Lesotho Country Operational Plan (COP/ROP) 2017

Strategic Direction Summary

March 16, 2017

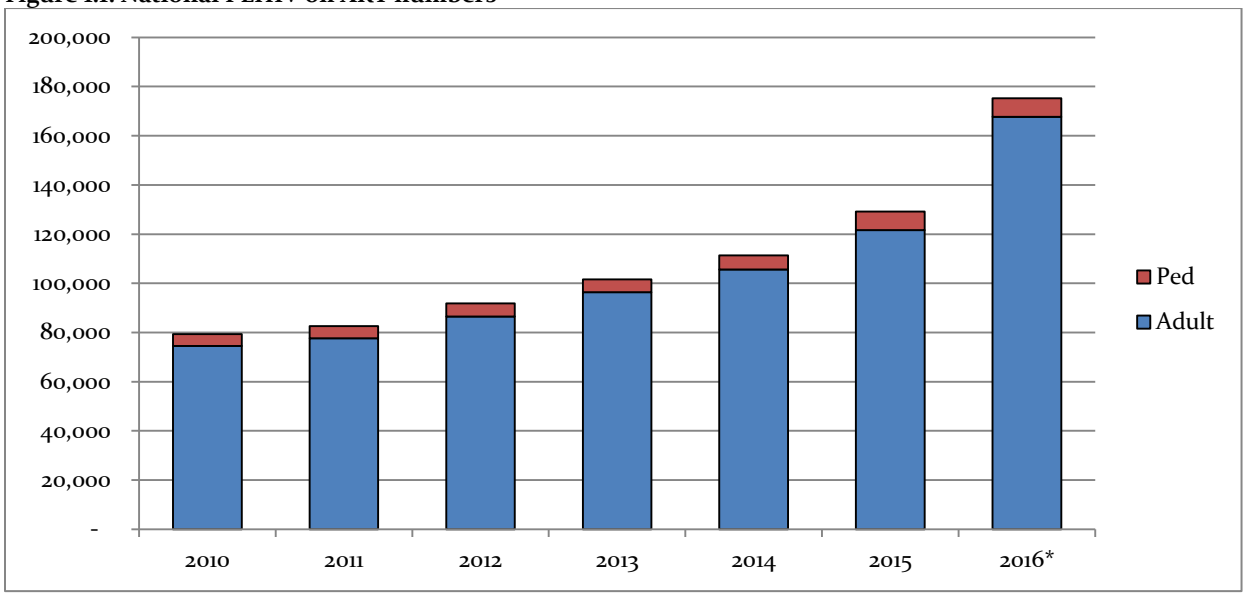
PEPFAR
U.S. President's Emergency Plan for AIDS Relief

Table of Contents

1.0 Goal Statement

The Country Operational Plan (COP) 2017 is a continuation of the COP16 approach set in the context of the broader PEPFAR Lesotho Strategic Framework 2015-2020. Lesotho introduced and rolled-out a national Test and Start policy which enabled ART coverage to increase from 42% in 2015 to 57% in 2016 and achieved the highest net increase in people on ART. ART coverage in children at 64% in the scale-up districts is higher than adult ART coverage and is a testament to the impact of the Accelerating Childhood Treatment (ACT) initiative. Equally important are the new service delivery models that have been implemented (e.g. fewer lab tests, less frequent clinic visits, multi-month prescriptions, and same day treatment initiation). These demonstrate that expanded treatment coverage is possible within the existing health system, as are improved retention rates among patients.

Figure 1.1: National PLHIV on ART numbers[1]



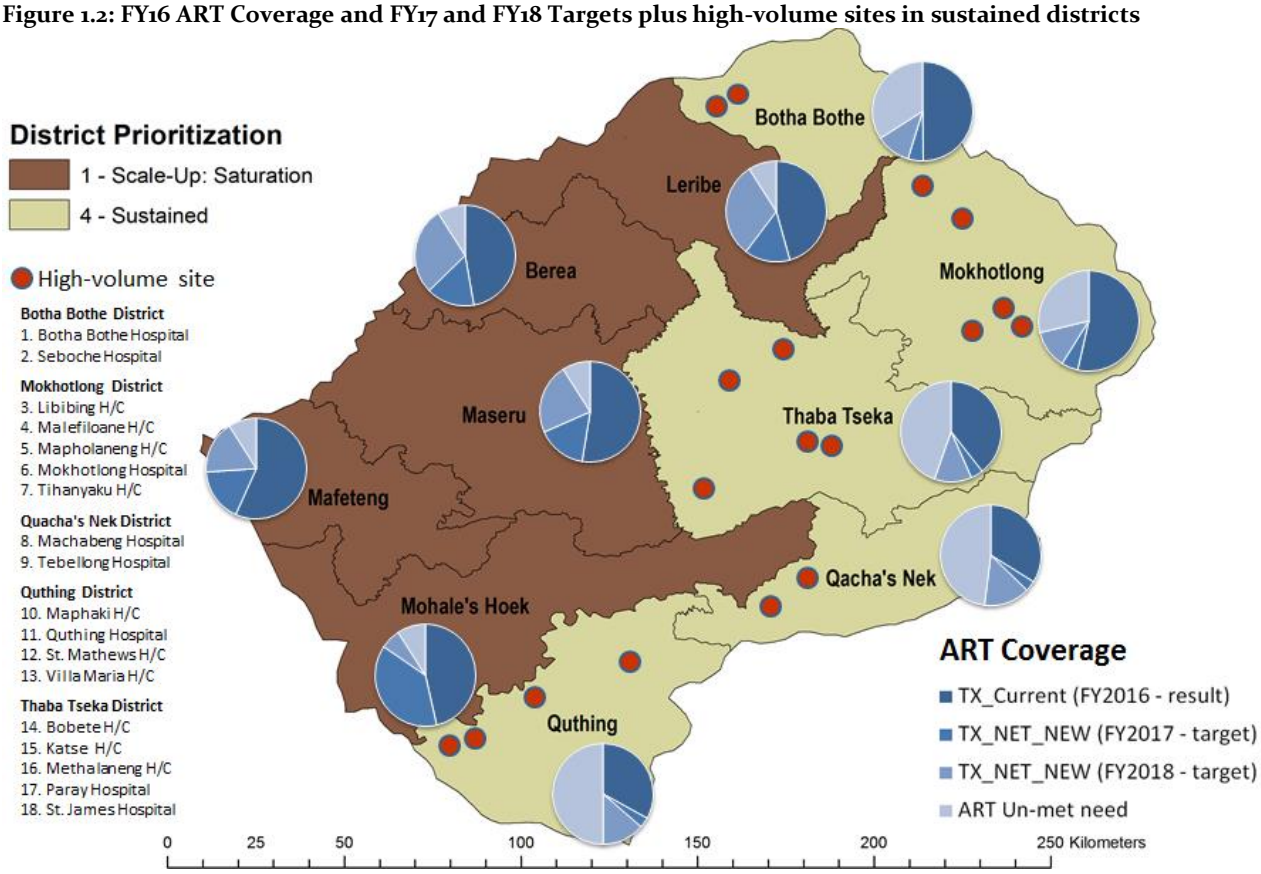
PEPFAR Lesotho has worked with a wide-range of stakeholders in developing COP17. Open and frank dialogue with civil society, monthly performance monitoring meetings with implementing partners and close collaboration with Government of Lesotho (GOL) as well as the Global Fund has become the norm. Through the biannual health summits and quarterly POART meetings the program aims to successfully achieve our shared goals and ensure synergy between national HIV programs and development partner projects.

Lesotho has the second highest national HIV prevalence in the world, yet still has sub-optimal HIV program coverage. Reaching epidemic control – the point at which new HIV infections fall below the number of AIDS-related deaths – remains our goal and one the USG program will support Lesotho to achieve. Therefore, COP17 investments will expand ART coverage in five scale-up to saturation districts to 90% during fiscal year (FY)18 in order to achieve saturation across all age groups and sexes. With the additional treatment performance funding, PEPFAR

[1] Source, http://aidsinfo.unaids.org/ DOI 3/2/2017 and 2016 data from the Directorate of Disease Control, MOH

Lesotho will also expand geographically to 18 high-volume sites within the five sustained districts; thus maximizing the efficiency of USG investments and expanding the capacity of the national program.

Figure 1.2: FY16 ART Coverage and FY17 and FY18 Targets plus high-volume sites in sustained districts



Building upon the success of the Test and Start roll-out and foundation of the DREAMS program, PEPFAR Lesotho will expand PrEP for high-risk adolescent girls and young women (AGYW), sero-discordant couples and key populations. With enabling policies and a commitment to provide the ARVs (both for treatment and PrEP), the Ministry of Health is again demonstrating its commitment and partnership in addressing the HIV epidemic. The program will also optimize HIV testing channels and strategies to better identify PLHIV not on treatment – particularly in adolescents and men – through expanding targeting of services as well as commencing innovative approaches such as self-testing for HIV. This will maximize the testing efficiencies as absolute numbers of tests will be minimized whilst yield will be increased.

An important comparative strength of the PEPFAR program is that it has implementing partners at the service delivery point and within populations, which improves program quality. Greater direct service delivery at site level has shown increased HIV diagnoses, enhanced linkages to care, faster initiation of treatment, and better adherence and retention. Using these platforms, and building on the Impact Funding, Performance Funding, and ACT and DREAMS initiatives, PEPFAR Lesotho will reach underserved communities through direct community and site support. At the central level, PEPFAR will support direct management of the supply chain to

ensure adequate access to laboratory reagents and medication, while also strengthening capacity within the Ministry of Health in this and other areas. Specifically, PEPFAR Lesotho will achieve:

- Significant reduction in HIV incidence commensurate with epidemic control.
- Saturation of combination prevention and core interventions in scale-up districts.
- Saturation equates to 80 percent coverage of those in need.
    - Saturation of ART in PLHIV with 90% of these PLHIV virally suppressed 12 months later.
    - Elimination of mother-to-child transmission of HIV.
    - Saturation of VMMC coverage in 15-29 year olds.
    - Increase in individual access, availability and consistent use of condoms.
    - Reduction in mortality related to tuberculosis among PLHIV.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Lesotho has a total population of 2,003,546 people, 51% of whom are women and 32% whom are under the age of 15. The country is topographically divided into four zones and 10 administrative districts. The country is classified as a lower middle income country with a Human Development Index of 0.497[2] and a Gross National Income (GNI) of $1,280 USD[3]. Sixty-six percent of the population resides in rural areas. Seventy-three percent of the population lives in the lowland districts of Berea, Leribe, Mafeteng, Maseru, and Mohale's Hoek.

Lesotho completed a national census in 2016 and these updated numbers have been incorporated into our population-level estimates. UNAIDS SPECTRUM EPP estimates and the 2014 DHS results were used for PEPFAR planning. Lesotho Population Based HIV Impact Assessment (LePHIA) is still ongoing in Lesotho, but results will be incorporated into the PEPFAR program as they become available. Prevalence among men and women 15-49 is 24.6%. The DHS results showed that women have a higher HIV prevalence among men at all ages. Women 25-29, 30-34, 35-39, and 40-44 have an HIV prevalence of 37.5%, 44.9%, 45.5%, and 44.6%, respectively. In comparison, men have an HIV prevalence of 17.9%, 27.5%, 41.2%, and 43.5% for the same age bands. The total number of PLHIV continues to remain highest in PEPFAR-supported districts.

Beginning in COP17, PEPFAR Lesotho will support 18 additional high-volume facilities outside the priority districts to increase the effectiveness of the program. Current on ART remains at or below the national average in four of the five sustained districts (Quthing 35%, Thaba Tseka 42%, Mokhotlong 60%, Butha Buthe 53%, and Qacha's Nek 36%). These 18 sites currently comprise approximately 12% of all persons on ART in Lesotho.

Lesotho continues to be ranked second-highest in HIV prevalence and incidence among people 15-49 years. Incidence has seen a significant reduction from 2.7% (2.5-3.0) in 2004 to 1.9% (1.6-2.1) in 2015[4]. Lesotho was the first country in sub-Saharan Africa to implement Test and Start (June 2016). In the first quarter of Test and Start (Q3 FY16) new on treatment increased 62% and looking

[2] http://hdr.undp.org/en/data
[3] http://data.worldbank.org/country/lesotho
[4] UNAIDS Spectrum

at Q1 FY16 (pre-implementation) and Q1 FY17 (post-implementation) new on treatment is 66% higher. PrEP will expand during COP17. VMMC activity remains seasonal in Lesotho, although an overall increase in meeting VMMC targets was seen in FY16 (82%).

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

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

Available funding for the GOL program is only half of the projected need of $557 million for 2015-2018. This funding shortfall is compounded by critical barriers to supply, demand and access to HIV services that cannot be addressed in isolation. The barriers are: low recruitment and absorption of human resources; poor quality of data; lack of accurate and timely laboratory diagnosis and patient monitoring; and weak community ownership and participation in service delivery.

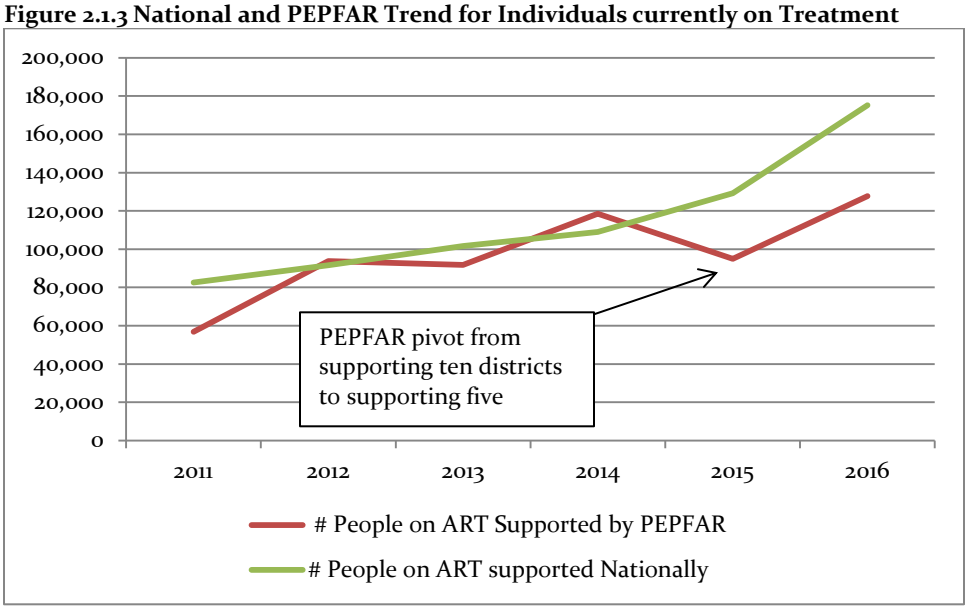
Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	2,003,546	100	316,394	15.8	317,009	15.8	203,387	10.2	205,016	*10.2*	500,485	25	459,066	23	2016, BOS
HIV Prevalence (%)		24.6		2.8		2.8		13.5		6.2		42 (25-49)		31.5 (25-49)	2014 LDHS (15-49)/2015 Spectrum
AIDS Deaths (per year)	6,636		316		326		205		151		2,646		2,992		2016, Spectrum
# PLHIV	327,504		6,169		6,289		21,933		12,782		162,754		117,577		2016, Spectrum
Incidence Rate (Yr)		1.9		--		--		--		--		1.7		2.1	2014, LDHS (15-49)
New Infections (Yr)	18,607														2016, Spectrum
Annual births	54,264	--													2016, Spectrum
% of Pregnant Women with > 1 ANC visit	--	95.2		--			--	97.1			--	93.4			2014, LDHS (all, <20, 20-49)
Pregnant women needing ARVs	10,658	28													2016, Spectrum/2015, GARP
Orphans (maternal, paternal, double)	111,350		36,311		36,311		19,364		19,364		--		--		2016, Spectrum (<15, 15-17)
Notified TB cases (Yr)	7,892		--		--		--		--		--		--		2016, Global TB report

% of TB cases that are HIV infected	5,258	72	--	--	--	-	--	-	--	-	--	--	--	--	2016, Global TB report
% Males (medically) Circumcised	--	22.2			--	--			--	28.9			--	16.6	2014, LDHS
Estimated Population Size of MSM*	11,294	--													In country estimates
MSM HIV Prevalence	--	33.3													2014, USAID/PSI (Maseru/Maputsoe avg)
Estimated Population Size of FSW	6,748	--													In country estimates
FSW HIV Prevalence	--	71.9					--	--			--	--			2014, USAID/PSI (Maseru/Maputsoe avg)
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*														

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year[5]**		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Estimated Total PLHIV (#)[6]**	**PLHIV diagnosed (#)[7]**	**On ART (#)[8]**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	2,003,546	23.4[9]	327,504	197,484	175,302	54[10]	87%	623,180	37,974	30,830
Population < 15	633,403	2.8[11]	11,660	7,031 (est)	7,600	65[12]	--	145,311	1,414	1,365
15-24 year olds	408,403	7.7[13]	34,715	21,072	--	--	--	165,942	7,575	4,665
25+ year olds	959,551	24.6[14]	280,285	169,334	167,702 (15+)	54[15]	--	273,957	28,977	24,800
MSM	11,294	33.3	3,611	--	--	--	--	--	--	--
FSW	6,748	71.9	4,304	--	--	--	--	--	--	--
Prisoners	4,947	31.4	1,553	--	--	--	--	--	--	--
Priority Pop (AGYW)	203,387	13.5	21,993	9,604	--	--	--	--	--	--
Priority Pop (Miners)	24,439	--	--	--	--	--	--	--	--	--
Priority Pop (Taxi Drivers)	4,947	--	--	--	--	--	--	--	--	--

[5] PEPFAR results APR FY16
[6] Spectrum
[7] PLHIV Diagnosed – ever tested and tested at 12 months was calculated based on received results from the LDHS 2014, the average of ever tested and 12 month, and average of men and women applied to the PLHIV.
[8] MOH provided numbers as of Dec 31, 2016
[9] Spectrum
[10] In country calculation – On ART/PLHIV
[11] Spectrum
[12] In country calculation – On Art/PLHIV
[13] Spectrum
[14] LDHS 15-49 year olds
[15] Spectrum

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment



2.2 Investment Profile

The HIV response in Lesotho is primarily funded by the GOL, the Global Fund and United States Government through PEPFAR. The Ministry of Health has increased its budget allocation to HIV/AIDS from 10% in 2014/15 of national budget to 16% in 2016/17, and this is projected to further increase in out years. The increase in the MOH allocation has largely been driven by additional commitments to ARVs. However, at the same time the GOL allocation to health of the recurrent budget has declined from 15.7% in 2014/15 to 14.4% in 2016/17, though the GOL allocation to health of the capital budget, has increased from 2.7% in 2014/15 to 4% in 2016/17. In real terms the GOL expenditure on HIV/AIDS increased by US$4 million from 2014/15 to 2015/16 but it is uncertain if it will meet the projected $10.7 million increase forecast last year as the GOL only increased its expenditure by $5 million as of the third quarter, although it is maintaining an upwards trend.

The Global Fund continues to support the response through an integrated grant agreement LSO-C-MOF with a projected annual disbursement agreement of $29.5 million for July 2016 to June 2017 and a regional tuberculosis project. Slower than anticipated contracting of sub-recipients and tendering has led to reduced disbursements in the first six months. The CCM and principal recipients are seeking to urgently address these constraints, as the grant only lasts two years and funding cannot be carried over between grants. Other significant funders to HIV and the health response in Lesotho include: the World Bank's support to a regional tuberculosis and a health systems support project and the United Nations multi-lateral programs supporting all aspects of the health related Sustainable Development Goals.

PEPFAR Lesotho's budget has significantly increased from $34 million in COP15 to $67 million plus $13 million in central funding in COP17. The program is matching expenditure to budget with >95% of COP15 funding expended in FY16. The implementing partner portfolio remains optimized and FY17 expenditure is on track.

Table 2.2.2: Annual Budget USG FY16 – GOL FY15/16 Profile by Program Area[16]

Program Area	Total Expenditure	% PEPFAR	% GF	% Gov. of Lesotho	% Other
Clinical care, treatment and support	$32,761,311	23%	28%	46%	2%
Community-based care, treatment and support	$1,980,920	67%	11%	0%	22%
PMTCT	$2,719,282	100%	0%	0%	0%
HTC	$6,487,775	72%	19%	3%	6%
VMMC	$5,144,085	96%	3%	0%	1%
Priority population prevention	$4,174,870	37%	43%	11%	8%
Key population prevention	$213,386	100%	0%	0%	0%
OVC	$9,470,582	26%	4%	62%	8%
Other impact mitigation	$10,217,402	0%	1%	24%	75%
Lab	$5,395,181	56%	16%	25%	3%
SI, Surveys and Surveillance	$2,175,618	100%	0%	0%	0%
HSS	$8,910,571	52%	14%	9%	25%
Total	**$89,650,981**	**39.5%**	**17.1%**	**29.1%**	**14.3%**

Table 2.2.1 shows increasing expenditure on HIV. HIV care and treatment account for almost half of the national expenditure with the GOL maintaining its commitment and accounting for 46% of the expenditure.

Figure 2.2.1: National HIV Resource Projection FY2015/16 – FY2017/18[17]

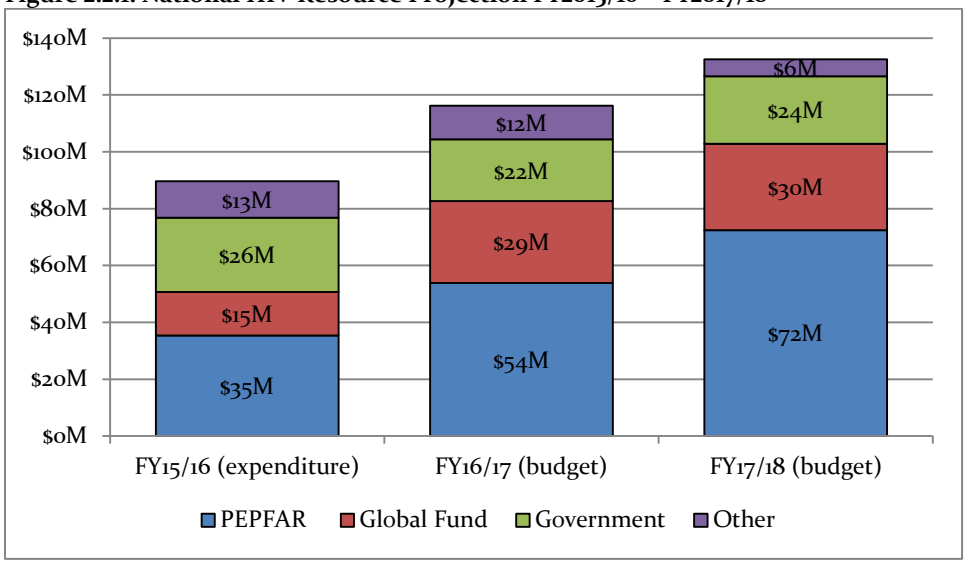


Figure 2.2.1 shows the GOL supporting 29% of the response, The Global Fund 17% and PEPFAR 40% with other donors the remaining 14% in FY15/16. Global Fund expenditure was 50% of their budget as the grant has executed slower than anticipated. In out years, the resource envelope rises to $116 million in USG FY17 - GOL FY16/17 and $132 million the following year. This increase is driven by the increases to the PEPFAR budget through DREAMS and Impact Funding for treatment though a number of 'other' donors are unable to forecast their HIV budget in FY18.

[16] [1]PEPFAR Expenditure Analysis FY16 [2]Global Fund Coordination Unit and GOL – SSFIA FY2015/16
[17] Resource Mapping Study, MOH, 2016, PEPFAR Expenditure Analysis FY16, Global Fund Coordination Unit and GOL – SSFIA FY2015/16

Table 2.2.2: Annual Procurement Profile for Key Commodities[18]

Commodity Category	Total Expenditure	% PEPFAR[1]	% GF[2]	% Gov. of Lesotho[2]	% Other
ARVs	$ 17,767,535	0%	25%	75%	0%
Rapid test kits	$ 1,918,225	12%	88%	0%	0%
Other drugs	$ 169,601	0%	1%	99%	0%
Lab reagents	$ 758,705	18%	75%	7%	0%
Condoms	$ 869,840	82%	18%	0%	0%
Viral Load commodities	$ 998,037	77%	0%	23%	0%
VMMC kits	$ -				
MAT	$ -				
Other commodities	$ -				
Total	**$ 22,481,943**	**8%**	**31%**	**61%**	**0%**

ARVs accounted for 80% of the captured commodity expenditures though challenges in collating the commodity expenditure data means that it is likely other expenditures / in-kind donations such as condoms, by other donors have been omitted in the national resource mapping. However, the commodity budget does reflect a focus on the clinical cascade that is in-line with the strategic priorities of the National Strategic Plan for HIV and AIDS 2012-2018.

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH					
USAID TB					
Family Planning					
Peace Corps	$1,416,100		1	$717,000	Funding for Peace Corps Lesotho
MCC					
Total	**$1,416,100**			**$717,000**	

Managed through USAID/Southern Africa in Pretoria, there are several regional development initiatives in the areas of economic growth, energy, democracy and governance, environmental, and education that put both funding and technical assistance into various projects in Lesotho. While outside of the health sector, they contribute to the overall economic and developmental growth of Lesotho and can often have indirect and positive effects on health determinants. Additionally, there are 2 projects in Lesotho, with funding from Food for Peace and from the US Office of Foreign Disaster Assistance (OFDA) and total $679,000 in funding. They support agriculture, food security and household livelihood and economic strengthening activities which more directly link to our PEPFAR program and work to improve individual and household level nutrition, food security and overall resiliency. Peace Corps supports education volunteers in addition to the healthy youth volunteers funded under PEPFAR. The second MCC Compact remains suspended pending GOL reforms though

[18] [1]PEPFAR Expenditure Analysis FY16 [2]Global Fund Coordination Unit and GOL – SSFIA FY2015/16

the PEPFAR program continues to leverage on the 138 health centers and 13 out-patient departments that were renovated under the first compact.

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
Health Information Systems for Impact	$3,000,000		$3,000,000	4	$0	Robust monitoring of clinical programs
Violence Against Children Study	$3,000,000		$3,000,000	1	$0	Conduct a violence against children study
DREAMS Innovation	$400,000	$186,000	$586,000	0	$0	
VMMC – Central Funds	$6,547,296	$0	$6,547,296	1	$713,088	Support implementation of VMMC program
Other PEPFAR Central Initiatives						
Drought Funding	$2,804,980	$7,505,617	$10,310,597	0	$0	Mitigate the impacts of the 2015 -2016 drought
Provide Miner Friendly Services for Integrated TB/HIV Care (PROMISE)		$500,000	$500,000	1	$0	Assess impact of enhanced TB/HIV services to miners and their families
Comprehensive TB and HIV Program Evaluation		$150,000	$150,000	1	$0	Evaluate the national TB and HIV programs and implement a package of TB infection control practices
Select Interventions for Patients with Advanced HIV Disease		$78,125	$78,125	1	$0	Determine impact of core interventions for PLHIV initiating ART with CD4<200
Lesotho Population HIV Impact Assessment (PHIA)	$7,500,000		$7,500,000	1	$0	Population based HIV impact assessment.
Blood Safety (Roadmap to Accreditation)		$200,000	$200,000	0	$0	Accreditation of National Blood Transfusion Service
Project SOAR	$592,224		$592,224	1	$0	Funding for two studies: IMPROVE - evaluating the effect of a multidisciplinary team on MCH outcomes, ART uptake and retention. VEID - analyzing the feasibility, acceptability, and cost-effectiveness of earlier HIV testing.

AIDSFREE	$133,198		$133,198	1	$450,000	Provide technical and organizational capacity building to CSOs
Health Policy Plus (HP+)	$39,817		$39,817	0	$0	Undertake a policy and regulatory scan of the HIV legal and policy environment in Lesotho
Other Public Private Partnership						
Vodafone MHIT project	$1,000,000		$1,000,000	1	$0	PPP to eliminate pediatric HIV/AIDS
Total	**$25,017,515**	**$8,619,742**	**$33,637,257**		**$1,163,088**	

The PEPFAR Lesotho program continues to benefit extensively from non-COP resources with more than $8 million of non-PEPFAR and $25 million of non-COP PEPFAR funding captured in table 2.2.4.

2.3 National Sustainability Profile Update

In the COP16 and COP17 sustainability profiles, Lesotho scored a green in Governance, Leadership, and Accountability on public access to information and planning and coordination. All other scores in the sustainability profile are yellow.

Since the submission of COP16, there has been one small change to the sustainability profile in Lesotho. This change was in the legal framework for private health sector. The MOH now has signed HIV/AIDS service agreements with all accredited private clinics or private provides.
The only other projected change is a shift in the percentage of the HIV response being funding by PEPFAR. Historically, the Global Fund, Government of Lesotho, and PEPFAR each funded about 30% of the HIV response. However, investments from the Global Fund, under the new program continuation application, are projected to decrease from $34 million a year to $22 million a year starting in 2018. The Government of Lesotho funding for HIV is generally consistent at about $25 million a year. However, in the past two years, PEPFAR Lesotho has seen a large increase in funding from $39 million in COP15 to $81 million in COP17.

2.4 Alignment of PEPFAR investments geographically to disease burden

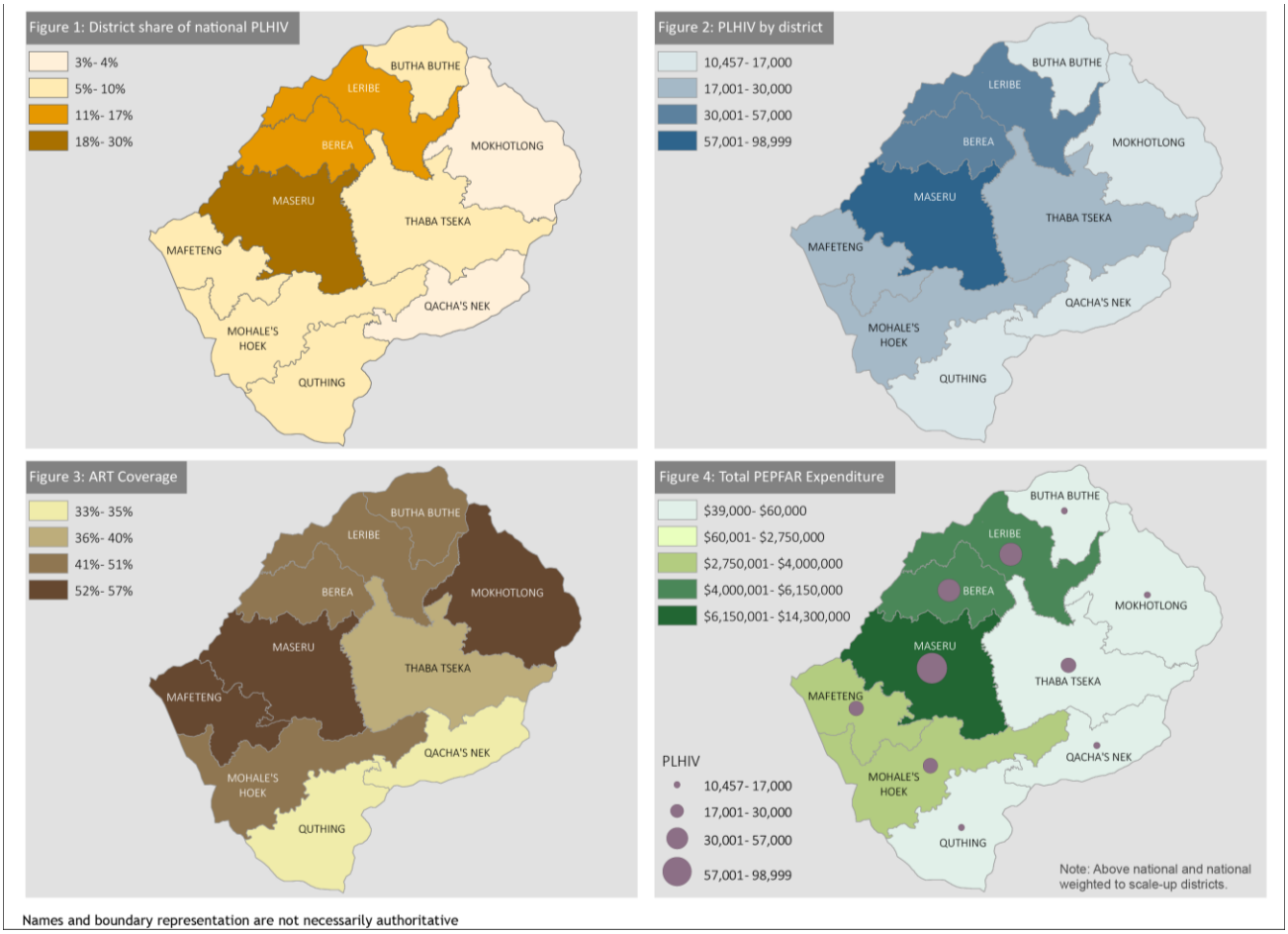
The HIV burden in Lesotho remains in the more densely populated and more urban lowlands to the west and south west of Lesotho. Provisional data from the census 2016 indicate that the population in these districts is growing whilst declining in most of the highland districts with the exception of Quthing. As a result the alignment of PEPFAR investments is strongly correlated to the COP15 pivot to the scale-up saturation districts of Maseru, Leribe, Berea, Mafeteng and Mohale's Hoek that account for 73% of the PLHIV.

Maseru accounts for 30% of the PLHIV and $14.3 million of the PEPFAR district expenditure. Both almost double the next highest district – Leribe – due to its large population and ongoing high HIV prevalence. Both Maseru and Berea are DREAMS districts and the program expects to see increasing resources expended in these districts in FY17 as the initiative was only fully established in the last quarter of FY16.

The expansion to the 18 high-volume sites in the five sustain districts is driven by the Treatment performance funding and generally lower ART coverage in these districts. It is expected that the five scale-up to saturation districts will achieve 80% saturation of ART in some populations (females 25+)

in FY17 and COP17 resources will therefore focus more on underserved populations. Therefore, by focusing upon a limited number of high-volume sites that are predominately in urban areas, PEPFAR can directly contribute to supporting Lesotho to nationally achieve 90-90-90 in the most efficient and effective approach.

Figure 2.4.1 Lesotho: People Living with HIV, Treatment Coverage, and Total PEPFAR Expenditure



2.5 Stakeholder Engagement

Since COP16, PEPFAR has been engaging with the Civil Society community as an important partner in the fight against HIV/AIDS in Lesotho. CSOs have been invited and have participated in each of PEPFAR Lesotho's POART meetings. These CSOs included; the Lesotho Network of AIDS Services Organizations (LENASO), the Lesotho Network of People Living with HIV and AIDS (LENEPWHA), MATRIX, the Community of Women Living with HIV & AIDS in Lesotho (CW-L), the Lesotho Council of NGOS (LCN), Lesotho Federation of Organizations of the Disabled (LANFOD), the Lesotho Inter-Religious AIDS Consortium (LIRAC), SkillShare Lesotho and Phelisanang Bophelong (PB). Last year, PEPFAR shared the final SDS with the CSOs for review prior to the submission of the COP.

With regard to the development of COP17, PEPFAR continued its engagement with CSOs. PEPFAR held four consultative meetings with the CSOs to deliberate on PEPFAR's program areas, share data, and subsequently hold comprehensive discussions on key PEPFAR results and COP17 priorities. For

the first meeting, the CSOs were invited and participated in the POART Q4 discussion with external stakeholders on November 8, 2016. The second meeting was the COP17 stakeholder strategic retreat held from January 23rd to January 26th. The Q4 POART results and COP17 Guidance were disseminated prior to the retreat for them to familiarize with and ultimately share their thoughts for input into the development of COP17. The third meeting was held between individual CSOs with PEPFAR's PCO from February 7-9, 2016 in an effort to open the space for dialogue with CSOs on PEPFAR programs and to consolidate their comments on COP17. The fourth meeting was the PEPFAR Panorama webinar for CSOs. Lastly, two umbrella CSOs will represent and participate at the COP17 review meeting in April in Johannesburg.

PEPFAR shared copies of the final SDS with the CSOs prior to the submission of the COP and seven umbrella CSOs provided feedback to the COP17 proposal. Their feedback included:

As PEPFAR programs transitions toward greater sustainability, national governments are more dependent on local structures in communities including civil society to meet the health needs of their citizens. PEPFAR engagement will build their capacity, better preparing them to play a leadership role now and into the future. Civil society engagement is an ethical and human rights imperative. It is an ethical principle to involve people in the decisions that affect their health.
Below are the CSO recommendations:

1. ***Support mobilization of People living with HIV:*** *Robust investments should be made to support community mobilization efforts. This could be done by: promoting already existing structures like support groups, CAGs, etc. to:*
    - *Support in the identification of more HIV positives through the mobilization for uptake of services such as PEP, PrEP and self-testing;*
    - *Strengthening linkage between HIV service providers and community PLHIV groups;*
    - *Support initiatives that improve linkage and retention in care and;*
    - *Support locally bred innovations to scale up access to treatment.*
2. ***Support Social Research initiatives:*** *The country stills grapples with limited documented evidence in a couple of areas for example the key populations. PEPFAR should; Support CSO to conduct research on different HIV related issues.*
3. ***Support CSOs Advocacy initiatives:*** *CSOs recommend that PEPFAR provides technical guidance on advocacy strategies but also financially support the implementation of advocacy efforts by: Strengthening CSO led health advocacy and; Reviving and strengthening the Health Advocacy Forum (HAF).*
4. ***Capacity building for CSOs:*** *PEPFAR should earmark resources to support CSO structures.*
5. ***Support CSOs to monitor supply chain issues:*** *Support CSO to monitor the quality assurance of health centers.*
6. ***Prevention:*** *it is noted with concern that behavior change and demand creation messages are given little attention.*

3.0 Geographic and Population Prioritization

For VMMC for 15-29 year olds, Maseru will achieve 74% saturation by the end of FY17; all scale-up districts will reach 80% saturation by the end of FY18. For the treatment program, all five scale-up districts will have achieved 91% treatment coverage by both age and sex disaggregation by the end of FY18.

Beginning in FY18, PEPFAR Lesotho will begin treatment programming at 18 high-volume sites in the five sustained districts. These 18 sites currently account for 60% of PLHIV on ART in the 5 sustained districts.

With an HIV prevalence of 24.6% among persons 15-49 years of age and an incidence of 1.9%, most PEPFAR supported activities are meant to reach the general population of sexually active individuals in Lesotho. However, to achieve epidemic control in the required sex and age bands as well as fulfill the mandates of the DREAMS and ACT initiatives, a special focus will be directed at key (CSW, MSM, prisoners) and priority (AGYW, men, children, adolescents, pregnant women) populations. Prioritization decisions will help achieve increased treatment coverage among groups, which are currently underserved. This would include primarily men and persons <25 years of age.

Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP17	# Current on ART (FY16)	# of SNU COP16 (FY17)	# of SNU COP17 (FY18)
Attained	-	-	-	-
Scale-up Saturation	252,150 (77%)	126,765 (50%)	5	5
Scale-up Aggressive	-	-	-	-
Sustained	75,850 (23%)	18,590 (25%)	5	5
Central Support	-	-	-	-

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

4.1 Targets for scale-up locations and populations

Table 4.1.1 Targets for scale-up locations and populations

Entry Streams for ART Enrollment	Tested for HIV	Newly Identified Positive	Newly initiated on ART (APR FY 18)
	(APR FY18) HTS TST	**(APR FY18) HTS TST POS**	***TX_NEW***
	Adults		
TB Patients	*21,278*	2,830	2,830
Pregnant Women	*37,643*	3,820	5,643
VMMC clients	*19,932*	1,028	874
Key populations	*6,599*	660	561
Priority Populations	-	-	-
Other Testing	*900,592*	83781	74,959
Previously diagnosed and/or in care	-	4,647	4,448
Total Adults	986,043	96,766	89,315
	Pediatrics (<15)		
HIV Exposed Infants	*11,199*	125	122
Other pediatric testing	*144,213*	1,282	1,147
Previously diagnosed and/or in care		67	67
Total Pediatrics	*155,411*	*1,474*	*1,336*
TOTAL	**1,141,455**	**98,239**	**90,651**

Table 4.1.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

	Target Populations	Population Size Estimate	Current Coverage (APR FY16)	*VMMC_CIRC (FY17)*	Expected Coverage (FY18)
Maseru	15-29	71,231	57%	12,268	85%
Leribe	15-29	50,686	40%	7,582	85%
Berea	15-29	39,374	49%	6,850	85%
Mafeteng	15-29	27,144	41%	5,051	86%
Mohale's Hoek	15-29	24,936	22%	4,330	87%
Total/ Average		**213,372**	**45%**	**36,081**	**85%**

Table 4.1.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up **SNUs**)	Coverage Goal (in FY17)	FY18 Target
MSM	5,164	24%	4,131 (80%)
FSW	3,085	23%	2,468 (80%)
TOTAL	**8,249**		**6,599 (80%)**

Table 4.1.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY18Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY18 Target) OVC
Maseru	87,620	20,523	33,819
Leribe	83,482	12,708	18,589
Berea	74,616	13,454	19,823
Mafeteng	46,849	6,492	9,809
Mohale's Hoek	51,205	5,447	7,926
TOTAL	**343,772**	**58,624**	**89,966**

4.2 Priority Populations

In Lesotho, HIV-related policies and legal frameworks do not specifically address groups at high risk such as key populations. The GOL and PEPFAR Lesotho have identified adolescent girls and young women (AGYW) as a priority population. The DREAMS initiative will support the enforcement of policy and advance national program targets within this population.

In COP17, PEPFAR Lesotho has a target of 87,694 for priority populations and a target of 6599 for key populations (MSM and FSW), which is a percentage of all subpopulations total. The priority populations addressed in our COP17 program with multiple interventions (including prevention, DREAMS, care and treatment, and TB services) include AGYW, factory workers, prisoners, men aged 25-49 who are sexual partners of the AGWYs, military, and mineworkers. Programming for priority populations will be guided by the data and integrated as much as possible with care and treatment programming. Given the fact that these populations are highly mobile and have different behavior patterns, PEPFAR will work on expanding service hours, initiation of community ART delivery, multi-

month prescriptions, supporting the border post points of care, and providing AGYW friendly services at specific clinics.

Men having sex with men (MSM) and female sex workers (FSW), which are the two main key populations in Lesotho, will also be targeted with HIV prevention interventions. Given the HIV prevalence and risk behaviors of MSM and FSW, the program will be specifically targeting key populations with a comprehensive package of prevention, care and treatment services to identify HIV positive members and link them to care and treatment. Activities will include: health care worker KP-friendly training and sensitization, strengthening community-based monitoring systems and linkages and retention into treatment and care, and initiation of self-testing as well as PrEP. Moving forward with our key populations programming, intensified efforts will be undertaken to better offer integrated prevention, testing and treatment activities/options and to improve tracking of KPs along the clinical cascade. Enhanced risk-reduction interventions, including condom promotion and intensified programming and behavioral prevention interventions will be supported given the high transmission and frequency of risk behaviors reported in these groups. Lesotho will continue to receive adequate condoms from a USAID centrally funded mechanism.

The military is a highly mobile population, has high HIV prevalence, and is therefore seen as a high-risk population. The DOD program, in line with the wider PEPFAR program, will focus on identifying HIV positive individuals and linking them to care and treatment within the military health services. They therefore will be able to continue treatment regardless of deployment.

Our implementing partners rely heavily on CSOs for their local expertise, culturally sensitive approaches and access to priority populations to work effectively to reach our target populations and implement our programming. For example, our partner working with key populations in Maseru and Leribe sub-grants to Care for Basotho and Matrix to do peer to peer prevention and outreach work with female sex workers (FSWs) and men who have sex with men (MSM) and to support them through linkages to testing and treatment.

All partners implementing priority and key populations activities will provide a monthly update on their progress and highlight implementation challenges, in order to better address issues as they occur to ensure improved performance. From its inception, DREAMS has built a strong partnership with government ministries and various stakeholders for buy-in for the project. There is a multi-sectorial steering committee, which meets quarterly to discuss progress, challenges and other key issues. Implementing partners also meet on a monthly basis to share lessons and discuss issues around implementing and capturing the layering approach.

4.2.1 Pre-Exposure Prophylaxis (PrEP)

Lesotho has an estimated 328,000 people living with HIV (PLHIV) that includes 13,000 children, 15,776 adolescents living with HIV (ALHIV), and 73,000 children orphaned by HIV (UNAIDS, 2016). Though the HIV epidemic is generalized, incidence is disproportionately highest among adolescent girls and young women (AGYW), female sex workers (FSW), men who have sex with men (MSM), multiple, concurrent partners (MCP), and those reporting sexually transmitted infections. Moreover, 15% of couples in Lesotho are discordant (LDHS-2014).

The revised Lesotho national guidelines on the use of antiretroviral therapy for HIV prevention and treatment (2016) recommend use of oral TDF/3TC for HIV-negative individuals at significant risk of

acquiring HIV infection. Other key enablers for PrEP implementation in Lesotho include: clearly articulated beneficiaries for PrEP, existing supportive services for HIV testing and counseling (HTS), laboratory services, risk behavior counseling at point of care, adherence, and retention counseling support, condoms/lubricants access as well as the DREAMS initiative and adolescent-friendly services, post exposure prophylaxis (PEP), voluntary medical male circumcision (VMMC) services, and community support groups. TDF/3TC is already registered for antiretroviral treatment and does not need a separate registration to be used for prevention/PrEP.

PEPFAR/Lesotho will increase access to PrEP services to AGYW, FSW, MSM, and sero-discordant couples in the priority districts using hybrid service delivery models.

The $3 million DREAMS PrEP budget allocation will support service delivery for AGYW (ages 18-24) and FSWs in the districts of Maseru and Berea. An additional $1,454,830 million in COP17 base funds will support sero-discordant couples in five districts and MSM and FSW in Berea and Maseru districts. Increased access to healthcare, advocacy and demand creation, and eliminating stigma and discrimination in healthcare settings are key pillars to ensuring high coverage and continuum of care among beneficiaries that result in reduction of HIV infection transmission. In FY18, PEPFAR aims to provide PrEP services to 23,721 beneficiaries (13,945 AGYW (ages 18-24); 8,256 Sero-Discordant couples; MSM 950: and FSW 570). Under the DREAMS initiative, FSW will be mapped out through utilizing one-on-one peer education within sites known to be 'hotspots'/meeting spots for the key population communities, this includes organized social and educational events, bars/restaurants and community centers. We will use peer educators trained on mobilization and HTS referrals and linkages to initiated and tracked referrals every month. These dedicated referral coordinators will be provided with airtime to ensure they can follow up all those who were referred.

During the startup of PrEP in Lesotho, PEPFAR will provide focused technical assistance on selected indicators to ensure quality of services and data for decision-making and ensure all the necessary systems are in place prior to rolling out PrEP. Key areas for support include training and sensitization of health providers, strengthening support services, advocacy and development of communication and marketing strategies, on-going strengthening of an enabling environment and demand creation for PrEP, appropriate service delivery platforms, modeling cost and impact of PrEP on the epidemic, and the development of a robust monitoring and evaluation framework.

4.2.2 DREAMS

For COP17, the DREAMS initiative will continue its implementation in the two districts of Maseru and Berea. Although there will be no expansion to a third district, there will be an addition of PrEP for AGYW ages 18-24 to the core DREAMS package. DREAMS will further expand to the other community councils in these two districts to ensure full coverage and saturation within the districts. This will enhance effective layering of the DREAMS activities to AGYWs. In COP17, there will be a greater emphasis on bio medical interventions for AGYWs as well as increasing their linkages to testing services, and enrollment and retention into care and treatment for those needing it.

The comprehensive and layered services that will be provided for AGYW are school-based HIV risk avoidance and violence prevention, community mobilization and norms change activities, condom promotion and distribution programming, post-violence care, HTS, contraceptive mix options and PrEP. The DREAMS activities are co-located with PEPFAR clinical programs which will foster linkages to clinical HIV service providers, better connecting AGYW and OVC beneficiaries to additional HIV

prevention and care and treatment services as needed. DREAMS is positioned to implement aggressive prevention for 79,510 AGYW and to provide GBV prevention for 2,746 AGYW.

Measuring incidence rate among AGYW will be vital to determine effectiveness of the laying effect of the combined prevention, care and treatment services and its impact on reduction of HIV infection among AGYW. We will conduct an incidence estimation survey in the two DREAMS districts among women attending ANCs in Maseru and Berea using a LAgavidity test. Specimens collected from first ANC visits during specific months in 2017 will be utilized for this study.

For COP17, the DREAMS initiative has very aggressive targets, which will ensure full district coverage. During first quarter of FY17, DREAMS made outstanding progress by having reached and exceeded their Q1 Targets. This is a trend that shows that even if their last Q4 results were relatively low they are now in full implementation mode and will be able to make up progress and meet their targets.

The PEPFAR Lesotho team works successfully across agencies and across and within the prevention, care and treatment continuum to ensure improved linkages and uptake of services. Specific to DREAMS, an ambitious and multi-faceted program, we hold monthly meetings for all our implementing partners working on DREAMS. These monthly check-ins are an important tool in our partner management repertoire and provide opportunities for improved collaboration, working through challenges and sharing ideas for strengthened programming. Additionally to improve further collaboration across technical areas, we have instituted periodic meetings between our DREAMS, KPs prevention, HTS and treatment partners, and have already seen an improvement in partner coordination, shared events and programming that has improved links to testing, as well as testing and same day initiation on treatment.

4.3 Voluntary Medical Male Circumcision (VMMC)

WHO/UNAIDS recommend that VMMC be offered to men in combination with other HIV risk reduction interventions in settings with generalized HIV epidemics and low prevalence of circumcision. PEPFAR Lesotho is working with the GOL to scale up VMMC coverage to 80% among males 15 – 29 years in 5 districts with a high unmet need for circumcision and HIV disease burden. In Lesotho, 72% of men aged 15-29 of age live in the five scale-up districts.

In FY18, PEPFAR aims to provide surgical direct service delivery to circumcise 50,182 men: (15 - 29 years = 41,400 and 10 – 14 years = 8,782). This represents 85% saturation in the age pivot 15 – 29 years in five priority districts of Berea, Maseru, Leribe, Mafeteng, and Mohale's Hoek. Technical assistance will be provided for the integration of early infant male circumcision (EIMC) in maternal and neonatal child health programs in the saturated districts for sustainability. Global Fund resources will be leveraged for the expansion of services, recruitment of additional manpower, and procurement of equipment and supplies in the sustained districts.

Demand creation activities in scale-up districts will include forging collaborations with the medical/traditional male circumcision due to a high prevalence and cultural significance of traditional circumcision that range from 32% to 65%. Ministry of Health with the support of Jhpiego has conducted mapping of traditional circumcisers in the supported districts as a first step to facilitate further engagement. Jhpiego will be providing medical circumcision to traditional initiates at health facilities prior to the rite of passage ceremonies. Ministry of Education and Training has given permission to Jhpiego to implement demand creation activities for VMMC in learning institutions, and

this initiative should result in increased demand and uptake of young men among secondary schools and tertiary institutions. Other initiatives for demand creation will include co-hosting VMMC/HTS campaigns and co-location of VMMC teams at HTS sites to ensure effective linkages, as well as the strategic engagement of women and female community groups as champions, Faith-Based Organizations, and workplace VMMC programs. Implementation of Geographic Information System (GIS) and site capacity and Site Capacity and Utilization online tools will enable the teams to conduct community mapping and site productivity in real-time to inform targeted demand creation among the age-pivot. Advocacy by community, traditional, and government leadership will be leveraged to create demand for the program. Additionally, JHPIEGO also sub-grants to two CSOs, LENASO and the Lesotho Planned Parenthood Association (LPPA), for a total of $273,000 a year.

Anticipated challenges to achieving the targets include transport logistics for hard-to-reach areas, overcoming the traditional belief that circumcision is better performed during winter months when healing is believed to be quicker, providing medical circumcision to men with prior "partial" traditional circumcision, and refocusing demand to encourage a larger percentage of 15 -29 year olds to access VMMC services. Timely policy change on task shifting for both surgical and EIMC service delivery to nurse providers is another anticipated challenge.

Given the need to achieve 80% coverage and attain sustained epidemic control in scale-up districts, PEPFAR also prioritizes focused technical assistance on selected indicators to ensure quality of services and data for decision-making. Partner performance will be tracked through weekly reports and periodic site utilization analysis to ensure the sites are performing at capacity. Technical assistance focuses on adherence to the WHO minimum package, the PEPFAR VMMC technical considerations as well as active referral of clients testing HIV positive at sites to care and treatment services. Technical assistance for robust data and service quality will involve conducting SIMS, DQA, EQA, and CQI on a regular basis in addition to training and mentorship of M&E officers at sites in data management and use.

4.3.1 Central VVMC Fund Narrative

PEPFAR central VMMC funding for Lesotho for the COP 2017 is $6,547,296. The funding will support direct service delivery at fixed and outreach VMMC sites, demand creation using cost effective strategies, salary support for health care providers and mobilizers, and procurement and logistics for circumcision kits and other supplies. In addition, the funding will support other program activities that include continuous quality improvement (CQI) and External Quality Assessment (EQA). Furthermore, above site partner performance monitoring online tools which include Decision Makers Program Planning 2.0 (DMPPT) and Site Capacity Utilization Analysis will be used to monitor real-time focused age pivot demand creation, impact, infections averted, and associated cost savings of VMMC services, and site performance index. Other initiatives to be supported include implementation of the Geographic Information System (GIS) tool to inform targeted community mobilization and the online training hub (OTH) modules for health care providers and community mobilizers to ensure continuous professional development and refresher trainings. Effectively implementing these activities will result in 41,400 VMMCs in age pivot 15 -29 years to reach 52% saturation in all the five supported districts.

4.4 Preventing Mother-To-Child Transmission (PMTCT)

The burden of HIV disease among pregnant women in Lesotho is among the highest globally with a 27% HIV prevalence rate among women attending ANC[19]. The Lesotho National Strategy for the PMTCT program is to eliminate new pediatric HIV infections and improve maternal, newborn, and child health and survival in the context of HIV. The quality of PMTCT service delivery has continued to maintain high uptake of services within health facilities, with over 95% of pregnant women knowing their HIV status at their first ANC visit and 93% of the identified HIV-positive pregnant women receiving ARVs to prevent mother-to-child transmission of HIV (MTCT)[20]. The MTCT rate among HEI tested within <2 months of age is 1.6%[21].

The national launch of the Test and Start policy in April 2016 had a direct positive impact on the national PMTCT program. The APR 2016 results demonstrated that 67% of pregnant women who presented for their first ANC visit with known HIV positive status were already on ART for their own health. Routine viral load monitoring for all pregnant and lactating women and children was adopted as a standard of care in 2016, which will continue to inform clinical management of PMTCT clients to further ensure viral suppression to reduce the risk of MTCT.

However, a major challenge to PMTCT in Lesotho is the low population level coverage of PMTCT service. Only 72% of expected pregnant women know their HIV status and only 70% of all estimated HIV-positive pregnant women are receiving ART. In addition, there is sub-optimal uptake of early infant diagnosis (EID) at 2 months of age, which was reported to be 77% at APR 2016. HEI who received EID late had a higher MTCT rate compared to those who had EID within two months of age. In COP 2017, PEPFAR Lesotho will continue supporting the national PMTCT elimination goal of attaining <5% MTCT rate in the five scale-up to saturation districts, where over 72% of expected pregnancies in the country are found. The strategic goals are to achieve 95% coverage of HIV testing and counseling services (HTS) and test and treat for HIV-infected pregnant and lactating women identified. To achieve these targets, PEPFAR Lesotho's strategic shift involves the continued expansion of direct service delivery support at site and community levels with the goal of improving the quality and uptake of PMTCT services by pregnant/lactating women, their children, and partners. HIV prevalence in PMTCT settings has continued to be high at 27% (for both known HIV positives at ANC 1 and newly diagnosed), and 11% for the newly diagnosed pregnant women. During COP 2017, routine opt-out PITC within MNCH and same-day treatment initiation will be provided. Sites will be supported to roll out the new national HTS policy guidelines, which include re-testing during pregnancy, delivery, and postnatal periods to identify those who seroconvert.

Community outreach will be restructured for intensified case finding using village health workers, community-based organizations and mentor mothers. During COP2017, PEPFAR Lesotho will support early identification of pregnancy at the community level. This will be done through regular screening for signs of pregnancy in women of childbearing age. Those who will be found to be pregnant will be linked to facilities and enrolled in ANC as soon as possible. Program results demonstrate that once a pregnant mother is successfully linked at the ANC clinic, the PMTCT service cascade is effectively offered.

[19] ANC Sentinel Survey Report, 2015
[20] MOH Report, 2016
[21] APR 2016

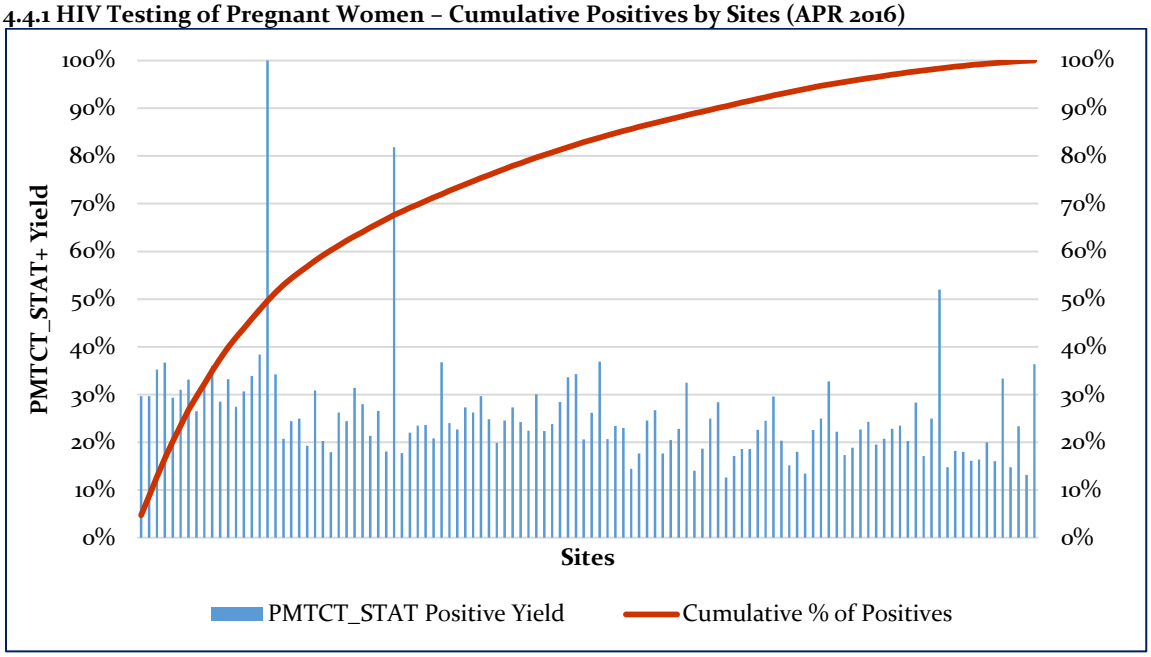
PEPFAR Lesotho will continue to leverage the Vodafone public private partnership (PPP) to mobilize high burden communities for HTS, strengthening linkages for index client/couple testing as well as tracking of ARV prophylaxis and EID uptake of HIV-exposed infants delivered outside of hospitals. COP 2017 funds will leverage the ACT and DREAMS initiatives to expand services for adolescent girls and young women (AGYW). PMTCT services will continue to be provided to AGYW building off the achievements of APR 2016, where 49% of new pregnancies identified were from AGYW aged 15-24 years with an HIV yield of 16% (for both known positives and newly diagnosed).

During COP 2017, the PMTCT program will continue to focus on strengthening retention of mother-infant pairs along the PMTCT cascade using both facility- and community-based interventions. The service package will include provision of mother baby packs, adherence counseling and support, TB/HIV screening and treatment, and cotrimoxazole prophylaxis. Early Infant Diagnosis (EID) services will be scaled-up with a focus on increasing uptake of the first DNA/PCR test to >80% at less than two months of age. Infants with a confirmed HIV positive status will be fast-tracked for treatment initiation. Retention of mother-infant pairs will be improved using peer counselors, mentor mothers, and linkage navigators who will conduct cohort tracking, actively follow-up missed appointments, notify caregivers when EID results are received at sites to reduce turnaround time of giving EID results to caregivers, and support linkage of mothers and newly diagnosed HIV-positive infants to the ART program. HIV-positive women of reproductive age attending PMTCT, ART, and care clinics will receive family planning education, counseling, and voluntary access to a wide range of contraceptives levering resources from UNFPA. Women living with HIV who wish to have children will receive safe pregnancy counseling.

Efficiency Analysis

FY16 results were generated from all 112 sites that offer PMTCT services in the scale-up districts. Site yield analysis shows that 66 (58%) sites identified 80% of the positives and 48 (42%) sites identified the remaining 20% of positives (Figure 4.4.1). The average positivity rate (weighted against volume) for these sites was 27%.

Figure 4.4.1 HIV Testing of Pregnant Women – Cumulative Positives by Sites (APR 2016)



During COP 2017, PEPFAR Lesotho will actively monitor the performance of the main clinical implementing partner and the community PMTCT implementing partner. Annual performance milestones will be defined for each mechanism based on the COP 2017 programming priorities and PEPFAR Lesotho Strategic Framework (2015-2020). Performance milestones will be defined in the agency-specific FY2018 work plans and M&E plans.

Performance monitoring will be through inter-agency monthly review meetings; quarterly stakeholder POART meetings; MOH-technical working group meetings (i.e. HIV and TB TWG), and agency-specific project reports. The inter-agency SI and technical teams will continue to conduct site-level performance analysis based on achievement of site level targets. The USG teams will conduct SIMS visits to all PEPFAR-supported sites to monitor the quality of services.

4.5 HIV Testing and Counseling Services (HTS)

The goal of the PEPFAR Lesotho program is to reach saturation in all of the five scale-up districts. The PEPFAR Lesotho HTS program's main role therefore is to ensure sufficient case identification and strong linkages to ART to meet the treatment numbers in the PEPFAR supported districts for all sex and age disaggregation. In FY18, the PEPFAR Lesotho program will test 1,141,455 adults and children and identify 98,239 positives at an average positivity rate of 8.6% (9.8% in adults and 1% in children 0-14 years) and link 85% of adults and 90% of children to treatment. This includes 90,052 tests and 7,803 positives from TB, VMMC, EID and PMTCT. The contribution of the 18 high volume sites in the five sustained districts is 108,694 tests and 8,977 positives (both children and adults). HTS targets are back calculated to meet the ART numbers required for saturation in the scale-up districts taking into consideration minimal losses throughout the cascade. These HTS targets were derived using the unmet ART need data by age and sex and taking into consideration the historic positivity rates by age/sex/modality of testing to optimize cost and yield for the program.

The program will scale up targeted facility (PICT) and community (CBHTS) level HTS to ensure enough case identification of PLHIV for ART in the five scale-up districts, and optimize PICT and family tree/index testing in the 18 high volume sites in the sustained districts. The need for demand creation and targeted community testing cannot be over-emphasized to compliment PICT outcomes. In the previous COPs PICT has always contributed over 80% to the total OU achievement both in terms of tests and positives identified. This was usually a financially driven decision based on the lower cost of PICT compared to CBHTS. However, program data provides compelling evidence that scaling up some community testing modalities has the potential to reach specific, populations not served by PICT and contribute more than has historically been the case.

The increased funding level for the HTS in COP17 will allow the program to scale up targeted community testing and change the PICT/CBHTS split to 65/35 respectively to leverage some high yielding community strategies as well as reaching some populations that are not otherwise reachable through PICT. Community testing will greatly scale up index and mobile testing strategies to reach mostly adults and young people. Self-testing will be integrated into all the community testing strategies and fixed community testing sites which are likely to reach groups that do not go to public health facilities such as key populations. OVC platforms will be leveraged to test, identify, and link orphans and vulnerable CLHIV to treatment. Collaboration among implementing partners has shown potential in reaching OVCs with HTS and treatment, with yield among double orphans being relatively higher that single OVCs and general pediatric yield.

PICT will continue to be optimized in outpatient departments, TB clinics, inpatient wards, MNCH and all service delivery points within the facilities with a goal of reaching individuals attending health facilities. Self-testing will be implemented in ART clinics, during ANC visits, and at adolescent and men-friendly corners to improve case identification. Linkage coordinators will be deployed in all high volume sites to ensure linkages to treatment and coordinate with community partners on linkages of PLHIV to treatment. The family tree model and partner notification will be used to track family members and partners of PLHIV in care to the community for testing and linkage to treatment. Community linkage coordinators will also be recruited to improve linkage to treatment especially from CBHTS. Other structural barriers will be addressed by provision of transport assistance to facilities, intensive use of ICT (Information and Communications Technology) and same day ART initiation for patients identified in the community. ART services will be introduced in fixed VCT sites to enhance linkages and same day initiation.

The continued DREAMS funding for Lesotho is an opportunity to reach adolescent girls and young women (AGYW) with a comprehensive package of services including HTS and linkages to treatment. The DREAMS initiative has contributed $1,652,985 to the testing budget specifically for supporting testing among AGYW and their sexual partners as part of the comprehensive DREAMS intervention package. The national HIV budget and Global Fund provide additional resources (including RTK procurements) to identify more PLHIV and link them to care and treatment.

In FY18 PEPFAR HTS program will focus on the following interventions:

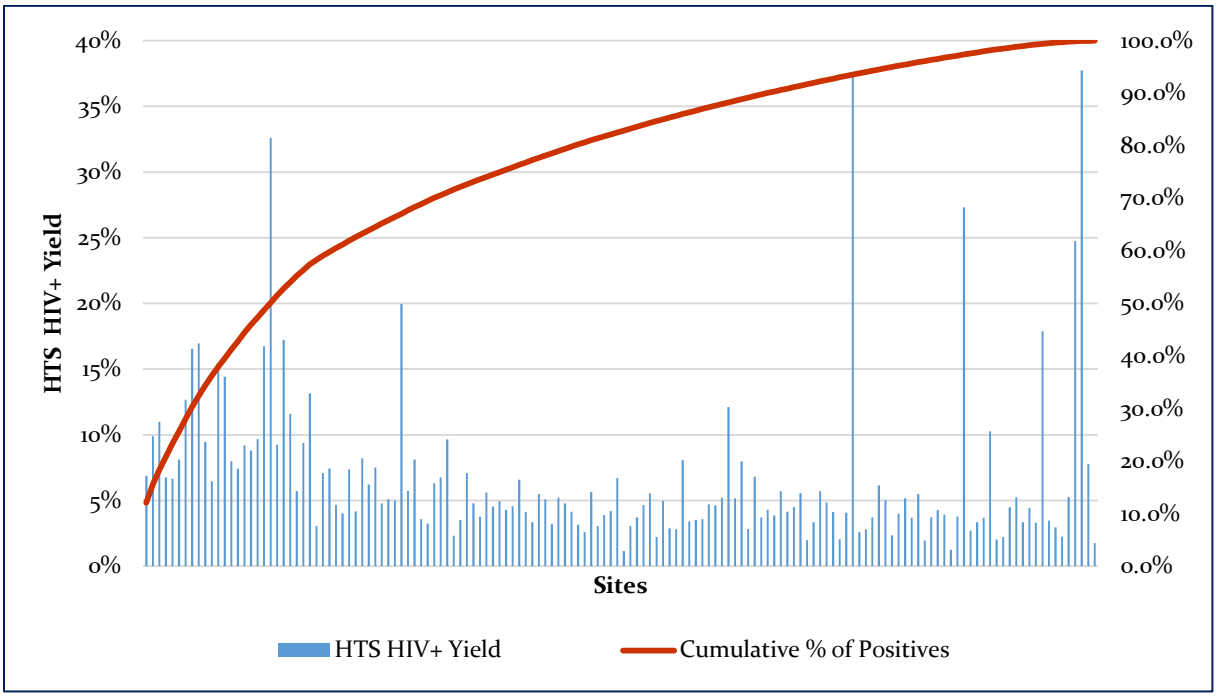
- Optimize Provider Initiated Testing and Counseling in all facilities in the scale-up districts and at the 18 high volume sites in the sustained districts
- Scale up Community Based HIV Testing Services (mobile & index modalities) to reach hard to get populations such as men, adolescents and key populations in the scale-up districts
- Introduce social networking and partner notification strategies to reach sexual partners, priority and key populations with HTS and treatment services
- Integrate self-testing in existing HTS modalities to optimize yield and uptake
- Implement same day ART initiation in community testing modalities to enhance linkages to treatment
- Closely monitor and track linkages to treatment through engagement of linkage facilitators, use of a simple unique identifier system, ICT, provision of transport assistance and revision of data collection tools to track linkages
- Strengthen strategic communication messages and community mobilization efforts to create demand for the uptake of HTS and other prevention and treatment services

In COP15, PEPFAR Lesotho transitioned out of any site that identified ≤4 positives in the 12-month reporting period. In FY16 PEPFAR supported a total of 146 sites including both facility and community testing sites. Site level efficiency analysis shows that 80% of the OU positives come from 49% (72) of the HTS sites in the five scale-up districts. The rest of the sites (51%) need close monitoring to identify systematic and/or programmatic challenges and feasibility for improving performance for the country to meet its targets. These sites will be prioritized for SIMS visits as well as supportive supervision to improve their performance.

The vast majority of HTS activities supported by PEPFAR Lesotho are conducted by the current treatment partner for PICT (EGPAF) and the TBD for CBHTS (for the cooperative agreement

previously awarded to PSI). Partner performance monitoring of EGPAF is the same as described in the treatment section of the SDS. With regards to HTS, the focus has been on testing volume, modality, yield, cost per positive identified, and ability to reach underserved groups such as men, adolescents and key populations. HTS results are reviewed with the implementing partner by the interagency team on a monthly basis. A similar approach will be taken with the partner receiving the new award for CBHTS.

Figure 4.5.1 HIV Testing Services Cumulative Positives by Site



4.5.1 Performance Funding for Testing

In COP17 the HTS program has benefited from an additional $1 million in performance funds to identify more PLHIV and improve linkages to treatment. Historically, the program had limited the scope for community testing approaches based on the available funding. Although community testing is a more expensive model at average national UE of $17.10 per test and $304.04 per positive identified compared to PICT with an average cost of $6.30 per test and $89.33 per positive identified (EA Data Navigation tool, 2016), the unmet need in some priority populations (such as youth, men and key populations) and the inability of PICT to effectively reach these populations, provide a strong basis for investing in targeted community testing modalities to reach these groups. Currently about 40% of male HIV cases aged 20-24 and 31% of those aged 25-49 come from community testing; the ART coverage in these groups is very low at 13% and 36% respectively. Closing the case identification gap between PICT and CBHTS in these groups to reach ART saturation is critical. The performance funds will recruit additional professional counselors and male oriented demand creation and mobilization agents. These cadres will be specifically capacitated to appropriately target men with messaging and interpersonal communication to increase uptake, case identification and linkage to treatment.

4.6 Facility and Community Based Care and Support

The Government of Lesotho has adopted the WHO 2015 guidelines for the initiation of antiretroviral therapy (ART) for all people living with HIV at any CD4 cell count. This policy shift is aligned with the revised National Strategic Plan goal of reducing HIV transmission, morbidity, and mortality in Lesotho and the UNAIDS 90-90-90 strategic goals for HIV epidemic control. Test and Start services are currently implemented nationally, and the core service package for all patients on ART includes provision of a standard package of care and support services at facility and community levels. During COP 2017, PEPFAR Lesotho will continue supporting the Ministry of Health to integrate facility and community-based care and support services that are aligned to the Test and Start policy framework. The goal is to provide a core package of care and support services to 229, 456 adults and children receiving HIV treatment services in the five scale-up districts of Berea, Leribe, Mafeteng, Maseru, and Mohale's Hoek.

The COP 2017 Care and Support core package in the scale-up districts is aligned with the PEPFAR Care and Support Prioritization Framework. Adults and children living with HIV who are on treatment will receive the universal care and support interventions which include: (i) cotrimoxazole prophylaxis for patients with WHO stage III or advanced HIV disease; (ii) clinical and laboratory monitoring (through routine viral load testing); (iii) prophylaxis and management of opportunistic infections (OI); (iv) screening and management of TB, including TB preventive therapy (TPT); (v) screening and management of sexually transmitted infections (STIs); (vi) screening and management of Cryptococcal meningitis, including secondary prophylaxis; (vii) nutrition assessment counselling and support (NACS); and (viii) adherence counselling and support.

PEPFAR will also continue to expand on the programmatic gains at community level which include pre-ART mop-up for treatment and active tracking of missed appointments through LENASO community focal persons, Village Health Workers (VHW) and expert clients at the community level. Community ART groups and mHealth technology will be scaled-up to facilitate linkages and retention in care. The DOS Small Grants Program will also continue to provide grants for community-initiated projects, which aim to strengthen clinical linkages and health care initiatives in communities affected by HIV.

This package of universal care and support services will be provided through direct service delivery in all PEPFAR-supported sites in the scale-up districts. PEPFAR will continue supporting additional human resources (HR) (i.e. clinical nurses, professional counselors, lay counselors, pharmacists, pharmacy technicians, records officers, and LENASO community focal persons) who are all critical for treatment scale up, improving quality of care, and providing support in bridging clinical cascade leakages. Integrated support supervision and mentorships through district-based technical teams and District Health Management Teams (DHMTs) will be provided to sites to improve the quality of care services.

During COP 2017, PEPFAR Lesotho will continue to leverage other resources to expand coverage of facility and community based care and support. The Government of Lesotho and Global Fund procure all drugs and commodities for care and support services that are used in PEPFAR-supported sites. PEPFAR will also leverage nutrition resources from the Global Fund and the PEPFAR drought mitigation NACS funds to scale up management of severe and moderate malnutrition in adults and children living with HIV.

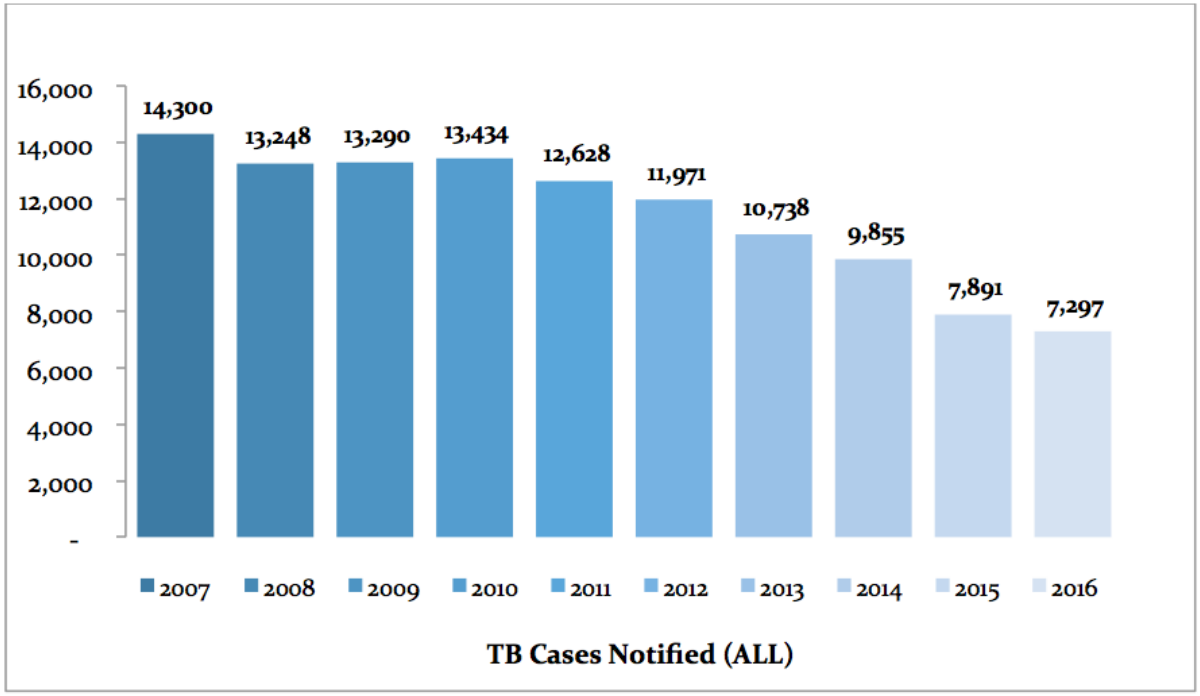
In COP17, EGPAF is the PMTCT, TB, facility and community based care and support, adult treatment, and pediatric treatment partner in both the sustained and scale-up districts. The same active monitoring of EGPAF will capture performance for all technical areas.

4.7 TB/HIV

Lesotho has the 2nd highest TB incidence in the world (788/100,000) and a low TB case detection rate of 49%. The treatment success rate has stagnated at approximately 70% for new and relapsed cases, with very high TB related mortality of 15%. Late diagnosis of TB remains a challenge contributing to high morbidity and mortality. Cross-border migration of TB clients leads to delays in diagnosis and to treatment interruptions which contribute to unfavorable outcomes. In addition the diagnosis and management of childhood TB remains a significant challenge. Drug resistant TB is increasing. According to the Drug Resistance Survey conducted in 2013-14, the national prevalence of MDR-TB was 3.8%, including 3.2% among new TB cases and 6.9% among previously treated cases.

The gap between the notification and estimated incidence has persisted, indicating missed TB notifications. Lesotho is observing declining TB notification trends despite the high WHO estimates. The HIV prevalence among TB patients is estimated at 72% and the ART uptake is 86% among the notified TB HIV+ patients. High risk groups for TB in Lesotho include children, pregnant women attending ANC, PLHIV, health workers, ex-/mine workers, military, inmates, and factory workers who are also predominately migrants.

Figure 4.7.1 TB Notification Trends in Lesotho



The 5 PEPFAR scale-up districts currently account for 80% of the notified TB cases. The Lesotho TB national policies and guidelines are aligned to effectively support TB control. Lesotho COP priorities will focus to (i) Achieve or maintain 100% HIV testing rates among all TB cases and patients with

presumptive TB as a contribution to the first 90, (ii) Provide universal ART for all people with TB diagnosed with HIV as a contribution to the second 90, (iii) Ensure timely TB diagnosis and TB treatment completion to ensure viral suppression, (iv) Scale-up TB preventive therapy (TPT) for all PLHIV without active TB disease and implementation of TB infection prevention and control interventions and (v) Support integrated and effective delivery of TB/HIV services at national, district and site level.

Based on the key COP 17 priorities, TB/HIV funds will support the following activities, leveraging Government of Lesotho resources and Global Fund activities: (i) Support the scale-up of GeneXpert MTB/RIF[22] and improve the early diagnosis of TB among PLHIV to close the gap between current estimated TB incidence and current notification rates. USG will continue to provide cartridges for GeneXpert, estimated at approximately $400,000. The roll-out of Gene Xpert placement is guided by the national GeneXpert roll-out plan and the national Xpert diagnostic algorithm. All HIV positive TB suspects receive Xpert as the initial test for TB. The national GeneXpert roll-out plan is monitored through measure of Xpert utilization, number of suspect, capacity of Xpert machines deployed. In FY17 COP, Lesotho will implement the new next-generation Xpert MTB/RIF Ultra; (ii) Scale-up intensified TB case detection using mobile laboratory loaded with Xpert MTB/RIF focusing on high risk groups within the country (factory workers, children, miners, contacts of TB/MDR-TB cases); (iii) Provide support for TB/HIV services at border points of care to address TB/HIV among miners, ex-miners and their families (iv) Support integration of TB/HIV care and treatment services in PEPFAR scale-up sites through support for clinical staff to strengthen and improve quality within TB clinics using the one stop approach; (v) Scale-up TB preventive therapy (TPT) for all PLHIV without active TB disease to cover all PEPFAR supported sites. COP 17 will make budgetary provision to facilitate the implementation of TB preventive therapy including support for the revision or update of the 3Is guidelines including tools for monitoring TB Preventive Therapy uptake and completion, partner monitoring, supportive supervision, forecasting, and distribution of TPT. HIV testing of presumptive TB cases and provision of IPT are parts of SIMS assessments. We plan to visit every site annually as well as the 7 highest volume sites every six months. INH and B6 stock outs have impacted the program; PEPFAR support for supply chain should help resolve future problems; (vi) Support the implementation of TB infection control measures and site-specific infection control plans in health facilities, provision of N95 respirators, and coordination of infection control committees; (vii) Support MOH to enhance and implement effective surveillance and M&E systems at central, district, facility, and community levels for TB and TB/HIV activities. This includes the implementation of revised TB/HIV MER indicators in both TB and HIV settings, TB/HIV cascade analysis, data quality assurance systems, strengthening the use and ownership of data for program planning, and active management and evaluation at district and facility levels; (viii) At the national level, continue to provide technical assistance for review of national plans, guidelines, and policies, tools, algorithms, and M&E systems for TB/HIV activities.

In COP17, EGPAF is the PMTCT, TB, facility and community based care and support, adult treatment, and pediatric treatment partner in both the sustained and scale-up districts. The same active monitoring of EGPAF will capture performance for all technical areas.

[22] Xpert MTB/RIF is the initial TB diagnostic test for PLHIV as per Lesotho Xpert MTB/RIF algorithm.

4.8 Adult Treatment

Lesotho became the first country in sub-Saharan Africa to adopt and implement Test and Start by launching the policy in April 2016 with nationwide implementation by June 1, 2016. By the end of FY16, 95% of the MOH accredited health facilities nationally were initiating anyone PLHV regardless of CD4 count. This demonstrated Lesotho's commitment to ending the AIDS epidemic as a public health threat by 2030 – an ambitious target of the 2030 Agenda for Sustainable Development adopted by the United Nations General Assembly in September 2015. This policy shift is also aligned with the National Strategic Plan goal of reducing HIV transmission, morbidity, and mortality in Lesotho. The MOH has an aggressive plan to scale-up treatment coverage to 90% by 2020 nationally.

COP17 builds on the achievements made in COP 16. By launching Test and Start, we have observed approximately 85 % increase in the number of new patients initiated on ART within the 5 PEPFAR supported scale-up districts and approximately 45% increase on number of patient on current on ART at the end of FY17 quarter one in comparison to APR15.

Other notable COP16 focused accomplishments include; (i) revision and national dissemination of the treatment guidelines, (ii) training for all health care workers linked to the HIV clinical cascade, (iii) scale-up of human resource support for direct service delivery to meet increased services demand, (iv) the scale-up of viral load testing (v) scale up of community adherence groups (2,900 CAGs) by the end of December 2016.

For COP 17, PEPFAR Lesotho is planning to support 256, 688 PLHIV on ART, this includes 229, 456 PLHIV on ART in the 5 scale-up, 24, 968 on ART at the 18 sites in the sustained districts and DOD sites. A total of 90,651 will be newly initiated on ART (81,734 in the scale-up districts and 8,575 in the sustained district). Overall a total of 64, 679 net new on treatment is expected in FY18. These targets apply to everyone: children, adolescents and adults; women and men and all priority key populations on ART. The five scale-up districts account for 90% of the overall treatment targets. These targets apply to everyone: children, adolescents and adults, women and men and all priority and key populations.

To achieve these aggressive targets, PEPFAR Lesotho will build on past gains of COP 16 through intensified direct service delivery model for all the PEPFAR supported sites. PEPFAR will continue to increase investments in scale-up districts to maintain high quality HIV care services with the rapid expansion of the treatment program by ensuring that all sites provide high quality care and treatment services to all those confirmed HIV positive (i.e. Test and Start).

In COP 17, direct service delivery support will be expanded to an additional 28 sites in the scale-up districts targeting priority populations such as prisoners, factory workers and key populations (FSW, MSMs, and LGBTs). All sites will continue to be supported to transition to a more cost-effective and client-centered service delivery model that is based on duration of treatment and health status of patients on treatment. All scale-up sites will be supported to implement interventions that enhance treatment initiation, linkages, and retention that include: rapid treatment initiation (same-day if ready for ART), reduced intensity and frequency of clinic visits for stable patients at 6 and 12 months, extended ART refills of 3-6 months, and extended working hours for selected sub-populations (i.e. men, factory workers, key populations). Patient volumes at site level will be controlled through the expansion of non-facility based ART delivery through Community Adherence Groups (CAGs), integrated outreach, and mobile clinics. Health facility staff will be supported to streamline commodity forecasting and ordering that is matched to the extended drug refills.

Service quality will be strengthened through continued support of the additional human resources from COP 16 to provide services to adults and children living with HIV to enhance treatment enrollment (nurses/multidisciplinary mobile teams), improve site-level reporting and data use (record officers), and manage site level supply-chain (pharmacy technicians). Site level support for treatment enrollment will include rapid initiation of newly diagnosed HIV positives to treatment, increased retention to 90% at 12 months, 90% for patients been on treatment more than 12 months, and attainment of viral load suppression in at least 90% of patients on treatment. The clinical care cascade linkages will be strengthened through: (i) maintaining support and recruitment of additional site-level linkage coordinators and adherence counselors to provide pre-initiation counseling, track missed appointments, and enhance intra- and inter-facility linkages and (ii) community level support through the use of VHW, PLHIV networks/community-based organizations and CAGS to improve retention. In addition community structures will be used to create demand for services and enhance treatment literacy among PLHIV on treatment. Mobile technologies will be used to facilitate linkages, retention, adherence support, and laboratory turn-around time of results.

National, district, and facility-level teams will be supported to scale-up and sustain collaborative quality improvement initiatives to improve patient outcomes, retention, and enhance provider skills. Despite the scale-up of treatment in COP16, major service gaps exist, and inequities in access persist. High quality data disaggregated by age, sex and other priority population characteristics across the health care system is required to make current HIV services more effective. Quality of data is required to measure service access, service uptake, populations covered, quality of services and acceptability along the entire continuum of HIV services. In COP 17, PEPFAR Lesotho will implement electronic individual patient level data entry at high volume sites to facilitate timely reporting, accurate linkage and retention measurement. PEPFAR Lesotho will continue to support intensified monitoring of service delivery at site level using patient level data. This will include: (i) monthly performance reviews to monitor coverage of index patient and PITC, average ART enrollment rates, clinical cascade linkages, and site-level commodity status, and (ii) quarterly cohort monitoring for retention, viral load uptake, and proportion of patients with a suppressed viral load. In addition, DHMT capacity building will be strengthened to enhance treatment program planning, coordination, and monitoring through quarterly stakeholders meetings and joint supportive supervision to health facilities. Scale-up districts will be supported to implement MOH Health Sector Reform, including the VHW model and District Organizational Restructuring to enhance integrated service delivery at facility and community levels. Stakeholder discussions on pharmacovigilance systems are ongoing.

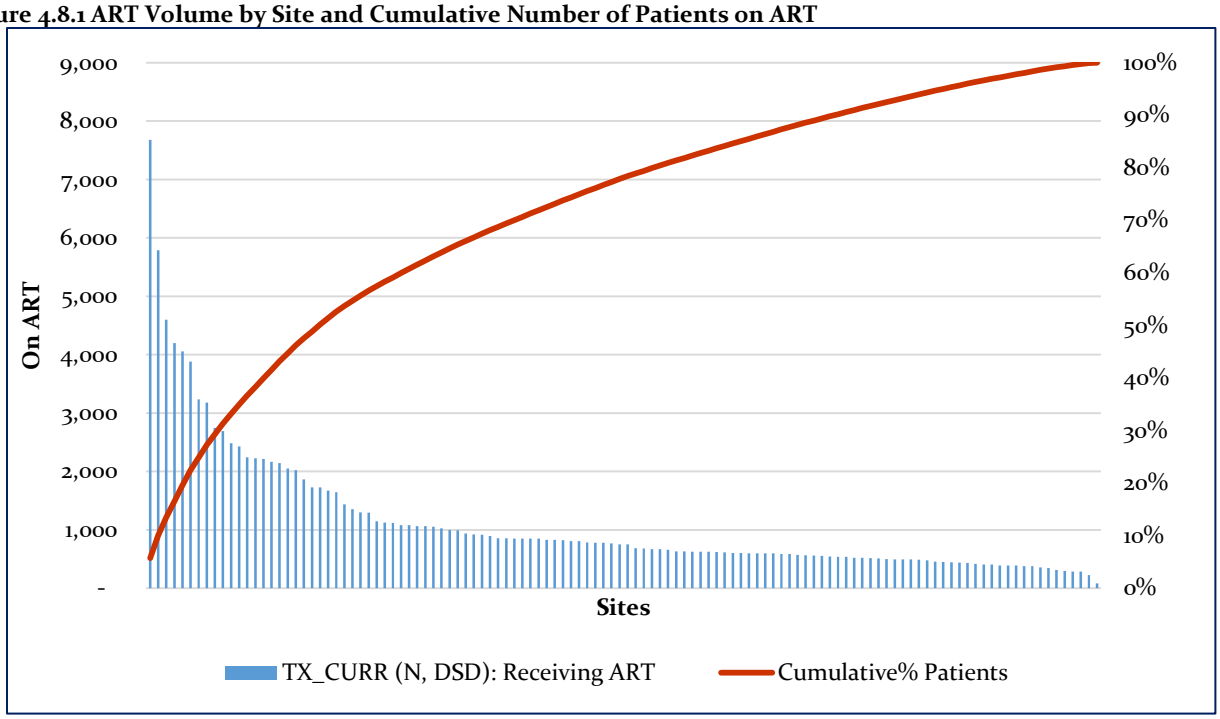
PEPFAR Lesotho will continue to support the implementation of MOH's national strategic plan for scale-up of VL monitoring. PEPFAR will support the procurement of reagents for VL, collaborate with the MOH to decentralize systems for monitoring and management of treatment failure, and strengthen the sample transport network for EID and VL. Other HSS activities critical to the treatment scale-up include technical support to the DHMT for forecasting and distribution of HIV-related drugs and laboratory commodities in collaboration with the supply chain partner.

In COP 17 PEPFAR Lesotho has proposed to provide direct service delivery to 18 sites in the sustained districts, these sites include mainly hospitals and high volume ART clinics. At the 18 sites the designated PEPFAR implementing partner will replicate the high impact interventions from the currently supported sites in the scale-up districts to be delivered along the continuum of HIV care to meet the proposed treatment targets.

In COP17, EGPAF is the PMTCT, TB, facility and community based care and support, adult treatment, and pediatric treatment partner in both the sustained and scale-up districts. The same active monitoring of EGPAF will capture performance for all technical areas.

Community Service Organizations (CSOs) are involved in multiple ways in treatment-related activities funded by PEPFAR Lesotho. USAID's project with AIDSFree develops the organizational and technical capacity of three CSOs (Lesotho Network of AIDS Service Organizations [LENASO], Lesotho Network of People Living with HIV/AIDS [LENEPHWA], and Lesotho Council of Non-Governmental Organizations [LCN]). In addition, CSO are sub-recipients of agreements with implementing partners. For example, LENASO and LENEPHWA receive support from EGPAF for community-based staff who track treatment defaulters and facility-based lay counselors, respectively.

Figure 4.8.1 ART Volume by Site and Cumulative Number of Patients on ART



ART Site Efficiency Analysis

PEPFAR supported ART in 118 sites in FY16, all the 118 sites are located in the scale-up districts. Patient volume analysis in the scale-up districts showed that 80% of the ART patients were seen in 53 % (64) of sites. The average patient volume in the remaining 20% (54) sites in the scale-up districts was 486.

4.8.1 Impact Funding for Treatment

The COP 17 Impact Funds will be used to address service delivery systems to decongest the clinics, remove barriers affecting access to ART, and remove barriers that lead to disengaging from treatment. In COP 16 Impact Funds were used to expand direct service delivery by recruitment of additional human resources to provide quality services for Test and Start to the anticipated volume of patients. PEPFAR Lesotho will continue to support 106 pharmacy technologists at high volume sites to support pre-packaging for community drug distribution, site level dispensing, forecasting, and ordering. Adherence counseling and support will be further strengthened by the recruitment of additional professional counselors targeting high volume sites in the scale-up districts. In addition, impact funds

will address programmatic gaps in the HIV clinical cascade that directly affect our ability to achieve COP17 targets.

Lesotho COP 17 Impact funds at the national level will ensure that the MOH develops detailed and specific guidance on implementation of differentiated models for the diverse patient populations, and develop step by step national algorithms and SOPs for the multiple differentiated service models (e.g. visit spacing, multi month prescribing , CAGS and other models).

At site level, Lesotho Impact Funds will continue to focus on adapting service delivery systems for at risk and underserved populations, which includes: (i) scale-up of outreaches (both number and frequency) to deliver ART in the community (ii) community ART delivery using designated pack homes or established health posts, (iii) scale-up community adherence groups, (iv) establish additional border points of care and HIV services, (v)covering staffing and costs for expanded evening clinic hours targeting factory workers, working groups, men and migrant workers, and (vi) implementing ART home delivery or designated places by lay counselor or village health care workers and lastly advocate MOH to scale-up the multi month drug dispensing for stable patients. See Annex D for Summary Budget allocation by Intervention.

4.9: Pediatric Treatment

PEPFAR Lesotho pediatric treatment services are aligned to the Accelerating Children's HIV Treatment (ACT) Initiative, whose goal is to double the number of children receiving treatment in high burden districts. Over the last two years, the ACT initiative was implemented in districts of Berea, Leribe, Mafeteng, Maseru and Mohale's Hoek, which has resulted in improved national pediatric ART coverage from 15% (at baseline APR 2014) to 64% at APR2016.

Lesotho has a strong national policy framework that fosters accelerated pediatric service uptake which includes HTS consent at ≥12 years of age, provision of Test and Start for all children living with HIV (CLHIV), and routine viral load monitoring. The pediatric clinical cascade has registered improvements with strong HTS-to-treatment linkages for all children aged below 15 years and OVC; increased treatment uptake among boys and girls aged 10-14 years; improved retention among children aged 5-14 years; and high viral suppression rates. These achievements are largely attributed to the use of a direct service delivery approach to build capacity of service providers on pediatric treatment, expansion of the community engagement programs, integration with OVC platforms, and improvement of the national M&E tools to effectively capture service uptake.

Despite these achievements, there are key programmatic gaps that remain to be addressed (i.e. low EID coverage for HIV exposed infants aged <2 months; sub-optimal cohort monitoring and tracking of aging-out of CLHIV on treatment; inadequate capacity of service providers in the provision of adolescent-friendly health services; and management of pediatric treatment failure).

During COP 2017, PEPFAR Lesotho remains committed to scaling up pediatric ART coverage, building on achievements of the ACT initiative, and ensuring that all, age and sex bands attain the treatment saturation goals. The COP 2017 pediatric programmatic priorities will include: (i) increasing EID coverage for HIV exposed infants aged <2 months to at least 80%; (ii) expanding treatment coverage to attain saturation in boys and girls aged 0-9years; (iii) strengthening retention to 90% for CLHIV on treatment through differentiated models of care and peer support groups; (iv) increasing coverage of viral load monitoring; and (v) decentralizing pediatric second and third-line management. Pediatric

TB/HIV services will be expanded to ensure that all TB/HIV co-infected children are initiated on treatment.

Pediatric HIV case identification for treatment will be enhanced using both facility and community level interventions. Community mobilization and bi-directional referrals for treatment will be enhanced using the existing community linkage navigators, village health workers, and mentor mothers. Active tracking of mother-infant pairs will be strengthened to increase EID uptake for all HIV exposed infants aged <2 months of age. Facility level case identification will continue to be strengthened through the provision of index testing and provider-initiated- HIV-testing and counseling (PITC) services at all entry points. All newly diagnosed children will be offered treatment, including same-day ART initiation.

PEPFAR Lesotho will continue using the direct service delivery approach to expand the number of sites providing pediatric treatment in the scale-up districts. At site level, this involves maintenance of the additional HRH (i.e. nurse clinicians, professional counselors, lay counselors, records officers, and adolescent ambassadors). Targeted training and mentorship will be strengthened to improve provider competencies in pediatric treatment, including provision of efficacious regimens, same-day ART initiation, pediatric adherence counseling, and effective monitoring for early detection of treatment failure. Technical support will be provided to decentralize 2nd and 3rd line pediatric management of ART. The PEPFAR program will continue to support the MOH to expand and improve HIV treatment of adolescents living with HIV through the expansion of adolescent corners in high-volume sites. Adolescent-friendly health services will continue to be expanded using adolescent/youth ambassadors as peer leaders to enhance HIV disclosure, treatment literacy, adherence, retention, and transition to adult treatment services.

Adherence and retention for CLHIV on treatment will be enhanced through differentiated models of care that include: multi-month dispensing for older children and adolescents in school, weekend or extended clinic hours, and family-centered community adherence groups. Ariel clubs and adolescent clubs will be further expanded in the scale-up districts. Adherence, aging-out, and retention monitoring will continue to be strengthened through cohort monitoring and active community follow-up of defaulters.

At the national level, PEPFAR will continue supporting the MOH national coordination framework for pediatric treatment through the ACT Stakeholders' forum and the PMTCT/Pediatrics TWG, oversight of pediatric training, and support supervision. PEPFAR will continue supporting the MOH with additional human resources to enhance national level oversight of the pediatric ART program, coordinate district-level pediatric scale-up, and mentor healthcare workers. At district level, PEPFAR will continue to provide technical support to the district health management team (DHMT) to improve and monitor the quality of care delivered to children and adolescents through site mentorships, support supervision and performance monitoring using patient outcome measures, and quality improvement (QI) tools.

In COP17, EGPAF is the PMTCT, TB, facility and community based care and support, adult treatment, and pediatric treatment partner in both the sustained and scale-up districts. The same active monitoring of EGPAF will capture performance for all technical areas.

4.10: OVC

The OVC program will continue to be implemented using existing national frameworks such as the Lesotho National Strategic Plan for Vulnerable Children.

In FY17, the main OVC program results exceeded the targets while the DREAMS OVC results were above 60%. It was agreed that the OVC program would enhance collaboration among partners, and improve strategies and linkages for HTS and ART programming. To improve partner performance, PEPFAR facilitates joint, quarterly meetings with OVC and DREAMS IPs. In addition, PEPFAR holds monthly update meetings with OVC partners. This platform is used to share program experiences, identify programmatic bottle-necks, and map out strategies for collaboration and linkages.

The OVC program is geographically aligned and implemented within the five PEPFAR Lesotho scale-up districts where OVC prevalence is also high. Lesotho phased out of the sustained districts in FY15. In COP17, the OVC implementing partners will utilize a family-centered case finding approach, and leverage all community and health facility platforms to intensify targeting of HIV positive children, adolescents, and their caregivers to access HIV prevention and care and treatment services.
To increase testing yield, the program will train OVC sub-grantees and community case workers in conducting HIV risk assessments in order to identify OVC beneficiaries to be referred for HIV testing. This will ensure that HTS is targeted at those most likely to be positive.

Additionally, the program will use other community platforms such as youth clubs and community health days, as entry points for targeting OVC. Our main OVC IP is also implementing ACT and adult care and treatment programs, which will help accelerate community-facility linkages. The program will further coordinate with other clinical and DREAMS implementers to facilitate targeting and referrals. Both ACT and DREAMS substantially overlap with OVC programs to foster synergies. Those caregivers or OVCs who are found positive will be linked with other OVC services such as psychological support, household economic strengthening, social grants, and any other social welfare services necessary.

Our 2 OVC partners work mainly through sub-grants to community based organizations, and currently sub-grant a total of $3.5M to 14 local CSOs to provide direct community and home based services to OVC and to link them with testing and treatment services.

The PEPFAR Lesotho team works successfully across agencies and across and within the prevention, care and treatment continuum to ensure improved linkages and uptake of services. Additionally to improve further collaboration across technical areas, we have instituted periodic meetings between our DREAMS, OVC, KPs prevention, HTS and treatment partners, and have already seen an improvement in partner coordination, shared events and programming that has improved links to testing, as well as testing and same day initiation on treatment.

4.11: Addressing COP17 Technical Considerations

With continued DREAMS and ACT support, PEPFAR Lesotho will program prevention activities for AGYW and treatment activities for children. In addition, to meet the age disaggregates required for epidemic control there will be a greater emphasis on providing services to persons <30 years of age along the clinical cascade.

Efforts to increase testing yield are centered around a careful examination of existing HTS data so that we can identify the modalities that achieve the highest yield, the greatest number of positives, and the lowest unit cost. For COP17 this means maintaining high coverage levels for all modalities under PITC (outpatients, inpatients, TB, ANC, etc.), along with a greater emphasis on index patient tracking. In addition, in COP17 increased funding is available for community-based testing as this approach helps identify PLHIV from hard to reach populations such as men, adolescents and key populations. Again, there will be an emphasis on index patient tracking. Home-based testing and door to door efforts will be discontinued.

Efforts to improve retention are based on multiple approaches: i) enhanced retention counseling, ii) increased efforts to follow-up on persons defaulting on treatment, iii) implementation of alternative methods of service delivery (e.g., CAG, multi-month dispensing, services after hours, etc.), iv) improved quality of services (as monitored through SIMS assessments), and v) reduction in stock outs of drugs and lab reagents. The national strategy for viral load testing calls for Lesotho to have the laboratory capacity to conduct viral load testing on 100% of persons on ART during 2017. This will require establishment of a third viral load facility under the MOH that should become operational in Q3 of FY17. The GOL will then have five platforms in three facilities in Maseru, Mafeteng and Leribe in addition to machines operated by SolidarMed and PIH.

As mentioned previously, quality of service delivery is monitored through SIMS assessments. Our goal is to conduct assessments of every PEPFAR-supported site annually. In addition, implementing partners provide QI activities to the MOH at central, district and site levels. By implementing the alternative methods of service delivery we hope to both decongest health facilities as well as decrease costs associated with treatment provision. This in turn should make it easier for Lesotho to sustain the program when PEPFAR support ends.

4.12: Commodities

By end of FY18, PEPFAR Lesotho is expected to achieve saturation in five scale-up districts. To scale-up HIV care and treatment services and achieve epidemic control, an uninterrupted supply of ARVs, and HIV diagnostic and monitoring commodities is critical.

In FY18, PEPFAR has allocated sufficient funds for laboratory commodities to cover viral load monitoring, EID and TB diagnosis in five scale districts. HIV tests kits, ARVs and other commodities, and logistics and distributions, will be funded by GF and MOH.

To address increasing demand for commodities, reduction of stock outs, and improvement of the national procurement and supply management systems, technical and financial support has been provided in partnership with the Global Fund (GF). In addition, in order to build the capacity of the National Procurement and Supply Chain Management System, PEPFAR will continue to provide significant levels of direct service delivery technical support to the District Health Management Team (DHMT), Supply Chain Coordinating Unit (SCCU) of MOH and National Drug Service Organization (NDSO). PEPFAR through the Global Health Supply Chain Management (GHSC) program is also providing central level direct management support for HIV and AIDS commodity procurement planning, distribution and the inventory management system.

A resource mapping was done to determine the required resources for commodities from 2016 to 2018 through the Procurement and Supply Chain Management Plan. A joint budget review with GF and

MOH was held across all budget categories to ensure sufficient resources are available for HIV and AIDS and essential commodities. This included budget adjustments for commodities during grant negotiation with GF. In addition, the Government of Lesotho has increased its contribution towards ARVs to cover 70% of the ARV needs in the country.

Although PEPFAR has provided comprehensive procurement and supply management (PSM) support, in the past, supply chain management has remained a challenge. Procurement planning using site level consumption data needs to be improved. Recurrent stock out of test kits, laboratory commodities and delays at different points of the procurement cycle, including untimely distribution of commodities, still occur. In addition, there are usually delays in the disbursement of allocated funds by both the GF and MOH.

In anticipation of stock out of supplies, PEPFAR will also allocate buffer-stock funds for test-kits as a stopgap measure. Through the CDC cooperative agreement, resources have been allocated to the Ministry of Health to procure laboratory reagents and supplies for VL, EID, CD4, and TB diagnosis for the five scale-up districts and the 18 high volume sites in the sustained districts. Due to the lack of clarity on the condom procurement and supply management system and the anticipated commodity gap, PEPFAR will rely on the USAID Central Commodity Funds to purchase enough condoms for the 5 Scale-up districts and 18 high volume sites. The anticipated commodity gap for ARVs due to the rapid and ambitious scale-up of services in the five PEPFAR supported districts and 18 high volume sites has led to discussions with the GF and the MOH to ensure that past savings from FY16 and FY17 could be reprogrammed to purchase more ARVs in FY18. To address the challenge of lack of consumption data for supply chain forecasting and supply planning decision making, the GHSC will support the DHMTs and the SCCU to implement an informed-push logistics information systems at site level. The informed-push will be the short- to medium-term solution while the GHSC will embed experts to develop a long-term electronic logistics management information system (eLMIS) at the SCCU and all service delivery points.

4.13: Collaboration, Integration and Monitoring

Since COP16, there has been progress made in collaboration, integration, and monitoring. PEPFAR agency leads and the Principal Secretary of Health have monthly meetings to discuss high level topics that need Ministry of Health or agency leadership to advance them and provide both parties an opportunity to discuss programmatic shifts or challenges. These meetings afford the opportunity to jointly discuss collaboration among donors, and a closer view into PEPFAR priorities and to ensure alignment within the GOL strategic framework.

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

In Lesotho, PEPFAR also plays a key role in national HIV coordination. PEPFAR is a co-chair of the AIDS Development Partner Forum. This forum is also co-chaired by UNAIDS and allows all HIV stakeholders in Lesotho an opportunity to learn about the work being done by other partners, capitalize on opportunities for collaboration, and provide technical input into Lesotho's HIV programs and results. PEPFAR is also an active member of the Lesotho Country Coordinating Mechanism

(CCM), the CCM Executive Committee, and the chair of the CCM Oversight Committee for the Global Fund. PEPFAR participation in these committees are key to helping ensure joint planning and program coordination between the two largest donors and ensure the programs are complementary and not duplicative.

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

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

5.1: Targets for attained and sustained locations and populations

PEPFAR Lesotho has no attained districts in COP17.

Table 5.1.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group		Expected result APR 17*	Expected result APR 18*
HIV testing in PMTCT sites	*PMTCT_STAT*	-	**5,032**
HTS (Only high volume sites in Sustained)	*HTC_TST*	-	**121,999**
HIV positives (all populations)	*HTS_POS*	-	**9,134**
Treatment new	*TX_NEW*	-	**8,575**
Current on ART	*TX_CURR*	-	**24,968**
OVC	*OVC_SERV*	-	-
Key populations	*KP_PREV*	-	-

*Sustained districts estimate a 10% increase in the national ART coverage in FY17 and FY18. Beginning in FY18, PEPFAR support to the 18 high-volume sites is estimated as additional impact.

5.2: Priority Populations

There are no priority populations programs planned in the sustained districts for COP17.

5.2.1: Pre-Exposure Prophylaxis (PrEP)

The clinical partner in the five supported districts is currently implementing pre-exposure prophylaxis (PrEP) for sero-discordant couples on a limited scale, at ART sites. In FY18, PEPFAR aims to scale-up the provision of PrEP services to 5,096 sero-discordant couples in the sustained districts. This initiative

will ensure countrywide coverage of PrEP services to sero-discordant couples. Refer to the scale-up saturation PrEP narrative section for details to the implementation strategy.

5.3: Voluntary Medical Male Circumcision
There are no VMMC programs planned in the sustained districts for COP17.

5.4: Preventing Mother-To-Child Transmission (PMTCT)
Lesotho has a strong policy framework for PMTCT following adoption of the WHO Test and Start guidelines that have been rolled out nationally. Since the implementation of these guidelines, the PMTCT program has successfully increased the number of HIV exposed infants (HEI) who are born free from HIV. The uptake of PMTCT services by pregnant women who present at health units continues to be high with >95% knowing their HIV status and >95% accessing treatment to prevent the risk of MTCT. The APR 2016 results demonstrated that 67% of pregnant women who presented for their first ANC visit with known HIV positive status were already on ART for their own health. Routine viral load monitoring for all pregnant and lactating women and children was adopted as a standard of care in 2016, which will continue to inform clinical management of PMTCT clients to further ensure viral suppression to reduce the risk of MTCT.
Despite these policy and facility level programmatic achievements, Lesotho's population-based coverage of PMTCT services has remained stagnant at 70-72% over the last four years. In addition, there is sub-optimal uptake of early infant diagnosis (EID) at 2 months of age, which was reported to be 77% at APR16. HEI who received EID late had a higher MTCT rate compared to those who had EID within two months of age.

During COP17, PEPDAR Lesotho will contribute to national efforts to improve PMTCT and EID service uptake by extending support to 18 health facilities, which contribute 47.8 % of ANC attendance in the five sustained districts.

The support will include increased direct service delivery (DSD), which will also focus on the quality of service delivery along the four PMTCT prongs. USG will advocate for flexible clinic hours to accommodate pregnant and lactating women and their babies. There will be establishment of quality improvement (QI) teams in the five sustained districts to spearhead QI activities. The community PMTCT program through mentor mothers will not be expanded to the sustained districts.
PEPFAR Lesotho will continue to support MOH with procurement of laboratory equipment and reagents for EID and viral load monitoring as well as transportation of specimen from facility to the laboratories including all the logistics. PEPFAR Lesotho will leverage resources from the UNITAID grant that is scaling up point of care EID in selected high volume sites to reduce the long turnaround time of results to caregivers.

Performance data will be reviewed regularly with the implementing partner to closely monitor program performance so that gaps can be identified and addressed as soon as possible. DHMTs will be supported with resources to supervise the facilities and take the lead on program implementation. In COP17, EGPAF is the PMTCT, TB, facility and community based care and support, adult treatment, and pediatric treatment partner in both the sustained and scale-up districts. The same active monitoring of EGPAF will capture performance for all technical areas.

5.5: HIV Testing and counseling Services (HTS)
In COP17 the PEPFAR Lesotho program will support an additional 18 high volume sites in the sustained districts. To meet the treatment targets for FY18, the HTS program will identify an additional 8,522 positives in these high volume sites and link them to treatment. Facility based (PICT) and family tree testing will be the primary modalities for case identification. Apart from using the newly identified PLHIV and those in care to reach their families and sexual partners (facility based index testing), self-testing will be integrated in ART, ANC and male and adolescent friendly corners to increase uptake and improve yield. The program will establish and address any system and structural barriers affecting access to HTS for the family members and sexual partners of the index clients.

5.6: Facility and Community Based Care and Support
During COP17, the PEPFAR Lesotho care and support package for the sustained districts will be aligned with the national policy framework for Test and Start, HIV testing and counseling services (HTS), and routine viral load strategy, which were launched in FY16. The facility and community based care and support package is similar to that in the scale-up districts and will be provided in 18 high volume sites located in the sustained districts of Butha-Buthe, Mokhotlong, Quthing, Qacha's Nek, and Thaba-Tseka. The 18 sites include all eight hospitals in the sustained districts along with ten health centers. This care and support package of services will be provided to 24,968 adults and children receiving ART services at 18 facilities in the sustained districts. These sites provide approximately 60% of all treatment services in the sustained districts. The remaining 52 facilities in the sustained districts account for the remaining 40% of patients currently on treatment and are generally located in remote mountainous locations serving relatively small catchment areas.
In COP17, EGPAF is the PMTCT, TB, facility and community based care and support, adult treatment, and pediatric treatment partner in both the sustained and scale-up districts. The same active monitoring of EGPAF will capture performance for all technical areas.

5.7: TB/HIV
Support for TB/HIV services for the 18 supported sites in the sustained districts will leverage on the TB/HIV national support described in section 4.7. In collaboration with the MOH and the DHMTs in the sustained districts, PEPFAR Lesotho will support implementation of enhanced models of TB/HIV integration through provision of TB/HIV focused nurses, counselors to provide testing, and ART and TB medication adherence counseling. Site level support will focus on (i) achieving and maintaining 100% HIV testing rates among all TB cases and patients with presumptive TB as a contribution to the first 90, (ii) provide universal ART for all people with TB diagnosed with HIV as a contribution to the second 90, (iii) timely TB diagnosis and TB treatment completion to ensure viral suppression using Xpert MTB/RIF, and (iv) scale-up of TB preventive therapy (TPT) for all PLHIV without active TB disease and implementation of TB infection prevention and control interventions.

PEPFAR Lesotho will work with the village health care worker teams attached to the 18 sites to strengthen referrals between facilities and between facilities and community, and with treatment supporters to enhance patient support and follow up to support DOTS. PEPFAR Lesotho will support the 18 sites to develop and implement performance improvement strategy and accountability.
In COP17, EGPAF is the PMTCT, TB, facility and community based care and support, adult treatment, and pediatric treatment partner in both the sustained and scale-up districts. The same active monitoring of EGPAF will capture performance for all technical areas.

5.8: Adult Treatment

As indicated in section 4.8, PEPFAR Lesotho will utilize performance funds to expand services to the 18 high volume sites in the 5 sustained districts. PEPFAR Lesotho will ensure that high impact interventions as prescribed in the revised Lesotho national ART guidelines are being implemented. Site level support for treatment enrollment will include rapid initiation of newly diagnosed HIV positives on treatment and improved retention to 90% at 12 months. Using lessons learned in the scale-up districts, the clinical care cascade linkages will be strengthened through: (i) recruitment of site-level linkage coordinators and adherence counselors to provide pre-initiation counseling, track missed appointments, and enhance intra- and inter-facility linkages and (ii) community level support through the village health care teams, improved retention through CAGs, and enhanced treatment literacy among PLHIV on treatment using available community structures. Mobile technologies will be used to facilitate linkages, retention, adherence support, and laboratory turn-around time.
By the end of December 2016, the 18 sites had 18,590 adult and children current on ART. By the end of FY18, the 18 sites are expected to have 24,968 adults and children current on ART (expected new ART enrollments is 8,575 and net new of 6,078).

In COP17, EGPAF is the PMTCT, TB, facility and community based care and support, adult treatment, and pediatric treatment partner in both the sustained and scale-up districts. The same active monitoring of EGPAF will capture performance for all technical areas.

5.8.1 Performance Funding for Treatment

Lesotho received performance funds as additive to the COP17 base funding. These funds will allow PEPFAR Lesotho to expand to 18 high volume sites in the sustained districts in Lesotho in COP17. PEPFAR Lesotho explored a variety of options for treatment activities after we obtain 80% coverage in one or more of the five scale-up districts. After examining various scenarios guided by the data pack, programmatic unit expenditure, and PBAC, PEPFAR Lesotho was in agreement that the greatest impact will be by supporting the 18 highest volume sites in the five sustained districts. Overall, the five sustained districts contain about one-quarter of the national population and one-quarter of the HIV disease burden. The 18 sites include all eight hospitals in the sustained districts along with ten health centers. All 18 facilities currently serve a minimum of five hundred PLHIV on ART. The 18 facilities currently serve 18,590 PLHIV on treatment. This represents approximately 60% of all people on treatment in the sustained districts. The remaining 52 facilities in the sustained districts account for the remaining 40% of patients currently on treatment. Resources will be used to strengthen the quality of services at the 18 proposed sites through recruitment of additional human resources to provide services to adults and children living with HIV to enhance treatment enrollment, improve site-level reporting and data use, and manage site level supply-chain and resources to improve linkages and retention along the clinical cascade. See Annex D for a summary of the budget allocation by for each intervention.

Table 5.8.1: Summary of treatment targets in the sustained districts

Sustained Districts	Number of sites supported	FY18 TX_NEW Target	FY18 TX_CURR TARGET	Est. Net New
Quthing	4	2,178	5,281	1,650
Thaba Tseka	5	2,219	6,479	1,571
Mokhotlong	5	1,290	5,586	731
Butha Buthe	2	1,483	5,135	970

Qacha's Nek	2	1,404	2,488	1,155

5.9: Pediatric Treatment

During COP17, PEPFAR Lesotho pediatric treatment program will be expanded in 18 high volume sites in the sustained districts. These 18 facilities currently serve over 962 children aged <15 years on treatment. This represents approximately 71% of all children on treatment in the sustained districts. The remaining 52 facilities in the sustained districts account for the remaining 29% of patients currently on treatment. These other 52 facilities are generally health centers in remote mountainous locations serving relatively small catchment areas.

PEPFAR national level support described in section 4.9 will also cover pediatric treatment services in the sustained districts. The current national policy framework for Test and Start, HIV testing and counseling services (HTS), and routine viral load monitoring strategy will be the cornerstone for pediatric treatment scale-up in the sustained districts.

PEPFAR Lesotho's support in these 18 new sites will be through a direct service delivery approach through provision of HRH, which is critical to bridge clinical cascade gaps based on lessons from the five scale-up districts. Pediatric treatment scale-up in the sustained districts will be aligned to the ACT initiative pillars 2-6.

Community engagement interventions will be limited to the use of LENASO focal persons to mobilize, actively track and foster bi-directional referrals for HIV exposed infants, pre-ART CLHIV, and their caregivers and linking them to facility level treatment. Provider initiated HIV testing and counseling (PITC) services and facility-based index testing will be the two main approaches for HIV case identification, utilizing all entry points for children. All newly diagnosed CLHIV and pre-ART CLHIV will be fast-tracked for treatment initiation, including same-day ART initiation.

PEPFAR Lesotho will utilize the COP17 ACT Initiative Plus-up funding to expand pediatric treatment focusing on three programmatic gaps in the sustained districts including (i) expansion of pediatric care and treatment services; (ii) strengthening pediatric counseling, adherence and retention support; and (iii) increased tracking of HIV exposed infants and uptake at <2 months of age.

PEPFAR will support capacity building of service providers on pediatric and adolescent treatment, and provision of differentiated service delivery for stable children on ART. Pediatric capacity building will be enhanced through the recruitment of three pediatric district mentors who will work with the MOH and DHMTs to train, mentor, and support site level staff on pediatric HIV and TB treatment. The three Baylor satellite centers of excellence in Qacha's Nek, Mokhotlong, and Butha-Buthe will serve as practicum training hubs for service providers through clinical attachments.

Pediatric counseling services will be expanded through the recruitment of 18 pediatric counselors to support pediatric treatment monitoring, adherence and retention support. In addition, support groups for children and adolescents on treatment will be expanded using lessons from the Ariel Clubs, Adolescent Clubs, and adolescent/youth ambassadors in the scale-up districts. COP base funds will be leveraged to strengthen M&E of pediatric treatment services through the use of records officers, provision of revised HMIS longitudinal registers, and quality improvement interventions.

In COP17, EGPAF is the PMTCT, TB, facility and community based care and support, adult treatment, and pediatric treatment partner in both the sustained and scale-up districts. The same active monitoring of EGPAF will capture performance for all technical areas.

5.9.1: Accelerating Childhood Treatment (ACT) Funding

The COP17 ACT Initiative plus-up funds ($770,745) will be used to expand pediatric HIV care and treatment services in 18 high volume sites located in the sustained districts.
These 18 sites account for 71% of the total children on treatment in the five sustained districts.
The table below shows pediatric treatment current numbers for the five sustained districts in FY17 and the TX_NEW and TX_NET_NEW to be supported by PEPFAR in COP17.

District	Total PLHIV <15	FY16 TX_CURR <15	FY16 Coverage	FY17 Expected TX_CURR <15	FY18_TX_CURR <15
Quthing	654	148	23%	147	173
Thaba Tseka	813	129	16%	128	262
Mokhotlong	453	380	84%	418	418
Butha Buthe	672	383	57%	379	412
Qacha's Nek	414	182	44%	180	185
TOTALS	**3,006**	**1,222**		**1,251**	**1,449**

PEPFAR Lesotho will utilize COP17 ACT Initiative Plus-up funding to expand pediatric treatment focusing on three programmatic gaps in the sustained districts: expansion of pediatric care and treatment services; strengthening pediatric counseling, adherence and retention support; and increased tracking of HIV-exposed infants and uptake of EID at <2 months. See Annex D for a summary of the budget allocation by for each intervention

5.10 OVC

There are no OVC programs planned in the sustained districts for COP17.

5.11: Establishing service packages to meet targets in attained and sustained districts

Prioritized activities for attained SNUs include:
No districts will meet the criteria for attained with regards to treatment criteria until the end of FY18.

Prioritized activities for sustained SNUs include:
In the five sustained districts in COP17 we will provide facility-based HTS, a complete set of treatment services (e.g., treatment, PMTCT, TB\HIV), and viral load testing at 18 high-volume sites that currently serve 60% of the PLHIV on ART in these districts.

5.12: Commodities

PEPFAR Lesotho in COP17 is proposing to scale-up its direct service delivery model of services to 18 high volume sites in the five sustained districts. The general approach to the implementation strategy is aggressive scale-up of Test and Start services in the 18 high volume sites. PEPFAR is planning on

implementing similar PSM strategies to those described under the scale-up to saturation districts in order to ensure commodity security for HIV and AIDS and laboratory commodities in the 18 sites.

5.13: Collaboration, Integration and Monitoring
In addition to the collaboration, integration, and monitoring activities that were discussed in section 4.13, there is one unique aspect for the sustained districts. In COP16, PEPFAR had no site level activities in the 5 sustained districts. With the shift to site level activities at 18 high volume sites in COP17, PEPFAR has worked closely with colleagues at the Ministry of Health and with the Global Fund to ensure transparency and program harmony. The Global Fund and Ministry of Health both attended the four day COP17 planning retreat and gave input into program planning. Moving forward, this shift will require more routine collaboration with the Global Fund to ensure that the programs work together and that there is no duplication of efforts.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1. Critical Systems Investments for Achieving Key Programmatic Gaps
In COP16, the PEPFAR team identified key systems level gaps associated with case identification, treatment initiation and treatment retention in order to achieve sustained epidemic control in the five scale-up saturation districts. These were defined as key in order to attain the 90-90-90 clinical cascade in the five scale-up saturation districts by FY18. However, in COP17, the PEPFAR team has decided to incorporate all proposed activities associated with the key systems programmatic gaps into the program area target-based budgets (TBB). The rationale was that in COP16, the main cost categories associated with the key systems gaps were personnel and training costs, and those are already cost categories within the target-based budgets (TBB).

It is, however, important to mention that all the staff proposed in the COP16 table 6 were recruited in FY16 and FY17 in line with the implementation of the Test and Start policy which was launched on April 14, 2016 and national implementation begun in June 2016.

6.2 Critical Systems Investments for Achieving Priority Policies
Similar to key systems programmatic gap investments above, most priority policy and new service delivery activities were achieved as a result of the April, 2016 launch of the Test and Start policy. PEPFAR successfully supported the MOH to develop a new Test and Start policy and the associated HTS and treatment guidelines in readiness for the June 2016 national launch.

The remaining activities related to the alternative and new service delivery models have now been incorporated into the various PEPFAR program areas and other proposed systems investments outside the programmatic gaps and priority policies.

6.3 Proposed system investments outside of programmatic gaps and priority policies.

6.3.1 Human Resources for Health (HRH)

PEPFAR will continue to support and build the capacity of the Lesotho Nursing Council (LNC) to credential nurses and accredit NIMART sites in the 5 scale-up districts and 18 high volume sites. The goal of this systems investment is to ensure that 100% of the nurses working in NIMART sites are credentialed and all service delivery sites are accredited to provide HIV and AIDS services. In FY16 97% of the 4,900 nurses working in the public health sector met the credentialing standards. In COP17, PEPFAR is aiming to support the expansion of the credentialing exercise to include nurses working in the private sector. It is premised that reaching the private sector will allow the LNC to meet the 100% targeted nurses. PEPFAR will continue to invest a flat-lined budget of $109,873 for HRH investments.

6.3.2 Laboratory - Systems/Institutional Investments

The purpose of laboratory investments is to provide quality-assured and integrated services to meet PEPFAR's goal towards sustainable control of the HIV epidemic and achieve 90-90-90 targets. PEPFAR will focus on ensuring patient access to quality services by supporting policy and guideline development, training, laboratory commodities, sample transport, referral networking, equipment maintenance, biosafety, laboratory lab information and M&E system for facilities. Laboratory services will ensure that patients are tested, and linked to care and treatment services. PEPFAR will support the implementation of integrated national laboratory services to improve quality, efficiency and cost-effectiveness for all core laboratory services including specimen transport, scale up of EID and VL coverage, results delivery, supply chain management and information systems. The provision of integrated laboratory service will allow both programs and clinicians to use comprehensive information for informed decision-making and effective patient care.

PEPFAR Lesotho will provide DSD to two reference laboratories (National Reference Laboratory and TB Reference Laboratory) and 18 clinical laboratories and TA-SDI support to all 142 health centers and/or clinics, which provide HIV rapid testing services. The DSD includes procurement and distribution of lab commodities, human resource support for provision of testing services, mentorship through rollout of SLMTA, quarterly site supervision, sample transport, referral testing, equipment maintenance and inventory management, external quality assessment/proficiency testing (EQA/PT) schemes for HIV test, CD4, VL, EID, TB AFB, GeneXpert, TB culture and susceptibility tests. TA-SDI will also be provided to 142 Point of Care Testing (POCT) sites (health centers/clinics). The support includes distribution of EQA/PT panels, training counselors and sample transporters and phlebotomists, and supportive supervision of sites that are poorly performing in PT schemes.

In COP17, PEPFAR Lesotho will support the following core activities:

1) Laboratory Continuous Quality Improvement (CQI) and Proficiency Testing (PT) program: technical support will be provided in Strengthening of Laboratory Management Towards Accreditations (SMLTA) and accreditation of labs and POC sites using the WHO AFRO Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) or the WHO/CDC Stepwise Process for Improving the Quality of HIV-Related Point-of-Care-Testing (SPI-POCT) checklist to audit the testing sites. Quality Management System (QMS) with the 12 elements of a quality system will be used as a working framework. The key areas to be reviewed include process control, corrective actions and documentation, safety and management reviews. All 18 hospital laboratories and 142 POCT sites will be enrolled in PT schemes for HIV/TB tests. In the reporting period, 80% of sites will achieve acceptable passing criteria (>80%) for the PT schemes.

2) Human Resource and Training: To address gaps in competency, training needs will be assessed and refresher training on biosafety, laboratory quality management systems, laboratory operation, HIV diagnosis, EID/VL, and TB diagnosis will be provided. In addition, laboratory technicians and data clerks will be recruited and retained to ensure timely HIV/TB diagnostic and patient monitoring services are provided.
3) Laboratory Information System and M &E system: the support includes strengthening the current electronic LIS system to improve testing coverage, and reduce turnaround time for prompt patient management and monitoring of ART patients. To increase efficiency and cost-effectiveness of laboratory services, the sample transport tracking and result delivery (SMS messaging) tools will be rolled out and interfaced with the LIS. The LIS will also be interfaced with electronic patient records and DHIS-2 for better management of patients on treatment, collating, reporting and clinical decision-making.
4) Referral network and integrated laboratory services: in order to increase access and coverage, local referral networks will be strengthened by implementing common standards of practice. The district hospitals will support neighboring health centers through referral testing services with a reliable transportation system for samples and result reporting. The National Reference Lab will also serve as reference hub for networks of district hospitals and neighboring health centers. Supporting tiered and integrated national laboratory services will improve efficiency including specimen transport, results delivery, and supply chain management and information systems.
5) Laboratory equipment procurement and maintenance system: the support includes purchasing of minor equipment, developing and/or revising guidelines and SOPs for maintenance services. Reinforcement of service contracts with manufacturers or vendors for Roche CAPCTM, GeneXpert, MGIT, CD4 machines and biosafety cabinets with timely maintenance services will contribute to provision of uninterrupted laboratory services.

6.3.3 Strategic Information (SI) - Systems/Institutional Investments

ICAP is in the process of completing an assessment of the current EMR. A consultant has been identified and the actual assessment will begin by April 2017. Results of the activity will be incorporated into planning for a new patient-level database and development of an electronic register system during COP17. Using HIS funding, PEPFAR Lesotho is planning to implement an electronic register that will use a biometric identification (fingerprint) system to track individual patients. Given the high rate of migration, both in and out of country, it is currently extremely difficult to follow an individual from diagnosis to care, including retention in treatment. The use of patient-level unique identifiers will increase our ability to follow individuals across the continuum of care. PEPFAR Lesotho will work with our in-country SI partners to implement an openMRS electronic register in a defined number of sites in country. The register will include fingerprint readers, allowing for tracking of individuals. In addition, support will include system development, equipment, training, and limited travel.

Site-level DHIS2 expansion is beginning in April 2017. Register revisions and ongoing training in the country delayed the roll out of site level expansion during the first few months of FY17. However, during this time continued support to district- and central-level DHIS2 occurred as planned. Data quality and timeliness and completeness of reporting remain an issue. In COP17, we are proposing to complete a DQA of all data in DHIS2 to better understand areas most contributing to late and incomplete reporting and poor quality of the data reported. During COP17, PEPFAR will continue to

support DHIS2 at the site, district, and central levels by providing training, equipment, and staff to support the system.

District and central DHIS2 activities include: support of biannual DHIS2 forums; maintenance of two senior MIS managers and one HMIS specialist to conduct DHIS2 development skill building workshops to MOH core development team; maintenance of an HMIS specialist to oversee data quality, completeness, and timeliness improvements; and maintenance of six district-level data clerks to support data capturing from private facilities. Site-level activities include: training and mentoring for site-level staff; maintenance of a senior HMIS specialist; and regional IT support. To assist with data quality, our in-country SI partner will continue support of the national and district SI TWGs; provide on-site mentoring on setting up and using DHIS2 dashboards; conduct trainings on packaging data in user- and decision-maker friendly formats for in-country use and decision making; organize an annual DHIS2 data use conference; second an epidemiologist to MOH to advance data use for decision making and to develop a work plan to address capacity gaps within the MOH surveillance team to allow the team to be less reliant on outside consultants; and migrate retrospective data into DHIS2. In addition to improving data quality, Lesotho will focus on expanding the amount of data available in DHIS2 by linking the laboratory information system (LIS) with DHIS2 and developing an interoperability layer between community-based testing information and DHIS2. Overall, we continue to work closely with the Ministry of Health to improve reporting.

In COP17, Lesotho will work with CDC HQ and the Ministry to implement a Violence Against Children Survey (VACS). Prior to the implementation of COP17, we will continue planning discussions with HQ and the Ministry.

6.3.4 Systems Development: Quality Assurance and Improvement

The USAID/ASSIST Follow-on Project will provide technical support to the MOH and ten District Health Management Teams (DHMTs) to effectively institutionalize and coordinate Quality Assurance/Quality Improvement (QA/QI) approaches along the 90-90-90 clinical cascade for HIV and TB services. The COP17 QA/QI goal is to ensure that 90% of the national and district QI coaches provide support to the HIV and AIDS clinical cascade; and 100% of PEPFAR supported DHMTs have documented QA/QI case studies that directly inform national and district level service improvements along the 90-90-90 clinical cascade. National and District-level QI coaches will provide district level oversight in the implementation of innovative and sustainable collaborative quality improvement (CQI) approaches with a focus on clinical care cascades and HIV treatment outcomes for adult and pediatric care and treatment, PMTCT, TB/HIV integration, and Nutrition Assessment Counseling and Support (NACS) services. During COP17, the project will utilize CQI approaches to contribute to national efforts of achieving epidemic control through technical support to the national and DHMT Quality Improvement Technical Working Group to coordinate the implementation of national and district level QI interventions; leadership on QI training and coaching based on clinical cascade gaps; and oversight of the district-level QI learning sessions. The ASSIST Follow-on project will support the national and district coaches to conduct integrated coaching, mentorship and support supervision with the goal of improving quality improvement approaches for HIV and TB services. The DHMTs and national QI TWG will regularly analyze DHIS II district-level results; define district-level QI projects; and measure service delivery processes and patient outcomes. The results will be presented in form of dashboards and case studies, which will be disseminated during the quarterly district QI Learning/Knowledge Exchange sessions. In addition, the ASSIST Follow-on project will utilize these

QI Learning/Knowledge Exchange sessions to facilitate peer-to-peer coaching/ knowledge exchanges as a strategy to scale-up best-practices across districts.

6.3.5 Systems Development: Commodity Security and Supply Chain Management

PEPFAR in COP17 will invest $2,150,000 in order to continue providing direct service delivery (DSD) support and capacity building to the Ministry of Health through the Supply Chain Coordination Unit (SCCU), District Health Management Teams (DHMTs) and the National Drug Services Organization (NDSO). The goal of this investment is to ensure that there is a fully functional Government -led HIV and AIDS commodities and supply chain management system, which can guarantee 100% commodity security for all Test and Start commodities (both ARVs and laboratory supplies and reagents). PEPFAR will achieve this goal through a four-pronged strategy. The details are in the following paragraphs:

1. Provide direct institutional and organizational support and capacity building to the MOH, SCCU, programs and NDSO: In order to contribute to the strategy for capacity building of the national PSM system, PEPFAR will continue to employ three SCM Specialists to the SCCU and seven District Logistics Officers (DLOs) to the DHMTs. The HRH employed and seconded to the Ministry of Health will support the SCCU to deliver their mandate of ensuring a functional SCM system that uses data for decision-making. In addition, the seconded-staff are expected to build the capacity of their host-government staff (compatriots) by providing on the job training and skills transfer. The seconded experts are also expected to support the SCCU to revitalize the Supply Chain Management Technical Working Group (SCM-TWG). The objective is to create four SCM-TWG sub-groups for Quantification/ Forecasting and Supply Planning (FASP), Inventory Management, Donor Coordination and Capacity Building.
2. Appropriate warehousing and inventory control for all HIV and AIDS commodities: In FY16 and 2017, PEPFAR seconded two short-term technical assistance (STTA) experts to the National Drug Services Organization (NDSO) to assist with warehouse/transportation network optimization, re-organization and warehouse systems improvement in the management of HIV and AIDS commodities. The STTAs were very successful, with visible improvements and evident utilization/ introduction of key performance indicators (KPIs) at the NDSO. In addition, PEPFAR will continue to second one Warehousing Liaison to NDSO to provide on-the-job training and transfer skills to compatriots at the central medical stores. In COP17, additional STTA will be provided in procurement planning, quality assurance and improvement, warehousing/ inventory management and commodity distribution network optimization at the NDSO and it supply pipeline in Lesotho.
3. Establish a functional LMIS for HIV and AIDS commodities: in the short to medium term, the district logistics officers (DLOs) will continue to be seconded to the DHMTs to support the implementation of the informed-push ARVs re-supply system in all service delivery sites in the five scale-up saturation districts and 18 high volume sites in the sustained districts. However the long-term strategy is to match the Health Information System (HIS) central funds of $150,000 to implement the electronic Logistics Management Information System (e-LMIS) in all the 10 districts of Lesotho. PEPFAR investments will go towards in-service training and support supervision of DHMTs and service delivery sites as they implement the e-LMIS. The e-LMIS will run on the DHIS2 platform and for that reason PEPFAR will not purchase any equipment.
4. Review current SCM SOPs and re-engineer process for efficient procurement of HIV and AIDS commodities for Test and Start, Multi-Month Prescriptions, and new service delivery models: PEPFAR will provide STTA to re-engineer all supply chain management functions at MOH, SCCU, DHMTs, and Service Delivery Points (SDPs)/ health facilities to include inventory

control systems that take into account MMP, new community service delivery models and commodity demands as a result of the new Test and Start policy. The Global Health Supply Chain Management program (GHSC) will provide STTA to support the GOL to develop new SCM standard operational procedures and guidelines. The guidelines will identify internal structures and functions critical to ensuring commodity security for ARVs and laboratory reagents and supplies.

6.4 HIS Central Funds

Electronic Registers

Electronic systems can facilitate efficient record keeping at the facility-level and patient care management. HIS funding will be used to support implementation of an electronic register system in the 181 public facilities providing ART in Lesotho. Support will include: personnel, trainings, mentorship, and equipment/supplies. An electronic register system will improve the ability of PEPFAR Lesotho and the Government of Lesotho to follow patients through the 90-90-90 cascade. Incorporating biometric patient identification with the electronic registers will improve our ability to track individual patients across facilities. Currently, with the high level of migration, both within and outside of Lesotho, it can be difficult to determine patient outcomes – especially among patients who are considered lost to follow up, as we cannot track patients across facilities. Electronic registers and unique identifiers will address this and also improve our overall data quality. Total budget: $1,650,000. The key activities and summary budget are listed in Appendix D.

Budget Assumptions:

1) Current HR resources at the sites will be leveraged (data and record clerks and providers) for data entry.
2) Investments will be focused on key needed devices (supply), desk top computers, UPS, finger print devices, WiFi connectivity, training, mentorship/trouble shooting.
3) DHIS2 resources will be leveraged and optimized
    a. DHIS2 developer will be trained on OpenMRS customization and will develop and test the system in two hospitals and associated health center networks (pilot will be completed before the HIS funding arrives).
    b. District DHIS2 implementation support officers will support pilot testing.
4) Will use current ICAP vehicles (originally procured through CDC funded HIV/TB project and currently being used for LePHIA)
5) System will be implemented at the registration point and HIV-related service points (HTC, ART, TB, MCH, delivery, etc).

DHIS2

HIS funding will be used to support site-level implementation of DHIS2. Rollout of DHIS2 to the facility-level is a key step in ensuring timely, high quality data that can be used for programmatic decision making. The data entry burden on district teams will be reduced with the expansion of DHIS2. Technical assistance will be provided to MOH to support the rollout of DHIS2 to the facility-level at ~185 public facilities in Lesotho. Activities will include support to MOH in sustained accessibility of DHIS2 to a growing number of system-level users while ensuring data security through a cloud-based server. Annual district-level DHIS2 forums for facility-level staff will be supported where staff will be encouraged to share experiences, challenges, and lessons learned, as well as to provide input on refinement of the system. Refresher trainings will be conducted as needed and ongoing mentorship to facility-level users will be administered. The current HMIS manager and two

senior HMIS officers will continue to support district-level MOH teams on site-level DHIS2 implementation. The six district level DHIS2 implementation support officers seconded to MOH district teams will continue to support site-level implementation. Total Budget: $500,000. The key activities and summary budget are listed in Appendix D.

A robust laboratory data management system is critical to ensuring smooth and efficient flow of specimens and results and informing clinical decision-making. In Lesotho, there are disparate laboratory information systems functioning at different levels of the health system and data are not summarized and analyzed on a routine basis. Technical assistance will be provided to the national reference laboratory to link the laboratory information system (LIS) to DHIS2 to enhance monitoring on core laboratory indicators, including viral load and DNA PCR testing data. Links will be developed to the national DHIS2 system to ensure programmatic indicators can be monitored by decision makers. A laboratory programmer will be temporarily recruited and seconded to MOH. Total budget: $100,000. The key activities and summary budget are listed in Appendix D.

Currently, Lesotho has no electronic system to monitor CBHTS. Strengthening CBHTS systems will improve tracking of HTS, linkage to care, and ART initiation. The national DHIS 2 can be leveraged to collect and monitor CBHTS data for improved data-based decision-making. Technical assistance will be provided to integrate CBHTS data into DHIS2. Activities will include working with MOH, DHMTs, and clinical and CBHTS implementing partners and the HTS technical working group to conduct a rapid assessment of existing CBHTS monitoring and evaluation systems and incorporation of CBHTS into DHIS2 including the development of customized reports and dashboards. Total Budget: $200,000. The key activities and summary budget are listed in Appendix D.

<u>Laboratory Information System (LIS)</u>
Sustainable Laboratory Information Systems (LIS) are needed for the continuum of patient care, monitoring and evaluation, and planning. In addition to the core LIS functions of laboratory management and quality assurance, capturing laboratory information is essential for identifying infected individuals for provision of prevention and treatment services, monitoring treatment efficacy and prevalence and incidence rates of infection and disease. An electronic LIS, is a necessity for management of the high volume of laboratory data generated in the effort for sustainable control of the HIV epidemic and meeting the 90-90-90 targets.

Lesotho has already implemented the electronic LIS country-wide. There is still a need to strengthen the current LIS to provide quality-assured services and meet with PEPFAR's goal towards sustainable control of the HIV epidemic and achieve 90-90-90 targets in Lesotho. In order to increase access to laboratory diagnosis (TB and EID) and improve VL monitoring of ART patients, efficient and reliable system of sample transportation and patient's results through referral testing is critical. To improve the referral testing services and reduce turnaround time, electronic Sample Transport and Tracking (STT) and result reporting (SMS) tools are being piloted in 2016/17. The sample transport and result delivery system is comprised of coordinated efforts across health centers, hospitals, sample transporters, courier services and testing laboratories.

In FY2017 COP, support will focus on scaling up of STT and SMS system and strengthening the current LIS to increase test coverage for EID, VL and TB and timely reporting of result for prompt patient management of test results, analysis and reporting, and decision making. It will also support clinical monitoring of patients on care and treatment. Interfacing LIS with other health information systems (DHIS-2 and electronic registries) for better management of patients on treatment, reporting analysis,

planning and decision making. The total proposed budget is $400,000. The key activities and summary budget are listed in Appendix D.

Electronic Logistics Management Information System (eLMIS)

The main goal of the HIS investments under supply chain management (SCM) is to establish a functional eLMIS for HIV and AIDS commodities in all service delivery points (SDPs) of the 10 Sub National Units (SNUs)/ districts in Lesotho. In the short to medium term, the district logistics officers (DLOs) will continue to be seconded to the DHMTs to support the implementation of the informed-push for the ARVs re-supply system in all SDPs in the five scale-up saturation districts and 18 high volume sites in the sustained districts. However the long-term strategy is to match the Health Information System (HIS) central funds of $150,000 to implement the electronic Logistics Management Information System (e-LMIS) that will transform the Procurement and Supply Management System (PSM) from a paper based to an electronic one by the end of FY 2018. PEPFAR investments will go towards revising the current site level SCM standard operational procedures (SOPs), in-service training, on-the-job training and support supervision by DHMTs to the SDPs as they implement the e-LMIS. The e-LMIS will run on the existing DHIS2 platform and PEPFAR will not purchase any equipment. The same electronic pads procured by the Global Fund will also have the software for the eLMIS module. The total proposed budget is $150,000. The key activities and summary budget are listed in Appendix D.

7.0 Staffing Plan

The PEPFAR Lesotho team conducted a staffing analysis to assess the degree to which the current staffing footprint is aligned with the PEPFAR new business model and the programmatic pivot. The following factors were key in the staffing analysis undertaken by PEPFAR Lesotho: the administration and management burden of the PEPFAR business practices (such as SIMS, POART, COP, and SID), the ambitious ART targets in the five scale-up to saturation districts, and the move to 18 high volume sites in the five sustained districts. Since COP16 submission, PEPFAR Lesotho has finalized all the COP15 staffing. As of March 2017, PEPFAR Lesotho will have three vacant positions: one with the Department of State and two with Peace Corps. For State, the position was a newly proposed position in COP16 and is currently being caged. For Peace Corps, the two historic positions are newly vacant since January 2017. For the first position, applications are currently being reviewed. For the second position, the candidate has accepted and is currently going through clearances. Both positions should be on board by the start of COP17.

In COP17, PEPFAR Lesotho is proposing no new positions. Despite the programmatic growth, the team feels the current staff footprint is sufficient to meet the additional demands. There are no large proposed changes from COP16 management and operation costs. The largest shift occurred in the USAID non-ICASS Administrative Costs. This increase was due to a larger amount that USAID PEPFAR Lesotho was asked to cover for the USAID Southern Africa Regional Mission's technical support from HIV/AIDS Program (RHAP) as well as administrative, IT, financial, contractual, HR, and program office support to Lesotho.

APPENDIX A

Table A.1. SNU Prioritization

SNU	COP15 Prioritization	APR16 Achievement	COP16 Prioritization	Expected Achievement By APR17	COP17 Prioritization	COP17 Target (APR18)
Maseru	ScaleUp Sat	44%	ScaleUp Sat	67%	ScaleUp Sat	91%
Leribe	ScaleUp Sat	46%	ScaleUp Sat	59%	ScaleUp Sat	91%
Berea	ScaleUp Sat	47%	ScaleUp Sat	61%	ScaleUp Sat	91%
Mafeteng	ScaleUp Sat	59%	ScaleUp Sat	72%	ScaleUp Sat	91%
Mohale's Hoek	ScaleUp Sat	67%	ScaleUp Sat	83%	ScaleUp Sat	91%
Quthing*	Sustained	33%	Sustained	36%	Sustained	50%
Thaba Tseka*	Sustained	39%	Sustained	43%	Sustained	55%
Mokhotlong*	Sustained	54%	Sustained	59%	Sustained	71%
Butha Buthe*	Sustained	50%	Sustained	55%	Sustained	66%
Qacha's Nek*	Sustained	34%	Sustained	37%	Sustained	52%

* Sustained districts estimate a 10% increase in the national ART coverage in FY17 and FY18. PEPFAR support to the 18 high-volume sites in FY18 is estimated as additional impact.

Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY 17)	Additional patients required for 80% ART coverage	Target current on ART (APR FY18) *TX_CURR*	Newly initiated (APR FY 18) *TX_NEW*	ART Coverage (APR 18)
Attained						
Scale-Up Saturation	252,150	172,919	28,801	231,720	82,076	91%
Scale-Up Aggressive						
*Sustained	75,850	34,812	25,869	44,371	10,622	58%
Central Support						
Commodities						
Total	**328,000**	**207,731**	**54,670**	**276,091**	**92,698**	

* Sustained districts estimate a 10% increase in the national ART coverage in FY17 and FY18. PEPFAR support to the 18 high-volume sites in FY18 is estimated as additional impact.

APPENDIX B

B.1 Planned Spending in 2017

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$5,650,923	**$62,220,482**	**$67,871,405**

Table B.1.2 Resource Allocation by PEPFAR Budget Code (new funds only)

PEPFAR Budget Code	Budget Code Description	Amount Allocated
CIRC	Male Circumcision	$581,559
HBHC	Adult Care and Support	$3,014,278
HKID	Orphans and Vulnerable Children	$5,028,859
HLAB	Lab	$800,522
HTXS	Adult Treatment	$23,110,502
HTXD	ARV Drugs	$0
HVCT	Counseling and Testing	$8,411,158
HVMS	Management & Operations	$2,993,181
HVOP	Other Sexual Prevention	$7,598,322
HVSI	Strategic Information	$1,671,671
HVTB	TB/HIV Care	$5,258,476
IDUP	Injecting and Non-Injecting Drug Use	$0
MTCT	Mother to Child Transmission	$498,768
OHSS	Health Systems Strengthening	$945,325
PDCS	Pediatric Care and Support	$753,904
PDTX	Pediatric Treatment	$1,453,957
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
HVAB	Abstinence/Be Faithful	$100,000
TOTAL		**$62,220,482**

B.2 Resource Projections

Program Area	Beneficiary Type	SNU	Unit Cost Applied	Source / Justification/ Other Notes (e.g., differed from EA UE result by X)
FBCTS	Adult ART	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	$91.67	UE Updates: Base UE consists of COP16 CC (73.39) [this CC includes IMPACT funding] and added in the fixed budget using the COP16 UE by CC (40.91) multiplying it by the COP16 CBCTS target and then dividing the final figure by the FY16 PY Result in order to get a fixed UE of 27.28). Included an additional amount of 3.43 (15/120 sites is 15% took 22.88 from the time motion study for 120 sites approved in COP15).
	Peds ART	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$123.71	UE Updates: Base UE consists of COP16 CC (73.39) [this CC includes IMPACT funding] and added in the fixed budget using the COP16 UE by CC (40.91) multiplying it by the COP16 CBCTS target and then dividing the final figure by the FY16 PY Result in order to get a fixed UE of 27.28). Included an additional amount of 3.43 (15/120 sites is 15% took 22.88 from the time motion study for 120 sites approved in COP15). The calculated UE of $93.01 is further multiplied by 1.33 to account for additional costs associated with Pediatric ART services.
PMTCT	Pregnant Women Tested	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$9.39	Base UE consists of COP16 cost categories (CC) (UE=$10.54) and the CC in-service training was fixed whilst the rest of the CCs were kept variable
	Women receiving ARV prophylaxis	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$152.34	Base UE consists of EA FY 2016 cost categories (CC). The CC in-service training was fixed whilst the rest of the CCs were kept variable
	Infants Tested	N/A	$215.94	Due to lack of COP 2016 information, PEPFAR used EA FY 2016 cost categories (CCs) as proxies. The CC in-service training was fixed whilst the rest of the CCs were kept variable
	Infants receiving Care	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$0	No UEs were applied for Infants on Care
VMMC	Males Circumcised	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	$107.24	Base UE consists of EA FY 2016 cost categories (CC). The CC in-service training, vehicles and personnel were fixed whilst the rest of the CCs were kept variable
HTC	HTC PITC	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$2.96	Base UE consists of EA FY 2016 cost categories (CC). The CC in-service training, vehicles and personnel were fixed whilst the rest of the CCs were kept variable
	HTC VCT	5 Priority Districts; Maseru, Leribe, Berea, Mohale's	$4.62	Base UE consists of EA FY 2016 cost categories (CC). The CCs in-service training, vehicles and personnel were fixed whilst the rest of the CCs

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

APPENDIX C

Section 6.0 Tables: Program Support Necessary to Achieve Sustained Epidemic Control

Table 6.3 Other Proposed Systems Investments									
Activity	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Year One (COP/ROP16) Annual Benchmark**	**Year Two (COP/ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
HRH - Systems/Institutional Investments									
1. Support the Lesotho Nursing Council credential and accredit NIMART sites in the 5 scale-up districts.	1,2,3,4	100% of nurses working in NIMART sites accredited to provide same day HIV and AIDS test & start services	80% of the nurses registered by LNC meet the accreditation and CPD standards for same day HIV test & start services	100% of the nurses registered by LNC meet the accreditation and CPD standards for same day HIV test & start services	The Data source is the LNC register. Total Nurses = 4900; Total registered 4798 (97.9%)	OHSS	$109,873	17549	7. Human Resources for Health (Score 5.75)
2. Monitor HIV and AIDS skills CPD performance for all nurses in the 5 scale-up districts.	1,2,3,4								
Laboratory - Systems/Institutional Investments									
1. Support Laboratory Quality system and Biosafety: Continuous Quality Improvement (CQI) and Proficiency Testing (PT) program	1,2,3,4	Standardized and quality assured laboratory services (EID, VL and TB diagnosed) and tests are provided. 10 clinical laboratories are certified by ASLM using WHO SLIPTA check list by ASLM National Reference Laboratory accredited	~~12 Laboratories are enrolled in SLMTA program, and five of them achieved a minimum of "3 STARS" and accredited by ASLM;~~ ~~75% (222/296) HIV testing sites enrolled in EQA/PT program and 85% (189/222) improved performance and passed~~	8 Laboratories are enrolled in SLMTA program, and five of them achieved a minimum of "3 STARS" and accredited by ASLM; 90% (266/296) HIV testing sites enrolled in EQA/PT program and 90% (200/222) improved performance and passed	LAB_PT CQI Indicator; Number of laboratories accredited; Rate of PT participation and passing score	HLAB	$300,000	17431	10. Laboratory (Score 4.17)
2. Strengthen the local referral networks through tiered lab services: national, district and health levels	1,2,3,4	1. Turn Around Time (TAT) for sample collection and results delivery within 2 - 3 Weeks. 2. Sample rejection rate reduced to <5%	Regional referral networking strengthened; Sample transport system and returning results is provided in 2-4 days a week in all health facilities; Sample Transport Tracking (STT) system is rolled out in five scale-up districts	Sample Transport Tracking (STT) system is integrated into LIS system and networked with the national laboratory services; Turn around time (TAT) of result delivery and quality of services improved	Reduction in turnaround time (TAT) from sample collection to results delivery; sample rejection rate reduced to <5%	HLAB	$160,000	17431	10. Laboratory (Score 4.17)
3. Establish national database for test repository, analyze and report on quarterly basis laboratory data, monitoring and evaluation.	1,2,3,4		Sample Transport Tracking (STT) and SMS messaging system are full integrated with LIS; Facility level LIS is networked, monthly and quarterly data are generated for reporting of diagnostic and monitoring tests;	Sample Transport Tracking and SMS messaging system are integrated with LIS and fully functional; Facility level LIS is networked, monthly and quarterly data are generated for reporting of diagnostic and monitoring tests	Improved routine data collection and reporting (disaggregated by age, gender, type of services and geographical region)	HVSI	$400,000	17431	10. Laboratory (Score 4.17)
4. Recruit and retain lab technologists and data clerks to support HIV diagnostic and monitoring testing services.	1,2,3,4	Gaps in HR addressed, trained and qualified personnel deployed at hospital and reference laboratories	~~10 lab techs, 7 data clerks are employed and retained~~	10 lab techs, 7 data clerks are employed and retained	HRH_CURR; Number of lab personnel full time employees support HVTB lab diagnosis and patient monitoring services	OHSS	$80,000	17432	10. Laboratory (Score 4.17)
5. Revise in-training curriculum and conduct refresher training on biosafety, laboratory quality management system, laboratory operation HIV diagnosis, (EID/VL, TB diagnosis).	1,2,3,4	Gaps in lack of competency addressed and quality of services improved.	~~100% of lab techs, microscopists, data clerks and sample transporters will be provided annual refresher Laboratory Biosafety trainings;~~ ~~10% of lab tech will be trained in QMS and laboratory operation to improve the competency of lab personnel.~~	100% of lab techs, microscopists, data clerks and sample transporters will be provided annual refresher Laboratory Biosafety trainings; 25% of lab tech will be trained in QMS and laboratory operation to improve the	Number of lab personnel who were trained and become competent in providing services	HLAB	$100,000	17432	10. Laboratory (Score 4.17)

Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	Outcomes expected after 3 years of investment	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Laboratory - Systems/Institutional Investments									
6. Laboratory equipment procurement and maintenance system	1,2,3,4	National equipment management and maintenance system.	Equipment maintenance and inventory system in place; Equipment down time and Service interruption reduced to less than 5 days.	Equipment maintenance and inventory system in place; Equipment down time is less than 2 days and no Service interruption.	Number of laboratories with no service interruptions due to equipment failure	HLAB	$100,000	17432	10. Laboratory (Score 4.17)
~~6. Lab diagnostic and monitoring reagents and supplies~~		~~Local capacity developed in quantification and distribution of laboratory commodities established~~ ~~Sustainable TB and HIV and treatment monitoring tests are provided with no interrelation of services~~	**This activity is for procuremnent of lab commodities and as funded through TBB, is no more applicable in this section (Table 6)**			~~HLAB~~		~~17431 and 17432~~	
							$1,140,000		

Table 6.3 Other Proposed Systems Investments									
Activity	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Year One (COP/ROP16) Annual Benchmark**	**Year Two (COP/ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Strategic Information (SI) - Systems/Institutional Investments									
1. Poor data quality, lack of on-time monthly data submissions, and non-complete monthly report submissions	Successful implementation of DHIS2 at district, and national levels leading to improved timeliness, completeness, and quality of monthly report submissions.	Use of DHIS2 by all DHMTs including 80% of relevant staff receiving an initial or refresher training Update DHIS2 to include revised HIV-related definitions	100% of all relevant staff trained on DHIS2 use at district and central level; Completion of two biannual DHIS2 forums 3. Full implemtnation of DHIS2 in all districts.	IP-specific training database and curriculum; Minimum 85% achievement for timeliness and completeness of report submissions.	1. MOH to conduct biannual DHIS2 forums; 2. Maintain two senior HMIS managers and one HMIS specialist to conduct DHIS2 development skill buidling workshop to MOH core development team; 3. Maintain HMIS specialist to oversee data quality, completeness, and timeliness improvements; 4. Maintain six district level DHIS2 data clerks to support data capturing from private	HVSI	$500,000	17123	13. Epidemiological and Health Data
2. Lack of data use for planning and service improvement	**90% of DHMT relevant staff, central, and district-level SI/M&E staff trained in data use, basic analysis, and conducting data reviews. Historical data in DHIS2 reviewed for quality.**	**1. DHIS2 trainings for site and district level SI/M&E staff and data clerks.**	**1. Completion of DQA report 2. 75% of all relevant staff trained in data use, analysis, and reviews 3. Monthly dashboard updates in DHIS2**	**workplans, meeting minutes and sign in sheets, reports from DQA, dashboards available for use on DHIS2**	**1. Deep-dive DQA of retrospective data in DHIS2; 2. DHIS2 dashboards used for in-country decision making; 3. Annual DHIS2 data use conference; 4. Second MOH epidemiologist to advance data use for decision making 5. Develop workplan to**	**HVSI**	**330,000**	**17123**	13. Epidemiological and Health Data
3. DHIS Site-level implementation	All	Use of DHIS2 in all MOH-supported health facilities in Lesotho. Data exchange between DHIS2 and LIS (lab system). Development of interoperability layer between community testing system and DHIS2	COP17 funding	85% completeness and on-time reporting by facilities. Exchange of information between LIS and DHIS2	Data availability, improved quality of data, partner training logs	HVSI	800,000	~~17123~~ 18524	13. Epidemiological and Health Data
4. Electronic register development and implementation	**1,2,3,4**	**use of electronic registers in a minimum of ten HV facilities. Ability to track individual patients between diagnosis, treatment initiation, and drug**	**COP17 funding**	**Development of system. Implementation of system in a minimum of ten high volume facilities. Training of 85% of system users in facilities (nurses, data**	**Register reviews, partner training logs, system evaluation**	**HVSI**	**1,650,000**	**18524**	13. Epidemiological and Health Data
5. Violence against Children Survey (VACS)	**1, 4**	**Completion of survey. Better understanding of violence against children in Lesotho and its**	**COP17 funding**	**Completion of survey**	**Data gathered during surveyHVSI**	**HVSI**	**3,000,000**	**18524**	13. Epidemiological and Health Data
							$6,280,000		

Table 6.3 Other Proposed Systems Investments									
Activity	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Year One (COP/ROP16) Annual Benchmark**	**Year Two (COP/ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Systems Development - Systems/Institutional Investments									
1. Quality Assurance and Quality Improvement support for HIV and AIDS services	**1,2,3,4**	**100% districts providing QA/QI support to all service delivery sites providing HIV and AIDS services**	**60% districts providing QA/QI support to all service delivery sites providing HIV and AIDS services**	**90% districts providing QA/QI support to all service delivery sites providing HIV and AIDS services**	**Number of QA/QI coaching sessions conducted by the national and district QI Coaches during the reporting period Proportiono of districts with atleast 5 QA/QI projects implemented during the reporting period**	HTXS, PDTX, and HVTB	**$450,000**	~~**18624**~~	Quality Management (5.5)
							$450,000		
Commodity Security and Supply Chain - Systems/Institutional Investments									
1. Quantification, forecasting and supply planning for HIV and AIDS including ARVs and laboratory commodities.	1,2,3,4	1. Fully functional Government-led HIV and AIDS commodities and supply chain management system. 2. 100% commodity security for all Test and Start commodities.	~~1. Three (3) SCM Specialists recruited and seconded to the Supply Chain Management Coordination Unit (SCCU). 2. Seven (7) District Logistics Officers (DLO) recruited to support the informed-push ARVs re-supply system in all service delivery sites in the five scale-up saturation districts~~	100% tracer commodities stocked according to plan at NDSO and SDPs/ health facilities/ community sites	MER Indicator = SC_Stock: Number of observed HIV commodities stocked according plan or stocked-out according to the prescribed plan	~~OHSS,~~ HTXS, PDTX, ~~HBHC and PDCS~~	$750,000	18048	8. Commodity Security and supply chain (Score 6.32)
2. Appropriate warehousing and inventory control for all HIV and AIDS commodities	1,2,3,4		~~1. One Warehousing Liason recruited and seconded to NDSO. 2. STTA provided in warehousing and commodity distribution network optimization~~		1. Recruitment Plan 2. STTA final report on NDSO warehousing and distribution network optimization report	~~OHSS,~~ HTXS, PDTX, ~~HBHC and PDCS~~	$750,000	18048	
3. Establish a functional LMIS for HIV and AIDS commodities	1,2,3,4		1. In the short to medium term, pilot the informed-push commidity re-supply system in service delivery sites. 2. In the long-term support the MoH develop an eLMIS that produces consumption data from all service delivery points (SDPs) using the DHIS2 platform		1. Functional Informed-Push Re-supply system developed 2. Functional eLMIS developed	OHSS & HVSI	$450,000	18048	
4. Review current SCM SOPs and re-engineer process for efficient procurement of HIV and AIDS commodities for Test and Start.	1,2,3,4		1. Provide STTA to re-engineer all supply chain management functions at MoH, SCCU, DHMTs, and SDPs/ health facilities		1. Revised and approved Supply Chain Management Standard Operations Proceedures (SOPs) developed	OHSS	$200,000	18048	
							$2,150,000		
TOTAL							$10,129,873		

Section 6.0: Systems Investments

Included Activities	Excluded Activities
Human Resources for Health (HRH): Systems/Institutional Investments	
In-service training systems support and institutionalization; HRH performance support/quality other HRH activities not classified as above 1. Support the Lesotho Nursing Council credential and accredit NIMART sites in the 5 scale-up districts. 2. Monitor HIV and AIDS skills CPD performance for all nurses in the 5 scale-up saturation districts and 18 hotspots in the sustained districts.	Pre-service training; HRH Governance, policy planning and management; HR assessments and information systems;
Governance	
N/A	N/A
Systems Development	
Provide direct institutional and organizational support capacity building to the MOH, SCCU, programs and NDSO in the whole supply chain cycle through the following activities: 1. Quantification, forecasting and supply planning for HIV and AIDS including ARVs and laboratory commodities. 2. Appropriate warehousing and inventory control for all HIV and AIDS commodities 3. Establish a functional eLMIS for HIV and AIDS commodities 4. Revision of the Standard Operational Procedures for the Procurement and Supply Management System to include Multi-Month Prescription and Community distribution of HIV and AIDS commodities 5. Train sites and staff on the new SOPs for Supply Chain Management	N/A
Institutional and Organizational Development – QA/QI	
Provide technical support to the Ministry of Health (MOH) and ten (10) District Health Management Teams (DHMTs) to effectively institutionalize and coordinate Quality Assurance/Quality Improvement (QA/QI) approaches along the 90-90-90 clinical cascade for HIV and TB services. Key activities include: 1. Review and update the national QI/QA strategic framework to align it to the 2013 WHO policy guidelines on Test and Treat. 2. Training and mentorship of health care providers on QI/QA principles and practices. This includes development of training curriculum for in-service providers. 3. Standardization of QI/QA tools for data collection based on the Test and Treat policy guidelines. 4. QI/QA Coaching and support supervision by the DHMTs 5. Coordination of quarterly QA/QI Learning/Knowledge exchange sessions.	Pre-service training on QA/QI
Strategic Information	
1. Enhance site-level and district-level DHIS2 technical support (training, mentoring, site supervision, equipment) for improved data quality and reporting timeliness. 2. Implement site-level electronic register with unique identifiers (system setup, equipment and initial training). 3. Support interoperability with Lab Information systems and DHIS2 for improved feedback/reporting of results. 4. Support Logistics Management Information systems for improved stock and supply forecasting.	N/A
Laboratory	
The following core activities will be supported: 1. Support Laboratory Continuous Quality Improvement (CQI) and Proficiency Testing (PT) program:	Vehicles, equipment and furniture, construction and

• EQA/PT participation for key lab diagnostic and monitoring tests (VL, EID TB, CD4, HIV tests • Implementation of HIV Raid Testing Quality Improvement • Implementation of SMLTA/SLIPTA program and accreditation of labs 2. Human resource and Training: • Employee and retain Lab personnel to support Lab CQI • Support targeted laboratory training to address gaps in scale up of diagnostic and patient monitoring services 3. Strengthen Laboratory Information System (LIS) and M&E system: • LIS DISA Maintenance and update services • Sample Transport Tracking (STT) and SMS support including scale up • Human resource for IT support and staff training • Site level technical support for data management and M&E support 4. Referral network and integrated laboratory services: • Strengthen the local referral networks through tiered lab services • Procurement and maintenance of equipment • Support minor renovation/refurbishment of clinical labs • Development/revision of training curriculum and refresher training 5. Laboratory equipment procurement and maintenance system: • Make an inventory and purchase critical lab equipment. • Develop and/or revise guidelines and SOPs for maintenance services for major lab equipment. • Implement preventive and routine maintenance. • Enforcement of service contract with manufacturers or vendors for major equipment and biosafety cabinets.	renovation for labs, and recurrent categories from labs such as lab reagents and supplies, travel and transport, building rental and utilities will not be included

APPENDIX D: Performance and Initiative Funding Budgets

D.1: ACT Summary Budget allocation by Intervention:

Programing Priority	Intervention	Amount	Quantity	Unit Cost	Comments
Expansion of pediatric care and Treatment Services in the high volume sites in the sustained districts ACT Pillar 5: HIV treatment initiation, monitoring, adherence and retention	Recruit pediatric district mentors to enhance treatment initiation, monitoring, and retention support	$61,200	3 Pediatric District Mentors	$1,700/ person /month	Three pediatric district mentors. Each will be covering two sustained districts based on pediatric patient volume and/or number of sites
	Capacity building of service providers on pediatric and adolescent treatment	$108,000	18 sites	$6000/site	District level and on-site trainings and mentorships. Cost of training per site maintained from the COP16 Impact funding budget
Strengthening pediatric counseling, adherence and retention support ACT Pillar 5: HIV treatment initiation, monitoring, adherence and retention	Recruit pediatric counselors to strengthen pediatric adherence and retention counseling	$280,800	18 Pediatric Counselors	$1,100/ person/month	One pediatric counselor per site located in the MCH/ART clinic. Cost based on EGPAF current salary rates
	Expand pediatric and adolescent peer leaders and support group activities	$155,945	36 Adolescent Peer Leaders	$8,664/ site	Two support groups per site (i.e. one for children and one for adolescents living with HIV). Fully loaded cost based on experiences from the EGPAF Ariel Clubs and Baylor adolescent support groups.
Increase tracking of HIV exposed infants and uptake of EID at <2 months ACT Pillar 2: Community Engagement	Recruit mentor mothers to strengthen community mobilization, tracking, and linkage of HIV exposed infants aged <2 months to EID services	$172,800	36	$300/person /month	2 mentor mothers per site. Fully loaded cost (based on m2m program), including community transport, job aides, M&E tools, and equipment.
TOTAL		**$778,745**			

D.2: Impact fund summary budget

Focus Area	Estimated Cost	Comments
Differentiated ART delivery	$4,780,616	This funding is will cover approximately 64, nurses, 64 professional counselors and 124 pharmacy technicians to deliver ART in the community by the different drug delivery model; the pharmacy technicians will provide logistical support at facilities to manage drug stock and related commodities ($3,800,000). The remainder of the funds will also cover costs of expanded outreaches (Hiring vehicles for outreaches by the districts and facility teams. These activities will be implemented by the PUSH and STAR-L implementing mechanisms.
Same day initiation mobile clinics	$2,780,000	Building from COP 16, the test and start initiative targeting Men, factory worker, and the border point clinic. The teams consist of pairs of HIV testing staff and clinical staff to start on ART. Other related costs include social mobilization , additional test kits, trainings
Patient monitoring (VL/3rd 90)	$ 3,314,384	This funding will cover the expanded viral tests to meet the FY18 VL testing targets, in addition, will cover costs of staffing which include lab technicians ad lab based data clerks. The funds will also cover costs of sample transportation (motorbikes, fuel costs and the riders
Patient level data	$1,000,000	The funds will support improvement of site level patient data, patients filing systems due to increased number of patients, support, entry into DHIS II, equipment at site level and related costs.
Total	$11,875,000	

D.3: Performance funding for treatment summary budget

Program Area	**Applied COP17 UE w PM**	**Targets in sustained**	**Budget**
Adult TX	$114.84	22985	$2,639,597
Ped TX	$154.63	1983	$306,631
Preg Women Tested	$11.70	6625	$77,513
Preg Women on TX	$189.73	1391	$263,914
Infant Tested	$262.49	1391	$365,124
HTC PITC	$3.70	68507	$253,476
Commodities (GXP, VL, EID, Consumables)			$742,816
Other HSS Costs (activity based)			$350,929
Total			**$5,000,000**

D.4: PrEP

Funding Source	Programming priority	Unit cost ($)	# of units	Total Cost ($)	Comment
DREAMS	AGYW (ages 18-24)	$155	13,945	$ 2,161,475	The budget will support service delivery at health facility adolescent corners and community facilities, clinical monitoring, demand creation, IEC materials, and social marketing, and laboratory services.
	Key Populations - FSW	$155	470	$72,850	The budget will support service delivery at community facilities, clinical monitoring, demand creation, IEC materials, and social marketing, and laboratory services.
	Health Systems Strengthening	$565,675	1	$565,675	Support for training and sensitization of health care providers and key population peers, development of risk assessment tools, SOPs, data capturing tools, training materials, facility needs assessment, and development of M&E Framework
COP Base	Sero-Discordant Couples	$155	8,526	$1,321,530	The budget will support service delivery at health facilities, clinical monitoring, demand creation, IEC materials, and social marketing, and laboratory services.
	Key Populations- FSW and MSM	$155	1,050	$162,750	The budget will support service delivery at community facilities, clinical monitoring, demand creation, IEC materials, and social marketing, and laboratory services.
TOTAL				**$4,284,280**	

D.5: DREAMS

COMPONENTS	UE	Target	Budget ($)	Comment
Empowering Girls			**$7,165,005**	Reach girls and young women with in tertiary schools and communities with prevention services and ensuring that those that are negative stay negative while those that are positive are tested and linked to treatment. Also the addition of PrEP to our prevention services to support girls who are at risk of being infected.
Condoms	$10	100,000		
Contraceptive mix	$10	40,710		
HTS	$19	124,220		
GBV	$230	2,756		
PrEP*	$155	14,415		
Mobilizing Communities for change			**$921,927**	Roll out the comprehensive sexuality education for girls aged 9-14 and also intensifying roll out of the stepping stone curriculum to girls aged 15-19 in ensuring that they can avoid risk. Also providing stepping stone curriculum to groups of men between ages of 20-49 who are sexual partners to the AGYW.
Community mobilization and Norms change	$5	156,619		
School based HIV and violence prevention	$2	65,000		
Strengthening Families			**$1,938,831**	Social Asset intervention has been scaled up to strengthen AGYW 10-14,15-17, 18-24. Aflateen will accommodate the AGYW10-14. For tertiary students, continuation of implementing Passport to Success Entrepreneurship program. There is an addition of under 1 interventions that will be linked to Social protection as it targets infants of young mothers 10-24. Parenting targets were reduced since the OVC program is intensify its efforts on OVC 15-19.
Social asset building	$51	20,031		
Combination social approaches	$51	9,000		
Parenting	$53	3,600		
TOTAL			**$10,025,763**	

*PrEP funding is a total of $2,800,000. This will fund PrEP for AGYWs and FSWs and that is broken down in the D.4: PrEP budget

D.6: Performance Funding for HTS

Program Area	Amount	Activity	Item	Quantity	Unit Cost $	Comments
Expansion of community testing and linkages for men & other priority populations	$746,000	Expand targeted mobile testing for men	Counselors	60	$1,036/ person/ month	Currently community testing does not cover all community councils in the scale up to saturation districts. If additional counselors were engaged, this would allow for expansion of mobile team, shifts to accommodate male-friendly hours and days to increase uptake among men and other priority populations.
	$210,000	Community mobilizatio n targeted towards men; enhances linkage and follow up for referrals	Community Mobilization and Linkage Agents	50	$350/ person/ month	Professional, full-time demand creation and linkages agents will implement interpersonal communication activities, reaching men and couples with messages to promote HTC services. These field educators will use standardized toolkits that are linked to the mass and mid-media activities to conduct male oriented community mobilization actives and ensure immediate linkage of newly identified positives to treatment, track and follow up referrals to ART
Capacity Building	$44,000	Training of human resources	Training	110	$400/ person/ month	The Counselors and Community Mobilization & Linkage Agents will be trained on male oriented mobilization and recruitment strategies and tools for increasing HTS uptake on men and other key & priority populations
TOTAL	$1,000,000					

D.7: HIS funding

Electronic Registers

Budget Line	Estimated Cost
Personnel	771,688
Training (development, TOT, end users)	338,157
Mentorship	178,655
Equipment/Supplies (finger print device, computers, UPS, connectivity)	361,501
Total	**1,650,000**

DHIS2

Budget Line	Estimated Cost
Site Level Implementation	500,000
Link the Laboratory Information System (LIS) to DHIS2	100,000
Integrate CBHTS in DHIS2	200,000
Total	**800,000**

Laboratory Information System (LIS)

Activity	Estimated cost
Strengthening LIS: DISA licensee, software updates, interface support and maintenance	$118,000
Sample Transport Tracking (STT) and SMS support including scale up: LIS and STT Server Integration and support, Cloud Hosting Services Procurement of phone, tablets and monthly data provisions	$210,208
Program Management and Technical Support: Personnel, training, oversight support, LIS Data	$71,792

management and M&E support	
Total	**$400,000**

Electronic Logistics Management Information System (eLMIS)

Activity	**Estimated cost**
Development of Standard Operational Procedures (SOPs) for the eLMIS	$10,000
In-service training for Frontline staff and data clerks in all Service Delivery Sites	$100,000
Supportive supervision visits and on-the-job training to service delivery points (SDPs) in the 10 Sub National Units (SNUs) by District Logistics Officers (DLOs).	$40,000
Total	**$150,000**