Target Populations | Population Size Estimate (SNUs) | Current Coverage (date) | VMMC_CIRC (in FY23) | Expected Coverage (in FY23) |
| Berea, Leribe, Mafeteng, Maseru, Mohale's Hoek | 15-29 | 210,378 | 58% | 20,220 | 80% |
| | Total/Average | 210,378 | 58% | 20,220 | 80% |

*Male population size estimate from national estimates

Standard Table 4.8.3

| Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control | | | |
|--|----------------------------------|-----------------|----------------|
| Target Populations | Population Size Estimate* (SNUs) | Disease Burden* | FY23 Target |
| PP_PREV (Berea, Butha Buthe, Leribe, Mafeteng, Maseru, Mohale's Hoek, Mokhotlong, Qacha's Nek, Quthing, Thaba-Tseka) | 726,599 | 5% | 218,476 |
| AGYW_PREV (10-24 years) (Berea, Mafeteng, Maseru, Mohale's Hoek) | 186,218 | 7% | 57,859 |
| KP_PREV (Leribe, Maseru) | 24,862 | 20% | 13,294 |
| TOTAL | 937,679 | 11% | 289,629 |

*AGYW population calculated based on the percentage of vulnerable children from the VAC Survey 2018

** KP size estimate for FY23 in Leribe and Maseru only. Priority population size estimate is based on OVC target population, AGYW, and the client of FSW including military and taxi drivers.

Standard Table 4.8.4

| Table 4.8.4 Targets for OVC and Linkages to HIV Services | | | | | |
|--|--|---|---|--|---|
| SNU | Estimated # of Orphans and Vulnerable Children | Target # of active OVC (FY23 Target) OVC_SERV Comprehensive | Target # of OVC (FY23 Target) OVC_SERV Preventative | Target # of active OVC (FY23 Target) OVC_SERV DREAMS | Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC* |
| Berea, Butha Buthe, Leribe, Mafeteng, Maseru, Mohale's Hoek, Mokhotlong, Qacha's Nek, Quthing, Thaba-Tseka | 363,500 | 69,960 | 7,707 | 17,760 | 52,545 |
| TOTAL | 363,500 | 69,960 | 7,707 | 17,760 | 52,545 |

*OVC estimate from Lesotho 2021 multidimensional child poverty report by BOS, UNICEF and MoSD

4.9 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 are six-times at higher risk of developing cervical cancer compared to HIV negative women.

The APR21 results from 117 sites show a total of 33,080 WLHIV were screened and 1,324 were identified to have pre-cancerous lesions, representing 4% positivity rates. Cervical cancer screen-and-treat services are provided either in ART clinics and/or within MNCH settings based on availability of space in the health units. A total of 1,022 women living with HIV diagnosed with precancerous lesions were treated, representing 77% treatment coverage rates. Thermocoagulation is the main treatment method with 82% of women treated with this approach, 17% treated with LEEP, and 1% treated with cryotherapy.

The APR21 results represent 23% screening coverage rates in WLHIV on ART. Lower screening rates, especially in the first three quarters of FY21, are a result of a combination of MOH regulatory COVID-19 framework that classified cervical cancer as a non-essential service; high MMD uptake reducing frequency of clinic visits; and HRH shortages due to reassignment to COVID-19 activities or PEPFAR staffing reductions. Programming adaptations included flexible working hours to start screening before ART services begin, use of roving teams to augment site level HRH to increase screening and treatment coverage, activity screening for screening eligibility at the triage desk, and enhanced demand creation with appointments within community-based DSD models.

During COP22, the PEPFAR Lesotho program will build on these gains to continue scaling up access to services for secondary prevention of cervical cancer in the 117 sites as a strategy to reduce morbidity and mortality among WLHIV aged 25-49 years. This Go Further initiative will continue to build on existing health systems to increase access to cervical cancer screening and treatment of precancerous lesions in the ART and MNCH settings and collaborate with the MOH on timely referral of women who screen positive for invasive cancer to the national referral hospital or to South Africa. Key interventions for COP22 include:

- **Policy Framework:** PEPFAR supported the MOH to update the national Cervical Cancer Prevention policy in 2021 that are aligned to the WHO and PEPFAR guidelines, including HPT DNA testing. PEPFAR will continue to provide technical support in step-down training on the new guidelines, updating of job aides, and M&E tools.
- **Screening and treatment approaches:** The program will continue to implement the “screen-and-treat” approach in all districts with <90% treatment coverage rates, and through a phased approach, gradually roll-out the “screen-triage-and-treat” approach using HPV DNA testing in two districts that will demonstrate attainment of 90% treatment coverage by end of FY22. The program will continue to scale up the use of thermocoagulation and LEEP based on eligibility criteria in the national guidelines, and cryotherapy will be offered when there are optimal stock levels for liquid nitrogen.
- **Approaches to increase linkage to cervical cancer screening and treatment services and quality standards:** The PEPFAR program will continue to support site level services

through HRH surge support of static and roving teams; finalization of VIA quality assurance SOPs; standardizing the critical care pathway to align screening with MMD refill dates; support of histopathology examination of LEEP specimens; and demand creation for screening and treatment through health talks, active triage during clinic visits, and within differentiated service delivery models. Capacity building to improve the knowledge and skills of national, district, and site-level staff is offered through on-site trainings, clinical attachments to the Senkatana cervical cancer center of excellence, and on-going mentorship. Site, district, and partner-level performance reviews will be conducted through monthly progress reviews, site-level visits for programmatic monitoring and SIMS.

- **Mechanism budgetary allocation for the cervical cancer program:** The COP22 budget is \$1,000,000 for the cervical cancer prevention program to expand cervical screening services to 55,146 WLHIV aged 25-49 years, which reflects 57% of the current on treatment (TX_CURR) target in this age group. The table below provides the IM-specific budgetary allocation for the COP22 FAST:

| Funding Agency | Mechanism Name | Partner Name | Mechanism ID | Program Area | Beneficiary | COP22 FAST Budget | COP22 Mechanism Total Budget |
|-----------------------------|--|--|--------------|--------------------------------|----------------------|--------------------|------------------------------|
| USAID | Providing Universal Services for HIV/AIDS (PUSH) | Elizabeth Glaser Pediatric Aids Foundation | 18020 | C&T: Not Disaggregated-NSD | Females: Adult women | \$70,350 | \$428,694 |
| | | | | C&T: Not Disaggregated-SD | Females: Adult women | \$358,344 | |
| USAID | Expanding Tuberculosis and HIV Clinical Services (ETHICS) | Baylor College of Medicine Children's Foundation - Lesotho | 81742 | C&T: Not Disaggregated-NSD | Females: Adult women | \$10,015 | \$28,030 |
| | | | | C&T: Not Disaggregated-SD | Females: Adult women | \$18,015 | |
| HHS/CDC | Accelerating Lesotho's Progress to Epidemic Control through Health Systems Strengthening | Elizabeth Glaser Pediatric Aids Foundation | 84517 | C&T: HIV Clinical Services-NSD | Females: Adult women | \$66,700 | \$416,700 |
| | | | | C&T: HIV Clinical Services-SD | Females: Adult women | \$350,000 | |
| USAID | [Placeholder - 85822 Lesotho USAID] | TBD | 85822 | C&T: Not Disaggregated-NSD | Females: Adult women | \$45,225 | \$126,576 |
| | | | | C&T: Not Disaggregated-SD | Females: Adult women | \$81,351 | |
| Total All Mechanisms | | | | | | \$1,000,000 | \$1,000,000 |

4.10 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 COP22, the technical support will focus on strengthening optimization and integration of both conventional and point of care (POC) instruments to scale up VL, EID, TB and COVID-19 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 with key performance indicators in place. The implementation and strengthening of diagnostic network optimization and integrated services is expected to improve quality, efficiency and cost-effectiveness.

The program has mapped instruments and laboratory networks with capacity and utilization. Specimen transport and laboratory network optimization has already been operationalized since

FY20. Lesotho is using 8 Roche platforms, 1 Hologic Panther, 15 Abbott m-PIMA and 63 GeneXpert (61 GX-IV and 2 GX-VIII) instruments. The POC-EID instruments (15 Abbott-PIMA and 15 GeneXpert-IV) that were rolled out separately have now been optimized and integrated across the program to support multipurpose testing services. 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 FY22, VL monitoring is expected to cover 95% of eligible PLHIV on ART while in COP22, 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, a high throughput C6800 Roche instrument was placed at NRL in addition to the already existing C4800 and Panther platforms. This increased the national testing capacity by 23% as a measure to mitigate the testing gap. 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 or POC VL testing services are not provided.

The reference and all clinical laboratories will optimize the use of LIS to improve data flow between laboratories and health facilities and strengthen the VL dashboard to support data analysis and visualization at the national level. SMS 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. In FY21 and FY22 Q1, roll-out and training of Health personnel for POC VL testing service has expanded to 20 Hubs and 60 spokes. This scale up covered additional health facilities where conventional testing services are not accessible and time-sensitive monitoring cannot be provided to PBFW and virally unsuppressed patients. The expansion also included testing for children and adolescents with the aim to increase their coverage. Both GeneXpert and mPIMA platforms are 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\$4,850,870, which is expected to cover 75% of the national need. The remaining cost is anticipated to be covered by GF. About US\$786,526 has been allocated to cover specimen transport services, consumables, and ancillary equipment. In addition, \$800,000 has been allocated for program management, personnel, training, and technical assistance across all testing areas.

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 COP22, 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, 80 health facilities will continue providing POC EID services. Through multiplexing, inclusion of EID on existing POC VL devices will continue to increase access to HIV testing services in infants. Using a hub and spoke approach, 200 health facilities will access POC EID services.

In COP22, 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\$433,188 for procurement and distribution of POC EID commodities. 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 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 83% with the transmission rate of 1.4% while the remaining proportion of HIV-exposed infants continue to present late for their first virologic test within 2 to 12 months. PEPFAR Lesotho has budgeted for procurement of pediatric sets to enable blood collection from infants. Because of that high coverage of EID, Lesotho will implement birth testing for high-risk infants in COP21. 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 COP22, 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. 75% of the GeneXpert capacity will be dedicated to TB testing while 25% will be dedicated for POC EID and POC VL testing services. To date 18 Hubs and 40 spokes are offering multi testing on VL, EID and TB with the aim of further increasing the sites. In addition, GeneXpert platforms are also used for the rapid Xpert Xpress SARS-CoV-2 test,

which is a rapid real-time RT-PCR test. The COVID-testing services will further be decentralized and will be further optimized using the available platforms.

As part of integrated laboratory support, PEPFAR will continue to procure TB lab commodities. In COP21, PEPFAR Lesotho budgeted US\$177,860 for TB/GeneXpert cartridge and other TB tests. 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 by mid FY22. Overall, PEPFAR's support is expected to cover 75% of the national testing demand while the remaining gap will be covered by GF. Apart from GeneXpert technology, Lesotho will utilize the urine LF-LAM assay as a rapid point-of-care diagnostic test according to national guidelines. The current WHO guidance (2021) also recommends use of LF-LAM for both in-patient and outpatient diagnosis of TB among PLHIV. However, the LF-LAM is not intended to replace initial mWRD tests, and it will be used in combination with other molecular diagnostic tests, for adults, adolescents, and children living with HIV. A positive LF-LAM result is considered as bacteriological confirmation of TB in PLHIV, and TB treatment will be initiated immediately while waiting for confirmatory molecular test results per national guidelines.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Key systems barriers identified include: 1) weak supply chain management systems at all levels of the public health care system, 2) limited capacity of diagnostic and monitoring services and 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.

For COP22, the areas identified for above site systems strengthening include:

1. Supply chain
2. Laboratory
3. Strategic information
4. HIV/TB program management

Investments in these areas will address current programmatic gaps in health systems strengthening (HSS), which are crucial to achieving national 95-95-95 targets by the end of COP22. PEPFAR Lesotho will: 1) strengthen the supply chain management system in order to prevent stock-outs of HIV-related commodities, such as HIV rapid test kits and VL reagents and consumables, 2) strengthen laboratory systems to support 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 ART and TB programs.

PEPFAR Lesotho is currently investing in these areas 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 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.

5.1 Supply Chain

Technical support and capacity building will continue to be provided to the MOH, SCMD, Pharmacy Directorate, DHMT, and NDSO to ensure an uninterrupted supply of quality assured HIV-related commodities. Supply chain activities will support the scale-up and sustainability of good inventory management practices; transfer of skills to the MOH and NDSO to conduct accurate and timely quantification exercises; and working with the GOL to address targeted, time-limited barriers identified in the 2018 Institutional Development Plan; differentiated service delivery models including MMD, CAGS, and DDD.

5.2 Laboratory

The key system gaps in laboratory service were identified during site improvement through monitoring system (SIMS) assessments, a national assessment, and the sustainability index dashboard (SID 2021). There is still limited capacity with diagnostic and monitoring services including laboratory systems. Challenges include lack of laboratory infrastructure, human resources, and a national accreditation system to sustain quality of services. PEPFAR will support laboratory network optimization, information systems, continuous quality improvement, and biosafety and waste management.

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 will include 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.

A quality management system with the 12 elements of a quality system will be used as a working framework. Clinical laboratories and POCT sites will be enrolled in proficiency testing (PT) schemes for VL, EID, CD4, and TB. The laboratories and 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).

5.3 Strategic Information

One of PEPFAR Lesotho's strategic priorities for COP2022 is the continuous improvement of data management, patient management and patient tracking. PEPFAR strategic information support has focused on eRegister, Health Information Exchange (HIE), DHIS2 Support and data quality assessments for HIV and TB program data. The eRegister has been scaled-up to 184 facilities nationwide. This ensures that >90% of all people taking antiretroviral medication can be accurately tracked and promptly updated in the national health information systems. For Lesotho to accurately measure progress towards the UNAIDS 95-95-95 goals, key features in the eRegister have been updated include Shared Health Record (SHR) that allows to retrieve and share longitudinal sentinel data among authorized clinicians. This longitudinal information may include HIV testing, linkage, treatment, and viral suppression records of transfer in patients (for both documented and silent transfers) to support care continuity. The improvement will allow facilities to uniquely identify and track silent transfers otherwise considered as LTFU prior to the use of SHR and health information exchange. The health information exchange will also allow the MOH HIV/TB program to access national deduplicated longitudinal HIV/TB care cascade data for systematic analysis, conducting case-based surveillance and epidemiological analysis to inform programmatic needs not answered by routine data. PEPFAR Lesotho will continue to support data quality assessments including the alignment of DHIS2, eRegister records and PEPFAR

reports. Other improvements that will continue to be addressed for all sites and ensuring complete entry and reporting will focus on the HTS, registration and pharmacy modules of the eRegister.

In addition, COP2022 will focus on the improvement of interoperability of eRegister, DHIS2 with other MOH information systems including the laboratory, pharmacy, and logistics information systems.

5.4 HIV and TB Program Administration

There remains a need to provide technical assistance to the MOH to improve overall management of the HIV/TB program. Support will be provided to the government to update national HIV and TB guidelines. Technical assistance will also be provided for the coordination of program implementation and 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.

Critical to the success of the ART program is the implementation of the Lesotho national quality assurance and quality improvement framework to ensure that quality management practices are fully integrated into HIV and TB service delivery. PEPFAR 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.

As Lesotho gets close to reaching the 95-95-95 targets, the human resources for health (HRH) mix must evolve to focus on retention and managing patients lost-to-follow-up. Staffing patterns will be reviewed to consider alternative service delivery models.

Through the MOH cooperative agreement with CDC, PEPFAR will continue to provide support for 1-2 trainees in the South African Field Epidemiology Program. To date, there have been two graduates; two trainees are currently enrolled in the program. The graduates have increased the epidemiologic capacity of the central MOH. This has been greatly appreciated by the GoL during the COVID-19 pandemic.

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, CLM, COP, and SID), and the space limitations of the Embassy.

As of March 2022, PEPFAR Lesotho has five vacant positions. Four vacancies are CDC staff: Country Director, Deputy Country Director, SI Team Lead and Monitoring & Evaluation Specialist. The Country Director and Deputy Country Director positions are awaiting selection; the SI Team Lead position is at the start of the recruitment process; and the Monitoring & Evaluation Specialist is anticipated to onboard shortly. The remaining vacancy is for the USAID-staffed DREAMS Coordinator. The recruitment process is underway. All five vacancies are anticipated to be filled within FY22. The COP22 budget also includes one new position for CDC, a TB & HIV Specialist. This position will support the existing Care & Treatment Advisor.

PEPFAR Lesotho's CODB costs for COP22 are 4 percent less than budgeted CODB costs for COP21 and account for approximately 13.3 percent of the overall COP22 budget. Beyond accounting for standard inflation, there were no notable increased budgets within the CODB categories.

APPENDIX A – PRIORITIZATION

Table A.1 Continuous Nature of SNU Prioritization to Reach Epidemic Control

| Attained: 95-95-95 (90%) by Each Sex and Age Band to Reach 95-95-95 (90%) Overall | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|-------|--|------------------|-----|-----|------|------|------|------|-------|------|-------|-----|-------|------|-------|------|-------|------|-------|------|-------|-----|-------|-----|------|------|---------------------|
| | | Treatment Coverage at APR by Age and Sex | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SNU | COP | Prioritization | Results Reported | <01 | | 1-4 | | 5-9 | | 10-14 | | 15-19 | | 20-24 | | 25-29 | | 30-34 | | 35-59 | | 40-44 | | 45-49 | | 50+ | | Overall TX Coverage |
| | | | | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | |
| Berea | COP18 | Scale-Up Saturation | APR 19 | 30% | 48% | 71% | 79% | 107% | 137% | 97% | 106% | 61% | 73% | 33% | 86% | 48% | 89% | 68% | 101% | 81% | 97% | 81% | 82% | 79% | 79% | 86% | 89% | 84% |
| | COP19 | Scale-Up Saturation | APR 20 | 13% | 17% | 57% | 53% | 94% | 117% | 94% | 92% | 62% | 61% | 28% | 73% | 48% | 92% | 67% | 96% | 78% | 96% | 78% | 83% | 83% | 82% | 94% | 96% | 84% |
| | COP20 | Attained | APR 21 | 81% | 81% | 81% | 81% | 100% | 117% | 107% | 107% | 81% | 81% | 81% | 81% | 92% | 81% | 96% | 79% | 96% | 83% | 93% | 87% | 95% | 94% | 96% | 91% | |
| Butha-Buthe | COP18 | Scale-Up Saturation | APR 19 | 44% | 22% | 107% | 112% | 150% | 184% | 128% | 159% | 104% | 73% | 40% | 75% | 35% | 83% | 51% | 90% | 67% | 87% | 77% | 79% | 78% | 85% | 93% | 101% | 84% |
| | COP19 | Scale-Up Saturation | APR 20 | 11% | 11% | 85% | 73% | 126% | 124% | 123% | 134% | 106% | 76% | 35% | 61% | 32% | 76% | 52% | 87% | 66% | 81% | 75% | 79% | 83% | 79% | 102% | 106% | 83% |
| | COP20 | Attained | APR 21 | 81% | 81% | 85% | 81% | 126% | 124% | 123% | 134% | 106% | 81% | 81% | 81% | 81% | 81% | 81% | 88% | 78% | 92% | 82% | 94% | 88% | 95% | 102% | 106% | 92% |
| Leribe | COP18 | Scale-Up Saturation | APR 19 | 16% | 17% | 59% | 78% | 129% | 160% | 110% | 115% | 69 | 69% | 57% | 98% | 50% | 102% | 81% | 103% | 83% | 97% | 80% | 79% | 78% | 76% | 77% | 82% | 85% |
| | COP19 | Scale-Up Saturation | APR 20 | 0% | 27% | 61% | 57% | 124% | 138% | 133% | 143% | 94 | 76% | 48% | 80% | 52% | 107% | 79% | 102% | 86% | 97% | 90% | 88% | 79% | 94% | 84% | 90% | 89% |
| | COP20 | Attained | APR 21 | 81% | 81% | 81% | 81% | 124% | 138% | 133% | 143% | 94 | 81% | 81% | 81% | 61% | 107% | 81% | 102% | 86% | 97% | 90% | 88% | 79% | 94% | 84% | 90% | 91% |
| Mafeteng | COP18 | Attained | APR 19 | 6% | 38% | 104% | 123% | 148% | 147% | 110% | 119% | 61% | 63% | 45% | 96% | 54% | 107% | 75% | 110% | 92% | 101% | 82% | 94% | 86% | 90% | 90% | 92% | 91% |
| | COP19 | Attained | APR 20 | 25% | 0% | 92% | 89% | 128% | 133% | 94% | 112% | 64% | 68% | 46% | 83% | 42% | 100% | 67% | 110% | 93% | 103% | 87% | 94% | 85% | 91% | 99% | 96% | 91% |
| | COP20 | Attained | APR 21 | 81% | 81% | 92% | 89% | 128% | 133% | 94% | 112% | 81% | 81% | 81% | 83% | 81% | 100% | 81% | 110% | 93% | 103% | 87% | 94% | 85% | 91% | 99% | 96% | 94% |
| Maseru | COP18 | Scale-Up Saturation | APR 19 | 31% | 28% | 69% | 59% | 133% | 147% | 129% | 132% | 85% | 86% | 56% | 101% | 100% | 126% | 74% | 98% | 76% | 89% | 66% | 70% | 98% | 81% | 76% | 83% | 85% |
| | COP19 | Scale-Up Saturation | APR 20 | 15% | 24% | 61% | 47% | 118% | 125% | 110% | 128% | 91% | 78% | 56% | 99% | 54% | 98% | 71% | 100% | 79% | 96% | 79% | 87% | 74% | 82% | 88% | 94% | 87% |
| | COP20 | Scale-Up Saturation | APR 21 | 81% | 81% | 81% | 81% | 118% | 125% | 110% | 128% | 91% | 81% | 81% | 99% | 81% | 96% | 81% | 99% | 77% | 95% | 77% | 85% | 72% | 81% | 85% | 92% | 88% |
| Mohale's Hoek | COP18 | Scale-Up Saturation | APR 19 | 20% | 14% | 84% | 114% | 91% | 109% | 73% | 94% | 54% | 54% | 21% | 67% | 50% | 88% | 56% | 80% | 59% | 77% | 58% | 67% | 65% | 67% | 71% | 79% | 70% |
| | COP19 | Scale-Up Saturation | APR 20 | 20% | 21% | 86% | 102% | 88% | 98% | 67% | 85% | 53% | 59% | 26% | 66% | 34% | 75% | 51% | 88% | 60% | 83% | 66% | 76% | 70% | 74% | 75% | 85% | 73% |
| | COP20 | Scale-Up Saturation | APR 21 | 81% | 81% | 86% | 102% | 88% | 98% | 81% | 85% | 81% | 81% | 81% | 81% | 81% | 81% | 81% | 88% | 81% | 87% | 66% | 76% | 70% | 74% | 75% | 85% | 80% |
| Mokhotlong | COP18 | Scale-Up Saturation | APR 19 | 38% | 38% | 80% | 104% | 160% | 156% | 110% | 88% | 54% | 62% | 18% | 62% | 29% | 58% | 47% | 78% | 67% | 83% | 63% | 72% | 61% | 74% | 67% | 89% | 70% |
| | COP19 | Scale-Up Saturation | APR 20 | 13% | 25% | 72% | 64% | 126% | 120% | 102% | 98% | 62% | 57% | 22% | 53% | 22% | 60% | 41% | 71% | 62% | 74% | 67% | 69% | 69% | 77% | 80% | 93% | 70% |
| | COP20 | Scale-Up Saturation | APR 21 | 81% | 81% | 81% | 81% | 126% | 120% | 101% | 100% | 81% | 81% | 81% | 81% | 81% | 81% | 81% | 82% | 81% | 87% | 78% | 81% | 81% | 81% | 81% | 93% | 84% |
| Qacha's Nek | COP18 | Scale-Up Saturation | APR 19 | 17% | 33% | 67% | 83% | 138% | 192% | 95% | 132% | 62% | 59% | 23% | 64% | 23% | 82% | 59% | 89% | 64% | 84% | 73% | 77% | 70% | 85% | 79% | 93% | 78% |
| | COP19 | Scale-Up Saturation | APR 20 | 17% | 33% | 72% | 94% | 133% | 213% | 121% | 162% | 79% | 74% | 28% | 66% | 36% | 85% | 68% | 97% | 63% | 90% | 65% | 77% | 69% | 86% | 83% | 96% | 82% |
| | COP20 | Scale-Up Saturation | APR 21 | 81% | 81% | 81% | 94% | 133% | 213% | 121% | 162% | 81% | 81% | 81% | 81% | 81% | 85% | 81% | 97% | 78% | 90% | 65% | 77% | 69% | 86% | 83% | 96% | 86% |
| Quthing | COP18 | Scale-Up Saturation | APR 19 | 11% | 13% | 73% | 92% | 81% | 96% | 77% | 82% | 43% | 41% | 19% | 52% | 23% | 68% | 38% | 75% | 47% | 75% | 52% | 64% | 48% | 61% | 64% | 80% | 62% |
| | COP19 | Scale-Up Saturation | APR 20 | 22% | 25% | 85% | 96% | 81% | 98% | 58% | 75% | 51% | 48% | 18% | 57% | 30% | 70% | 47% | 78% | 54% | 76% | 59% | 69% | 56% | 68% | 72% | 89% | 68% |
| | COP20 | Scale-Up Saturation | APR 21 | 81% | 81% | 81% | 81% | 97% | 97% | 102% | 103% | 75% | 62% | 53% | 65% | 57% | 75% | 66% | 81% | 73% | 86% | 59% | 69% | 56% | 68% | 72% | 89% | 74% |
| Thaba-Tseka | COP18 | Scale-Up Saturation | APR 19 | 0% | 18% | 85% | 103% | 93% | 107% | 77% | 87% | 48% | 38% | 23% | 52% | 32% | 71% | 53% | 78% | 66% | 71% | 63% | 68% | 69% | 67% | 70% | 85% | 68% |
| | COP19 | Scale-Up Saturation | APR 20 | 27% | 27% | 74% | 82% | 83% | 91% | 70% | 84% | 55% | 36% | 24% | 51% | 26% | 64% | 45% | 74% | 61% | 73% | 65% | 70% | 74% | 71% | 77% | 94% | 69% |
| | COP20 | Scale-Up Saturation | APR 21 | 81% | 81% | 81% | 81% | 83% | 91% | 81% | 84% | 75% | 63% | 54% | 68% | 58% | 77% | 67% | 81% | 75% | 81% | 79% | 81% | 81% | 81% | 81% | 94% | 79% |

APPENDIX B – Budget Profile and Resource Projections

Table B.1.1 COP22 Budget by Program Area

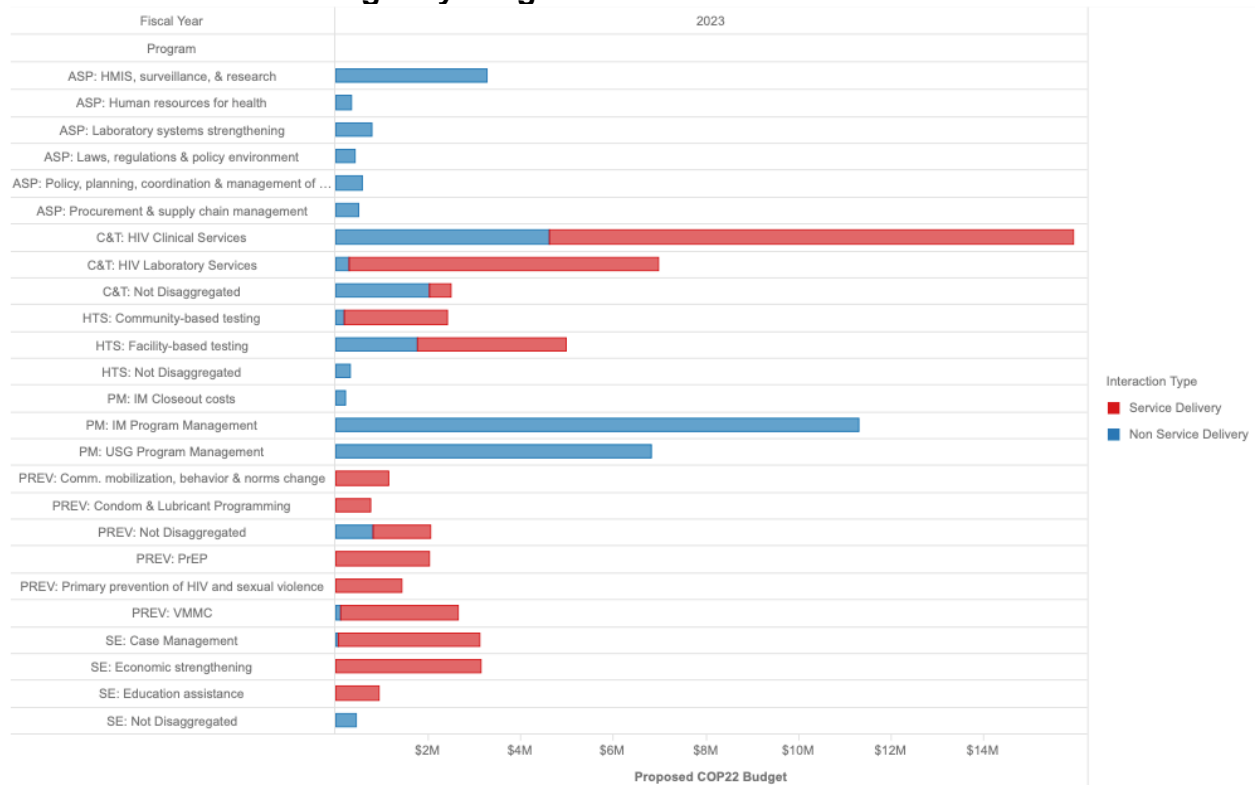


Table B.1.2 COP22 Budget by Program Area

| Program | Metrics | Proposed COP22 Budget | | | Percent of Proposed COP 22 Budget | | |
|--------------|---|-----------------------|---------------------|---------------------|-----------------------------------|------------------|-------------|
| | Sub-Program | Non Service Delivery | Service Delivery | Total | Non Service Delivery | Service Delivery | Total |
| Total | | \$34,790,426 | \$40,209,574 | \$75,000,000 | 46% | 54% | 100% |
| C&T | Total | \$6,940,455 | \$18,484,341 | \$25,424,796 | 27% | 73% | 100% |
| | HIV Clinical Services | \$4,628,343 | \$11,328,631 | \$15,956,974 | 29% | 71% | 100% |
| | HIV Laboratory Services | \$280,455 | \$6,698,000 | \$6,978,455 | 4% | 96% | 100% |
| | Not Disaggregated | \$2,031,657 | \$457,710 | \$2,489,367 | 82% | 18% | 100% |
| HTS | Total | \$2,256,132 | \$5,431,201 | \$7,687,333 | 29% | 71% | 100% |
| | Community-based testing | \$181,267 | \$2,220,062 | \$2,401,329 | 8% | 92% | 100% |
| | Facility-based testing | \$1,768,714 | \$3,211,139 | \$4,979,853 | 36% | 64% | 100% |
| | Not Disaggregated | \$306,151 | | \$306,151 | 100% | | 100% |
| PREV | Total | \$901,555 | \$9,142,166 | \$10,043,721 | 9% | 91% | 100% |
| | Comm. mobilization, behavior & norms change | | \$1,132,016 | \$1,132,016 | | 100% | 100% |
| | Condom & Lubricant Programming | | \$760,982 | \$760,982 | | 100% | 100% |
| | Not Disaggregated | \$793,411 | \$1,257,622 | \$2,051,033 | 39% | 61% | 100% |
| | PrEP | | \$2,016,412 | \$2,016,412 | | 100% | 100% |
| | Primary prevention of HIV and sexual violence | | \$1,425,735 | \$1,425,735 | | 100% | 100% |
| | VMMC | \$108,144 | \$2,549,399 | \$2,657,543 | 4% | 96% | 100% |
| SE | Total | \$487,358 | \$7,151,866 | \$7,639,224 | 6% | 94% | 100% |
| | Case Management | \$57,168 | \$3,067,422 | \$3,124,590 | 2% | 98% | 100% |
| | Economic strengthening | | \$3,138,464 | \$3,138,464 | | 100% | 100% |
| | Education assistance | | \$945,980 | \$945,980 | | 100% | 100% |
| | Not Disaggregated | \$430,190 | | \$430,190 | 100% | | 100% |
| ASP | Total | \$5,871,237 | | \$5,871,237 | 100% | | 100% |
| | HMIS, surveillance, & research | \$3,275,766 | | \$3,275,766 | 100% | | 100% |
| | Human resources for health | \$350,000 | | \$350,000 | 100% | | 100% |
| | Laboratory systems strengthening | \$769,096 | | \$769,096 | 100% | | 100% |
| | Laws, regulations & policy environment | \$403,000 | | \$403,000 | 100% | | 100% |
| | Policy, planning, coordination & management of disease control programs | \$573,375 | | \$573,375 | 100% | | 100% |
| | Procurement & supply chain management | \$500,000 | | \$500,000 | 100% | | 100% |
| | Total | \$18,333,689 | | \$18,333,689 | 100% | | 100% |
| PM | IM Closeout costs | \$200,000 | | \$200,000 | 100% | | 100% |
| | IM Program Management | \$11,312,097 | | \$11,312,097 | 100% | | 100% |
| | USG Program Management | \$6,821,592 | | \$6,821,592 | 100% | | 100% |
| | Total | \$6,821,592 | | \$6,821,592 | 100% | | 100% |

Table B.1.3 COP22 Total Planning Level

| Metrics | Proposed COP22 Budget | | |
|--------------|-----------------------|--------------------|---------------------|
| | Operating Unit | Applied Pipeline | New |
| Total | | \$6,291,689 | \$68,708,311 |
| Lesotho | | \$6,291,689 | \$68,708,311 |

Table B.1.4 COP22 Resource Allocation by Program and Beneficiary

| Operating Unit | Metrics | Proposed COP22 Budget | | | | | | | Percent to Total | | | | | | |
|----------------|--------------------------------|-----------------------|--------------------|---------------------|--------------------|--------------------|---------------------|---------------------|------------------|-------------|-------------|-------------|-------------|-------------|-------------|
| | | C&T | HTS | PREV | SE | ASP | PM | Total | C&T | HTS | PREV | SE | ASP | PM | Total |
| Lesotho | Total | \$25,424,796 | \$7,687,333 | \$10,043,721 | \$7,639,224 | \$5,871,237 | \$18,333,689 | \$75,000,000 | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | Females | \$1,000,000 | \$1,111,987 | \$3,207,434 | \$2,789,452 | | \$1,567,684 | \$9,676,557 | 4% | 14% | 32% | 37% | | 9% | 13% |
| | Key Pops | \$664,431 | \$197,828 | \$427,441 | | | \$355,002 | \$1,644,702 | 3% | 3% | 4% | | | 2% | 2% |
| | Males | | \$810,247 | \$2,823,624 | | | | \$3,633,871 | | 11% | 28% | | | | 5% |
| | Non-Targeted Pop | \$21,607,820 | \$5,382,271 | \$3,197,708 | | \$330,190 | \$5,868,237 | \$51,826,163 | 85% | 70% | 32% | 4% | 100% | 84% | 69% |
| | OVC | \$165,610 | | \$60,000 | \$4,519,582 | | \$851,066 | \$5,596,258 | 1% | | 1% | 59% | | 5% | 7% |
| | Pregnant & Breastfeeding Women | \$1,606,480 | | \$317,514 | | | | \$1,923,994 | 6% | | 3% | | | | 3% |
| | Priority Pops | \$380,455 | \$185,000 | \$10,000 | | | \$3,000 | \$120,000 | \$698,455 | 1% | 2% | 0% | | 0% | 1% |
| | | | | | | | | | | | | | | | |

B.2 Resource Projections

Resource projections for COP22 budgeting were done using the COP22 Planning Level Letter, historic expenditures, and COP21 budgets as a baseline. COP22 budgeting used COP20 expenditure data to understand how mechanisms have historically spent money compared to their budgets. For the budgeting of program shifts, the PEPFAR Lesotho program also had discussions with implementing partners on projected costing data.

Additionally, PEPFAR Lesotho considered HIV investments across Lesotho, including funding from the domestic government, Global Fund, UN and other funders highlighted in the HIV Resource Alignment country profile to inform resource allocation decisions for COP22 to ensure better alignment of resources, avoiding duplication and maximizing programmatic impact of PEPFAR's resources.

APPENDIX C – Tables and Systems Investments for Section 6.0



Lesotho COP22
Table 6SRE Tool.pdf

APPENDIX D– Minimum Program Requirements

| Minimum Program Requirement | Status |
|--|--|
| Care and Treatment | |
| 1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups. | Completed. |
| 2) Rapid optimization of ART by offering TLD to all PLHIV weighing ≥ 30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥ 4 weeks of age and weigh ≥ 3 kg, and removal of all NVP- and EFV-based ART regimens. | In process. This MPR has a target date of completion by Q3 of COP21. |
| 3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups. | Completed. |
| 4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. | Completed. |
| 5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks. | In process. This MPR has a target date of completion by Q4 of COP21. |
| Case Finding | |
| 6) 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 | Completed. |

| | |
|--|--|
| age 19 with an HIV positive biological parent should be offered testing for HIV. | |
| Prevention and OVC | |
| 7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) | In process. This MPR has a target date of completion by Q4 of COP21. |
| 8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. | Completed. |
| Policy & Public Health Systems Support | |
| 9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups. | In process. |
| 10) 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. | Completed. |
| 11) OUs assure program and site standards, including infection prevention & control | |

| | |
|---|---|
| <p>interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p> | <p>In process. This MPR has a target date of completion by Q4 of COP21.</p> |
| <p>12) Evidence of treatment literacy 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.</p> | <p>In process. This MPR has a target date of completion by Q4 of COP21.</p> |
| <p>13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses</p> | <p>In process.</p> |
| <p>14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended</p> | <p>In process.</p> |
| <p>15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p> | <p>In process. This MPR has a target date of completion by Q4 of COP21.</p> |
| <p>16) Scale-up of case surveillance and unique identifiers for patients across all sites.</p> | <p>In process. This MPR has a target date of completion by Q4 of COP21.</p> |

APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

Misalignments between Investments and Outcomes

Note: We have chosen to limit analysis of data from the Resource Alignment, Sustainability Index and Dashboard (SID) (Table E.1), and Responsibility Matrix (RM) (Table E.2) due to concerns about the validity of some data underlying these tools. We were unable to verify GOL budgets or expenditures for Resource Alignment with either the Ministry of Health or the National AIDS Commission. For the SID and RM, results seemed dependent on who was participating in the exercise to complete these tools as opposed to programmatic realities. Participants were concerned that their responses might jeopardize future funding or reflect badly on the GOL. While the tools may still have value, analyzing the results in combination with other data sets may give a false impression of Lesotho's ability to sustainably manage the HIV response.

Table E.1 Sustainability Index and Dashboard Results

| Sustainability Analysis for Epidemic Control: Lesotho | | | | | |
|--|--|----------------|----------------|----------------|------|
| Epidemic Type: Generalized | | | | | |
| Income Level: Lower middle income | | | | | |
| | | 2015 (SID 2.0) | 2017 (SID 3.0) | 2019 (SID 4.0) | 2021 |
| SUSTAINABILITY DOMAINS and ELEMENTS | Governance, Leadership, and Accountability | | | | |
| | 1. Planning and Coordination | 8.00 | 9.07 | 9.50 | 8.33 |
| | 2. Policies and Governance | 5.01 | 7.97 | 7.47 | 6.90 |
| | 3. Civil Society Engagement | 6.50 | 7.17 | 7.38 | 4.96 |
| | 4. Private Sector Engagement | 3.80 | 4.13 | 7.97 | 4.29 |
| | 5. Public Access to Information | 9.00 | 6.00 | 6.11 | 5.78 |
| | National Health System and Service Delivery | | | | |
| | 6. Service Delivery | 4.81 | 6.06 | 4.58 | 5.38 |
| | 7. Human Resources for Health | 5.75 | 6.50 | 6.03 | 5.81 |
| | 8. Commodity Security and Supply Chain | 6.32 | 3.56 | 4.85 | 6.74 |
| | 9. Quality Management | 5.48 | 4.24 | 3.81 | 3.86 |
| | 10. Laboratory | 4.17 | 3.75 | 5.89 | 4.08 |
| | Strategic Financing and Market Openness | | | | |
| | 11. Domestic Resource Mobilization | 5.00 | 4.13 | 6.07 | 5.99 |
| | 12. Technical and Allocative Efficiencies | 5.47 | 6.33 | 8.83 | 8.50 |
| | 13. Market Openness | N/A | N/A | 9.40 | 9.01 |
| | Strategic Information | | | | |
| 14. Epidemiological and Health Data | 6.01 | 4.60 | 5.45 | 3.78 | |
| 15. Financial/Expenditure Data | 3.75 | 5.83 | 5.83 | 5.83 | |
| 16. Performance Data | 4.71 | 6.51 | 7.67 | 7.67 | |
| 17. Data for Decision-Making Ecosystem | N/A | N/A | 6.83 | 7.60 | |

Table E.2 Responsibility Matrix Ratings

| Percent Primary Responsibility Ratings from Responsibility Matrix | | | |
|--|------------------------------|---------------|--------------------|
| Health Systems Area | Government of Lesotho | PEPFAR | Global Fund |
| Service delivery | 96% (47/49) | 73% (32/44) | 30% (14/47) |
| Non-service delivery assistance | 95% (63/66) | 57% (43/76) | 10% (7/68) |
| Strategy formulation and planning | 100% (71/71) | 13% (9/70) | 0% (0/65) |

The Lesotho PEPFAR program was designed to achieve epidemic control. It does not currently represent an approach that is sustainable. Now that the country is at epidemic control (or at least was in early 2020 prior to the COVID pandemic), we will need to determine what is essential to maintaining our achievements with regards to the clinical cascade (eg, 90-97-92 for those ≥ 15 years of age from the 2020 LePHIA) and reductions in incidence (1.1% among persons 15-59 years of age in the 2016-17 LePHIA compared to 0.5% in the 2020 LePHIA). Many of the achievements are likely fragile given the underlying vulnerabilities of the health care system in Lesotho.

A focus on sustainability will require a large-scale shift in how the program is structured. Lesotho does not have the financial or technical capacity to manage the national HIV program as it currently exists. PEPFAR priorities also do not always align with GOL priorities. If donors are unable to make long-term commitments to support the existing program, it may be best to transition to a program with a smaller footprint that has a better chance of being maintained in the future. Even if epidemic control can be maintained, the country will need to manage a population with high HIV prevalence for generations. The transition to a sustainable approach will need to ensure that the health care system is capable of meeting this requirement in order to avoid preventable morbidity and mortality.

Areas for Transition

The negative impact of the COVID-19 pandemic on the economy in Lesotho has resulted in the Government of Lesotho being unable to meet some of its basic functions (i.e., purchasing fuel for its vehicles, providing uniforms for the police). This in turn has made for a difficult environment in which to discuss transitioning programs that are donor funded to the government. The impact of the pandemic is likely to constrain government spending for years to come.

Consideration should be given to right-sizing the HIV program as it currently exists to better align with GOL capabilities, both financial and technical. This will require making difficult decisions as to what is critical to maintaining epidemic control and continuing to reduce HIV incidence. In general, activities that are provided through the existing facility-based health care system may have the best chance for being supported long-term by the GOL. This is mainly because the facilities and staff are in place and GOL has historically supported these efforts. Services provided include adult and pediatric HIV care and treatment, PMTCT, PrEP, HTS, family planning, condom and lubricant distribution, cervical cancer, and clinical services for victims of GBV.

What may be more difficult to maintain are the community and prevention programs (e.g., DREAMS, KP, VMMC and OVC); above-site level activities (e.g., health information systems, laboratory, supply chain), and new initiatives (e.g., CLM and recency testing). Some of these

programs/activities may be transitioned to other donors in the short-term such as The Global Fund and Millennium Challenge Corporation. However, this does not solve the sustainability issue over the longer-term. It will therefore be incumbent on the PEPFAR-Lesotho team to convey the importance of these programs and initiatives to their government counterparts, and work together to determine how these activities and the goals that underlie them can be supported in the future.

Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

The Ministry of Health has established a sustainability technical working group (TWG) to begin discussing how the national HIV effort can transition to a sustainable model. The sustainability TWG will be chaired by the Principal Secretary of the MOH. The launch of the TWG has not yet occurred.

Once COP22 is approved, the PEPFAR Lesotho team will begin work on the sustainability roadmap required for submission to S/GAC by October as part of the “Sustaining the Impact” initiative. We will continue our discussions with other donors such as The Global Fund, World Bank, UNAIDS, and Millennium Challenge Corporation on how best to align our efforts towards a sustainable approach now that epidemic control has been achieved.