

**Lesotho**

**Country Operational Plan (COP) 2016**

**Strategic Direction Summary**

May 20, 2016

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## Goal Statement

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The Country Operational Plan 2016 is a continuation of the COP15 approach set in the context of the broader PEPFAR Lesotho Strategic Framework 2015-2020. The PEPFAR Lesotho team has largely completed the programmatic pivot described in COP 2015 which aims to accelerate the number of eligible people receiving antiretroviral therapy (ART) with the goal to achieve 80% coverage in the five districts most burdened by HIV by September 30, 2017. Accelerating ART will prevent both morbidity and mortality among people living with HIV (PLHIV) and will help avert new infections. PEPFAR Lesotho has worked with a wide-range of stakeholders in developing the 2016 COP and collaborates closely with the Government of Lesotho (GOL) and the Global Fund as essential partners to successfully achieve our shared goals and ensure synergy between national HIV resourced programs and The Global Fund's HIV and TB grant to Lesotho for 2016-2018.

Lesotho has the third highest national HIV prevalence rate in the world, yet has sub-optimal HIV program coverage. However, for the first time, pediatric ART coverage exceeded adult ART coverage which is a testament to the early impact of Accelerating Children's HIV Treatment (ACT) Initiative. Reaching epidemic control – the point at which new HIV infections fall below the number of AIDS-related deaths – remains our goal, one the USG program will support Lesotho to achieve. Therefore, COP 2016 investments are focused on achieving 80% coverage of ART in five scale-up to saturation districts by FY2017.

Following release of the new World Health Organization (WHO) recommendations, the Ministry of Health has agreed to adopt and implement a Test and Start approach. The government, together with other stakeholders, established workgroups in December 2015 to begin revising the national treatment guidelines. The Government of Lesotho was the first country in sub-Saharan Africa to launch the new guidelines on April 14, 2016 with full nationwide rollout completed by June 2016. Reaching the PEPFAR goal of 80% treatment coverage in the scale-up districts by 2017 would not be possible without a Test and Start approach. Equally important are the new service delivery models that will be implemented along with Test and Start (fewer lab tests, less frequent clinic visits, extended medication refills, same day treatment initiation, and differentiated models of care). These should allow expanded treatment coverage without substantially increasing the resources required as well as improve retention rates among patients.

The comparative strength of the PEPFAR program is that it has implementing partners at the service delivery point and within populations that can improve program quality. Greater direct service delivery at site level will increase HIV diagnoses, enhance linkages to care, hasten initiation of treatment, and foster adherence and retention. Using these platforms, and building on the Impact Funding for Test and Start as well as ACT and DREAMS initiatives, PEPFAR Lesotho will prioritize scale-up in high-burden districts through direct community and site support. At the central level, PEPFAR will support direct management of the supply chain to

ensure adequate access to testing materials 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.
  - o Saturation of ART in PLHIV with 90% of them virally suppressed 12 months later.
  - o Elimination of mother-to-child transmission of HIV.
  - o Saturation of VMMC coverage in 15-29 year olds.
  - o Increase in individual access, availability and consistent use of condoms.
  - o Reduction in mortality related to tuberculosis among PLHIV.

## 1.0 Epidemic, Response, and Program Context

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### 1.1 Summary statistics, disease burden and country or regional profile

Lesotho has a total population of 1,924,381, 52% of whom are women and 36% under fifteen years of age. The country is divided into ten administrative districts, five of which are considered PEPFAR scale-up districts. The country is classified as a lower middle income (LMI) country with a Human Development Index score of 0.497 (161/188 countries) (2015) and a Gross National Income (GNI) per capita of \$1,330 USD (World Bank, 2014). Seventy-three percent of the population resides in rural areas (World Bank, 2014). The lowland districts of Maseru, Mafeteng, Mohale's Hoek, Leribe, and Berea (PEPFAR scale-up districts) are home to 72% of the population.

Lesotho ranks third in worldwide HIV prevalence among people aged 15-49 years at 23.5% (23.5%, 2014; 23.5%, 2013; 23.4%, 2012; and 23.4%, 2011). While a slight reduction in incidence has occurred, Lesotho still has the highest HIV incidence among people aged 15-49 in the world at 2.0% (2.0%, 2014; 2.1%, 2013; 2.2%, 2012; and 2.2%, 2011).<sup>1</sup>

The distribution of HIV in Lesotho varies by district, gender, and age. Utilizing 2015 Spectrum estimates, prevalence ranges from 15.3% (10,291 adults 15-49) in Butha-Buthe to 28.2% (67,357 adults 15-49) in Maseru. Among the remaining PEPFAR scale-up districts, prevalence is 24.3% (40,227 adults 15-49) in Leribe, 22.0% (31,808 adults 15-49) in Berea, 23.8% (26,195 adults 15-49) in Mafeteng, and 23.4% (23,388 adults 15-49) in Mohale's Hoek.

HIV prevalence in individuals under 15 years of age is 2.8%, but for those 15+, HIV prevalence differs by gender at 26.1% for women and 19.7% for men. Prevalence is higher in urban areas (27.9%) versus rural areas (21.9%).

In December 2015, the National AIDS Commission (NAC) was reestablished; however it will take several months for the Commission to begin to function. Lesotho's HIV program coverage is low and on a slow trajectory to epidemic control. The GOL's revised National Strategic Plan for HIV and AIDS (NSP) 2011/12 – 2017/18 aims 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
4. Prevention of new infections among key populations through targeted programs and other critical enablers and development synergies

The recently re-established NAC has committed additional resources to health and HIV against a backdrop of a reduced national budget. As a result of the COP16 discussions, particularly

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<sup>1</sup> UNAIDS Spectrum 2015

around the Impact Funding, the Minister of Health committed to adopting the 2015 WHO Guidelines and the launch of Lesotho's Test and Start policy in April. The PEPFAR team is positioned to support the roll-out of Test and Start in the scale-up districts as soon as possible with a goal of establishing national coverage by June 2016. Additionally, the antiretroviral therapy (ART) and HIV testing and counselling (HTC) guidelines will be released in April 2016 and will endorse PrEP for four priority populations: sex workers, factory workers, prisoners, and men who have sex with men (MSM).

Though funding for the HIV response has increased there remains a shortfall to fully fund the National Strategic Plan. Lesotho is fully funding the treatment requirements with support from PEPFAR and The Global Fund but government resources remain insufficient to meet the overall gap. The gap remains though an additional \$7 million has been allocated by government to ARV procurement supporting Test and Start. 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 weak supply chain management; low recruitment and retention of human resources, limited access to and poor quality of data, lack of accurate and timely laboratory diagnosis and patient monitoring, and weak community ownership and participation in service delivery.

**Table 1.1.1 Key National Demographic and Epidemiological Data**

	Total		<15				15+				Year, Source
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	1,924,381	100	348,933	18.1	348,921	18.1	653,883	34.0	572,644	29.8	2015, BOS
HIV Prevalence (%)		23.5		2.8		2.8		26.1		19.7	2015, Spectrum
AIDS Deaths (per year)	7,950		385		374		3,514		3,677		2015, Spectrum
# PLHIV	315,002		7,256		7,420		178,372		126,056		2015, Spectrum
Incidence Rate (Yr.)		1.76						1.96		1.56	2015, Spectrum
New Infections (Yr.)	19,068										2015, Spectrum
Annual births	54,033	100									2015, Spectrum
% of Pregnant Women with at least one ANC visit	--	95.2	--	97.1			--	93.4			2014, LDHS (<20; 20+)
Pregnant women needing ARVs	11,349	21.0									2015, Spectrum
Orphans (maternal, paternal, double)	120,960										2015, Spectrum
Estimate of	17,722		--		--		--		--		2015, Spectrum

incident TB cases (Yr.)											
Estimated number of TB cases that are HIV infected	12,816	72	--	--	--	--	--	--	--	--	2015, Spectrum
% of Males Circumcised	--	26.5			--	--			72,842*	--	2014, LDHS; 2015, MOH
Estimated Population Size of MSM	10,845										2014, USAID/PSI
MSM HIV Prevalence	--	33.3									2014, USAID/PSI (Maseru/Maputsoe avg.)
Estimated Population Size of FSW	5,986										2014, USAID/PSI
FSW HIV Prevalence	--	72.0									2014, USAID/PSI (Maseru/Maputsoe avg.)

\* number of medical male circumcisions performed among 15-49 year olds

**Table 1.1.2 National 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)**

				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV <sup>2</sup> (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	1,924,381 <sup>3</sup>	23.5 <sup>4</sup>	315,002	146,790 <sup>2</sup>	13,729 <sup>12</sup>		549,913	43,006	27,087
Population less than 15 years	697,854 <sup>5</sup>	2.8 <sup>6</sup>	14,676	5,324	1,081		106,132 <sup>7</sup>	2,247 <sup>8</sup>	1,195 <sup>9</sup>
Pregnant Women	57,750	25.9 <sup>10</sup>	12,900	7,417 <sup>11</sup>	-	-	35,709	9,971	7,417
<b>MSM</b>	10,845	33.3%	3,611	--	--	--	--	--	--
<b>FSW</b>	5,986	71.9%	4,310	--	--	--	--	--	--

<sup>2</sup> UNAIDS Spectrum 2015

<sup>3</sup> ibid

<sup>4</sup> ibid

<sup>5</sup> ibid

<sup>6</sup> ibid

<sup>7</sup> MOH HMIS/DHIS<sub>2</sub>

<sup>8</sup> ibid

<sup>9</sup> ibid

<sup>10</sup> ANC Sentinel Surveys 2013

<sup>11</sup> MOH PMTCT Report Oct 2014 to Sep 2015

<sup>12</sup> MOH

\* PEPFAR figures. Low submission rate for MOH, data still under review at MOH and not approved for release as of 5-16-16

## 1.2 Investment Profile

The HIV response in Lesotho is primarily funded by the Government of Lesotho, The Global Fund, and PEPFAR. Limited amounts of funding have also been provided by other partners including the UN agencies, Irish Aid, European Union, Millennium Challenge Corporation, Clinton Foundation, and the World Bank. Thirty-four percent of the funding in 2015 came from domestic resources while 64% came from international sources.<sup>12</sup>

The government of Lesotho plans to increase investments committed to HIV/AIDS over the coming years. From the provisional 2016 budget of the Ministry of Health, HIV/AIDS investments will increase by approximately \$10.7 million (including ~\$6,850,000 to launch Test and Start), a 57% increase when compared to the 2015 budget. Similarly, projections for 2017 and 2018 are estimated to increase slightly by 5% and 2% respectively.<sup>2</sup>

The Government plans to invest these additional funds in the purchase of HIV/AIDS drugs. The Government has also committed funding of about \$1 million through counterpart financing to the Vodafone Consortium's project on Maternal, Neonatal and Child Health. This project has a heavy focus on acceleration of pediatric HIV/AIDS treatment in Lesotho.<sup>2</sup>

HIV Care and Treatment funding makes up the largest proportion of total HIV/AIDS funding. The proportion of HIV care and treatment by funding agent in 2015 was broken down as follows: GOL 47%, Global Fund 24%, PEPFAR 15%, and other donors 14%. The main interventions funded within HIV Care and Treatment include Antiretroviral Treatment (ART) for adults, Pediatric ART, TB/HIV, Nutritional Support, Home Based Care, Mentoring, Opportunistic Infections, and other care and treatment interventions which consist of strengthening activities that cut across the previously mentioned care and treatment interventions. ART has the highest allocation within the funding envelope (54% - 62% of funding) and is mainly funded by the GOL (61% - 99% of funding across the fiscal years). The high trend in proportion of ART funding by GOL will decrease once new Global Fund grants are approved for the next two fiscal years<sup>2</sup>. Table 1.2.1 and 1.2.2 detail program area funding.

The Government is committed to identifying sustainable strategies for funding the national HIV/AIDS response. This includes increasing domestic funding and improving the efficiency and cost effectiveness of service delivery systems. The Government is committed to investing strategically for results in high impact programs and in districts with the highest disease burden. Interventions will also focus on targeting the most affected or high-risk sub population groups.

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<sup>12</sup> Data were obtained by triangulating 2 data sources: 2014 Resource Mapping data and 2015 provisional budget from the Medium Term Expenditure Framework (MTEF) template

<sup>2</sup> Clinton Health Access Initiative: Lesotho HIV/AIDS National Strategic Plan (FY 2014/15- FY 2017/18): Report on Counterpart Financing, Willingness to Pay Analysis and Financial Gap Analysis

**Table 1.2.1 Investment Profile by Program Area**

<b>Program Area</b>	<b>Total Expenditure</b>	<b>% PEPFAR</b>	<b>% GF</b>	<b>% GOL</b>	<b>% Other</b>
Clinical care, treatment and support	\$32,428,092	18.9%	25.5%	46.6%	8.9%
Community-based care	\$1,258,380	39.9%	0.0%	0.2%	59.9%
PMTCT	\$4,275,162	70.2%	6.4%	0.0%	23.4%
HTC	\$4,743,193	72.6%	23.3%	2.7%	1.4%
VMMC	\$6,693,824	96.5%	2.4%	0.0%	1.1%
Priority population prevention	\$6,866,831	59.8%	22.9%	1.6%	15.8%
Key population prevention	\$0				
OVC	\$19,533,391	21.2%	24.1%	39.8%	14.9%
Other impact mitigation	\$1,465,418	0.0%	16.1%	0.0%	83.8%
Laboratory	\$4,819,401	40.4%	26.6%	24.2%	8.7%
SI, Surveys and Surveillance	\$1,206,908	52.6%	18.4%	0.0%	28.9%
HSS	\$7,719,016	5.9%	60.5%	20.9%	12.7%
<b>Total</b>	<b>\$91,009,616</b>	<b>33.9%</b>	<b>24.7%</b>	<b>28.5%</b>	<b>12.9%</b>

**Table 1.2.2 Procurement Profile for Key Commodities<sup>13</sup>**

<b>Commodity Category</b>	<b>Total Expenditure</b>	<b>% PEPFAR</b>	<b>% GF</b>	<b>% GOL</b>	<b>% Other</b>
ARVs	\$20,274,851	0%	37%	63%	0%
Rapid test kits	\$765,773	0%	100%	0%	0%
Other drugs	\$1,020,478	20%	75%	1%	5%
Lab reagents	\$2,733,971	0% <sup>14</sup>	47%	43%	10%
Condoms	\$815,901	91%	9%	0%	0%
VMMC kits	\$839,308	0%	93%	0%	7%
Other commodities: Family Planning	\$12,971	0%	0%	0%	100%
Other commodities: Food Supplies	\$541,981	33%	0%	0%	67%
<b>Total</b>	<b>\$27,005,233</b>	<b>4%</b>	<b>41%</b>	<b>51%</b>	<b>3%</b>

<sup>13</sup> MOH Resource Mapping done by CHAI in 2013/2014

<sup>14</sup> \$1,000,000 was a contribution from PEPFAR, which is about 37%.

**Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration**

<b>Funding Source</b>	<b>Total USG Non-PEPFAR Resources</b>	<b>Non-PEPFAR Resources Co-Funding PEPFAR IMs</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>
USAID MCH	-	-	-	-	-
USAID TB	-	-	-	-	-
USAID Malaria	-	-	-	-	-
Family Planning	-	-	-	-	-
NIH	-	-	-	-	-
CDC NCD	-	-	-	-	-
Peace Corps	\$1,742,600	-	1	\$687,000	Funding for Peace Corps Lesotho
DOD Ebola	-	-	-	-	-
MCC	-	-	-	-	-
USAID Foreign Disaster Assistance (USAID/OFDA)	\$50,000	-	4	\$400,000	To provide immediate relief assistance to support urgent water and sanitation programs for the populations in Lesotho most severely affected by the current drought
<b>Total</b>	<b>\$1,792,600</b>			<b>\$1,087,000</b>	

**Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP**

<b>Funding Source</b>	<b>Non-COP PEPFAR Resources</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>	<b>Notes*</b>
ACT	\$0*			Accelerating the number of children on treatment	Lesotho has received a total of \$13,750,000 in ACT funds. This money is for 2 years of implementation (midFY15-midFY17). The entire amount was reported in COP15 and is therefore not re-reported in COP16.
DREAMS	\$14,039,500*			Focusing on adolescent girls and young women	Lesotho has received a total of \$14,039,500 in DREAMS funding. This money is for 2 years of implementation (FY16 and FY17, but given delays this may extend into FY18). The funding was not approved until after submission of COP15. We are reporting the full amount in COP16.
DREAMS Innovation	-	-	-	-	
DREAMS Test and Start – Men	\$2,990,744*			Implementation of Test and Start for men in DREAMS districts.	Lesotho has received a total of \$2,990,744 in DREAMS Test and Start funding. This money is for 2 years of implementation (FY16 and FY17, but given delays this may extend into FY18). The

					funding was not approved until after submission of COP15. We are reporting the full amount in COP16.
VMMC	\$3,175,470			Conduct VMMCs in the two DREAMS districts	Lesotho has received a total of \$3,175,470 in VMMC plus-up funding. This money is for FY16, but was not approved until after submission of COP15. Therefore, we are reporting it in COP16.
Viral Load	-	-	-	-	-
EQUIP	\$1,000,000	1	\$1,000,000	Training and support to scale-up treatment provision, cost-outcome evaluation of differentiated models of HIV treatment; support the treatment of young boys in DREAMS districts; expand strategies for Test and Start	Lesotho will receive funding for EQUIP. The non-COP funding comes from USAID/OHA through a centrally funded mechanism, EQUIP.
AIDSFree	-	-	-	Capacity building of civil society organizations	Lesotho will receive funding for AIDSFree. All funding comes from USAID/OHA through the centrally funded, AIDSFree.
PHIA	\$0*	-	-	PHIA is the population based AIDS impact assessment.	Activity implementation is supported by funding from CDC HQ. CDC/Lesotho funds staff from ICAP/Lesotho to provide technical support to implement PHIA activities in country. Along with ICAP/Lesotho staff, CDC/Lesotho funds a full-time Fellow to assist in the implementation of PHIA activities.
Other PEPFAR Central Initiatives	\$2,368,897	1	\$450,000	This funding is for Project SOAR which will fund two studies: IMPROVE and VEID. IMPROVE is focused on evaluating the effect of a multidisciplinary team on MCH outcomes and HIV Service, as well as, Antiretroviral Therapy Uptake and Retention. VEID study is building off the PMTCT Effectiveness (PEA-WIL) cohort study that is following MTCT outcomes of HIV positive and negative women during pregnancy who will be followed for the next two years. The VEID study will test all the of	This is a 4 year project (June 2014-2018). All funding is being reported here in COP16.

				infants born to these women at birth and will analyze the feasibility, acceptability, and cost-effectiveness of earlier HIV testing.	
Other Public Private Partnerships	\$300,000*			This \$300,000 is CDC/HQ special initiative funds that was put into a CDC/HQ specific mechanism focused on migrant workers	PEPFAR Lesotho also has a PPP with Vodafone for \$3,000,000. This entire amount was reported during COP15 and is therefore not re-reported in COP16.
<b>Total</b>	<b>\$22,874,611*</b>		<b>\$1,450,000</b>		<b>This funding should not be looked at as COP16 funding. Much of this funding is multiple year money that will be spread across historic, current, and prospective COP cycles</b>

### **1.3 National Sustainability Profile**

The PEPFAR team completed a draft Sustainability Index Dashboard (SID) to assist with identifying areas of weakness that are critical to the HIV and AIDS response and the attainment of Epidemic Control in Lesotho. The SID process for COP 2016 began with the formation of the SID technical working group (TWG), co-chaired by UNAIDS Lesotho. The SID TWG was composed of PEPFAR Lesotho, UN Agencies, Civil Society Organizations (CSOs), and PEPFAR Implementing Partners (IPs). The draft SID generated by the TWG was electronically circulated widely to a broader stakeholder group in the health sector but little feedback was received. Due to MOH Senior Management and PEPFAR staff time limitations the SID stakeholder meeting was cancelled. However MOH Senior Management buy-in into the SID was secured and the SID was finalized in February 2016.

Of the fifteen sustainability elements four were classified as unsustainable (Red), nine scored partially unsustainable (Yellow), one scored partially sustainable (Light Green), and one scored sustainable (Green). With 13 of the 15 elements scoring either unsustainable or partially unsustainable, the Lesotho HIV and AIDS response seems static and requires measures to change the course towards sustainable epidemic control.

The elements that scored either unsustainable or partially unsustainable included policies and governance (red), domestic resource mobilization (red), performance data (red), financial/ expenditure data (red), civil society engagement (yellow), private sector engagement (yellow), service delivery (yellow), human resources for health (yellow), commodity security and supply chain (yellow), quality management (yellow), laboratory (yellow), technical and allocative efficiency (yellow), and epidemiological and health data (yellow).

Following up on COP 2015 investments and Test and Start agenda, the PEPFAR team will continue to invest in policies, governance activities, and service delivery. Investments will be less in human resources for health, but more in commodity and supply chain management epidemiological and health data, and laboratory commodities and systems. In COP 2016, the PEPFAR team will continue to support the MOH to strengthen these elements, which are in line with the PEPFAR Lesotho 2015-2020 Strategic Plan. Unique to COP 2016 is the expansion of Test and Start programs to all PLHIV and the implementation of new service delivery models to improve efficiency and reduce the burden on frontline health workers. In addition, COP 2016 will continue to scale up high-impact access and demand investments throughout the continuum of response. PEPFAR will scale-up demand for HIV/AIDS services by ensuring that PLHIV know their HIV status either through provider initiated testing and counseling (PITC) or community based testing and counseling (CBTC) and are linked to treatment services. In addition, treatment access will expand through expansion of HRH capacity for VMMC, OVC, HCT, PMTCT, FBCT and CBCT services in scale-up districts (refer to sections 4.2-4.10 and/or section 6.0 for program/system support activities).

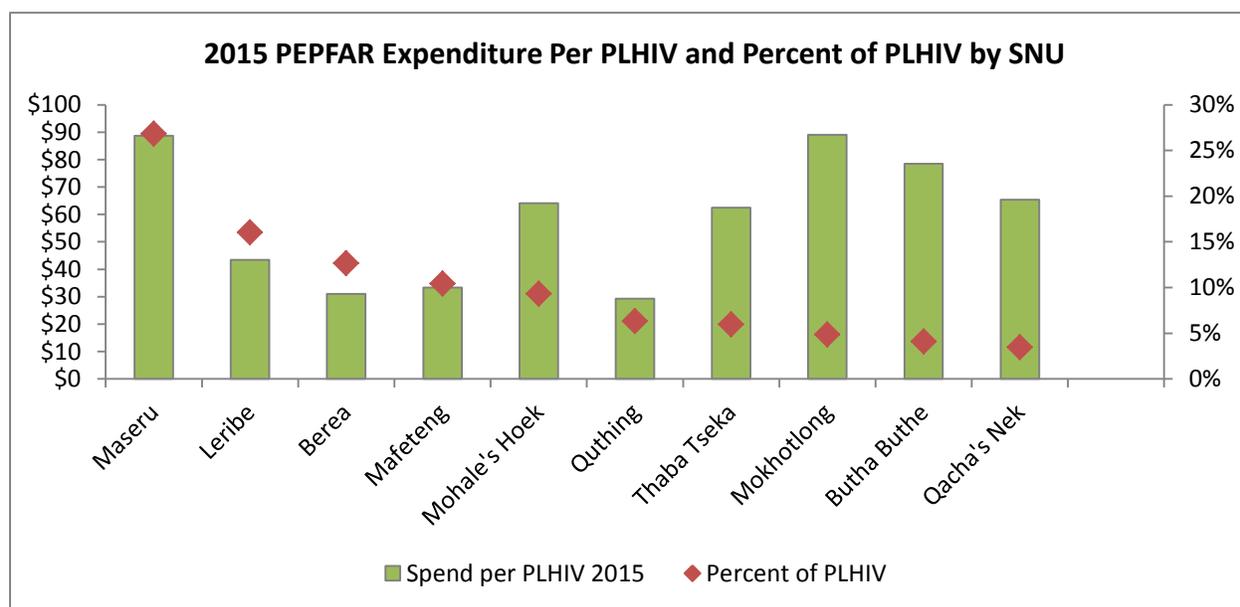
### 1.4 Alignment of PEPFAR investments geographically with disease burden

COP 2015 total expenditures were aligned with the geographic distribution of the disease burden, with a few exceptions. Improved alignment of resources with disease burden is a key consideration for COP 2016; the PEPFAR team will make appropriate changes based on findings.

PEPFAR spending per PLHIV at the district level varied from \$29 in Quthing to \$89 in both Mokhotlong and Maseru. There are several issues that put this variation in context including: different service delivery models across PEPFAR clinical partners; different cost drivers across SNUs related to distance, remoteness, and lower densities of PLHIV; and different levels of investment by the GOL and Global Fund across districts.

In COP 2014, the PEPFAR team’s efforts to program with national reach led to higher expenditures in places with lower disease burden. This is because it costs more to operate a diffuse program in the rural, remote parts of the country that have poor infrastructure, lower population overall, and a lower density of PLHIV.

**Figure 1.4.1 Percent of PLHIV by SNU and PEPFAR 2015 Expenditure Per PLHIV<sup>15</sup>**

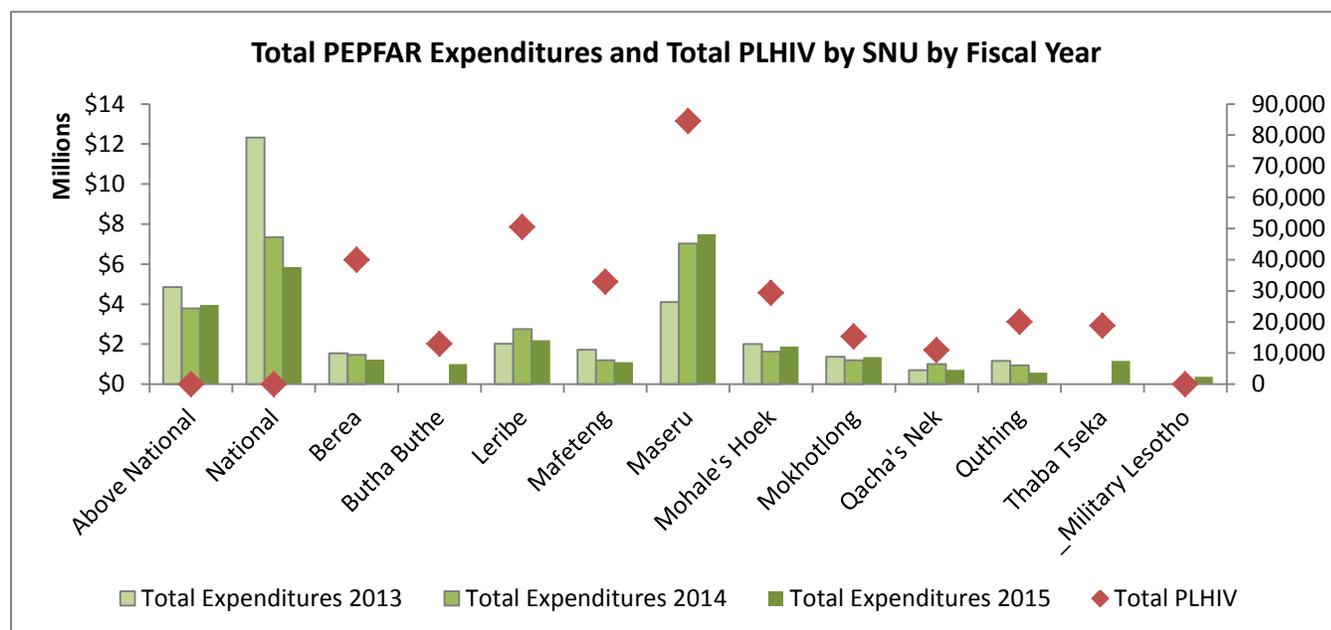


Further analyses of the geographic alignment of PEPFAR investments in 2015 indicated that several districts exhibit comparatively high PEPFAR investments with comparatively low disease burden, with Butha Buthe, Mokhotlong, and Qacha’s Nek standing out in particular. Figure 1.4.2 illustrates how expenditures have changed from 2013 to 2015 across SNUs; this

<sup>15</sup> Lesotho EA Epi-Tool, February 22, 2016

table demonstrates some planned and executed corrective shifts in a few key districts, namely Maseru and Leribe.

**Figure 1.4.2 Total PEPFAR 2013, 2014, and 2015 Expenditures and Percent of PLHIV by SNU by Fiscal Year<sup>16</sup>**



**Table 1.4.2 Summary of Unmet Need, including Total PLHIV,<sup>17</sup> Percent PLHIV, and Coverage of Total PLHIV for ART by SNU**

SNU 1 – District Level	Total PLHIV	% of PLHIV	Current on ART	ART Coverage	Unmet Need (all PLHIV)	Unmet need (per national guidelines)	Net New Needed for Saturation
Maseru	84,532	26.8	37,332	44.2%	47,200	Assume Test and Start	30,294
Leribe	50,485	16.0	18,256	36.2%	32,229		22,132
Berea	39,918	12.7	15,795	39.6%	24,123		16,139
Mafeteng	32,874	10.4	9,099	27.7%	23,775		17,200
Mohale's Hoek	29,352	9.3	9,603	32.7%	19,749		13,879
Quthing	19,959	6.3	3,550	17.8%	16,409		12,417
Thaba Tseka	18,785	6.0	7,372	39.2%	11,413		7,656
Mokhotlong	15,263	4.8	3,152	20.7%	12,111		9,058
Butha Buthe	12,915	4.1	7,212	55.8%	5,703		3,120
Qacha's Nek	10,919	3.5	3,116	28.5%	7,803		5,619
<b>National</b>	<b>315,002</b>	<b>100%</b>	<b>114,487</b>	<b>36.3%</b>	<b>200,515</b>		<b>137,515</b>

<sup>16</sup> Lesotho EA Epi-Tool, February 22, 2016

## 1.5 Stakeholder Engagement

The PEPFAR Lesotho team holds quarterly POART meetings with the host government, umbrella civil society organizations, and other stakeholders. Apart from the introduction of Test and Start in FY 2016, the priorities and approaches of COP16 are consistent with the pivots enacted in COP15. The host government is supportive of the geographic and program prioritization. Semi-annual health summits between the Minister of Health and the U.S. Ambassador strengthen the PEPFAR program's synergies through alignment with national programming. The Government also reinstated the National AIDS Commission (NAC) in December 2015 and has begun to staff up the secretariat in FY 2016. The resuscitation of NAC signals a renewed commitment of the GOL to HIV/AIDS and the USG expects the NAC to play a pivotal coordination role. The MOH was engaged in COP16 target setting and reviewed program priorities throughout the process. The Minister and top management were involved in the policy and strategic direction of the program and SID assessment.

The PEPFAR team held an initial consultative meeting with local civil society organizations in March 2016 that built upon their participation at the quarterly POART review meetings. Primarily the meeting was to orient CSOs and discuss what programmatic approaches would help reach the clinical cascade targets required to achieve ART saturation. A follow-up meeting was held on April 6, 2016 to brief CSOs on the final COP16 version for submission and secure written feedback. PEPFAR Lesotho reflected on this feedback as the COP was finalized and continued to engage CSO colleagues after COP submission.. Namely, several CSO representatives were able to join the PEPFAR team at the COP review in Johannesburg. The PEPFAR team engaged with the Global Fund and other health donors during the course of COP 2016 planning through bilateral meetings. COP development took place at the same time as the finalization of grant making for 2016-2018 funding. 100 percent of the essential HIV commodities are supported by the GOL and Global Fund including GOL 'willingness to pay commitment' for an additional \$10 million for ARV procurement. Due to an iterative release of analytical tools, discussions with stakeholders continued during the interval between submission and review to further examine site level targets.

## 2.0 Core, Near-Core and Non-Core Activities

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PEPFAR Lesotho updated its analysis of the PEPFAR Lesotho program in the context of current results of the national program and other donor funding to achieve sustained epidemic control. The current investment portfolio as well as the bottlenecks identified by the Sustainability Index and SIMS data were integrated with the technical approaches to maximize our impact. Though the majority of clinical services are provided within national health centers, PEPFAR Lesotho is the primary donor at the site / service delivery level for prevention of mother-to-child transmission (PMTCT), HTC, care and treatment, TB/HIV, laboratory, strategic information, and supply chain management. Therefore given the projected roll-out of Test and Start nationally in FY 2016 and aggressive national ART scale-up targets, the plan has reinforced core service delivery support and quality assurance components of these interventions.

In line with our strategic vision, PEPFAR Lesotho has integrated the activities related to orphans and vulnerable children (OVC) and non-biomedical prevention activities into our care and treatment framework. The program no longer supports any non-core activities. PEPFAR Lesotho will provide technical assistance for the integration of early infant male circumcision (EIMC) in maternal and neonatal child health programs. In addition, EIMC direct service delivery will be provided in the districts of Maseru and Berea where there is greater than 60% coverage of the VMMC program in 15-29 year old men. The core and near-core activities have also been geographically focused on the high-burden scale-up districts and on priority populations. Appendix A provides a full list of core, near-core, and non-core activities.

## 3.0 Geographic and Population Prioritization

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Beginning with COP 15, PEPFAR focused on five districts which represent 75% of the HIV disease burden in Lesotho. Current treatment coverage for PLHIV in these five scale-up districts is estimated to be 38% and in order to reach 80% ART coverage, an additional 99,644 patients will need to be initiated and retained on ART. The target for newly initiated on treatment (TX\_NEW) for COP 16 is 83,293.

Current plans are to reach 80% treatment coverage in five scale-up to saturation districts (Maseru, Berea, Leribe, Mafeteng, and Mohale's Hoek) by September 2017. PEPFAR support in the scale-up districts is focused on 120 sites that each provide ART to at least 200 PLHIV. Sites with smaller patient volumes do not receive direct support from implementing partners.

There have been multiple gaps in Lesotho's ability to reach epidemic control in the past (i.e., a lack of human resources, commodity stock outs, the absence of a functioning National AIDS Commission, frequent turnover in MOH leadership, poor data systems, a highly mobile population, political instability, and sub-optimal efforts at linkage and retention). Efforts to

reach epidemic control in future will depend, in part, on Lesotho's recent decision to adopt Test and Start in the first half of 2016 as well as the country's ability to successfully implement the new WHO recommendations for optimization of service delivery.

Final results of the 2014 Demographic and Health Survey (DHS) are expected in the first half of 2016. Current national estimates are based on the 2009 DHS. Results from the 2016 Population-based HIV Impact Assessment (PHIA) are expected in 2017. Both surveys should help validate estimates of disease burden from SPECTRUM models.

Fifty-one percent of base funding and 100% of Impact Funds in COP 16 will be allocated to care and treatment activities. With current support from the Global Fund, the Government of Lesotho, and PEPFAR, it is estimated that sufficient commodities (ARV, laboratory reagents, test kits, etc.) will be available to achieve treatment targets through at least 2017.

With a generalized epidemic (HIV prevalence of 23% among persons 15-49 years of age) and a small population of 2 million, most Basotho fall into one priority category or another. ACT and DREAMS funds focus on children and adolescent girls and young women. COP funding for key populations is for MSM and commercial sex workers.

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

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### 4.1 Targets for scale-up locations and populations

COP 16 targets for treatment coverage are consistent with what was originally proposed in COP 15 which in turn was aligned with both PEPFAR 3.0 and the UNAIDS 90/90/90 strategy. We have made no major adjustments to last year's underlying strategy, which we believe is sound, but will take time to implement successfully.

The plans for epidemic control in the five scale-up districts call for achieving 80% treatment coverage among PLHIV in five districts by September 2018. The approach for achieving these goals emphasizes support at the clinic level through direct service delivery. We have de-emphasized efforts involving technical assistance. .

Treatment targets for COP 16 are consistent with what was originally proposed last year. All targets are based on what is needed to achieve epidemic control (e.g., 80% treatment coverage for PLHIV by 2017/18). Due to our inability to meet targets in FY 2015, the targets have become even more ambitious going forward. Our ability to reach treatment targets is based to a large extent on the results of the PEPFAR pivot enacted in COP 15 along with adoption of WHO recommendations for Test and Start and optimized service delivery.

Identifying sufficient PLHIV to meet the treatment targets will require high coverage of provider-initiated testing and counselling (PITC). We estimate that approximately 400,000 of 700,000 individuals who visit health facilities annually are tested. We need to test most of the remaining 300,000 to reach our targets for treatment initiation. Community-based testing accounts for a relatively small percentage (~10-15%) of newly-diagnosed PLHIV, however, it complements PITC and allows us to target hard to reach populations. For PITC, outpatients account for the majority of persons tested. ANC and TB clinics have achieved high testing coverage. More needs to be done with inpatients. Our ability to quantify the contribution from each approach is limited by insufficient data. As noted below, we lack sufficient data to complete Table 4.1.2.

The most current assessment of resources for the national HIV response is from the recent Global Fund submission. In general, Test and Start and optimized service delivery were not included in resource assessments as the Concept Note was essentially completed before WHO released the new recommendations. However, the overall treatment coverage goals of the National Strategic Plan for 2015/16 align well with PEPFAR 3.0 goals for epidemic control (e.g., 80% treatment coverage for PLHIV). The absolute numbers for ART in the PEPFAR scale-up districts are presented in Table 4.1.1. In addition to COP funding, Lesotho receives support through ACT and DREAMS initiatives as well as a PPP with Vodacom that focuses on pediatric treatment.

Potential challenges to meeting the 90/90/90 targets are numerous. These include a lack of human resources at all levels of the health care system, commodity stock outs, poor multisectoral cooperation within the GOL, frequent turnover in MOH leadership, inadequate data systems, difficulty in attracting men to health services, longstanding cultural practices regarding sex, and continued political instability. Advocacy on the aforementioned issues by the civil society community is invaluable and COP 2016 provides an opportunity for further engagement on these issues.

Data systems are poor in Lesotho and limit our ability to measure the number of PLHIV actively enrolled in treatment. Without a unique personal identifier and with a highly mobile population, both within Lesotho and South Africa, it is challenging to track patients across the continuum of care. Efforts to develop an electronic medical record have been largely unsuccessful. Current efforts to improve data systems focus on 1) supporting implementation of DHIS2 and 2) enhancing paper-based medical records at the site level.

Efficiency gains for HTC are dependent on improving coverage for PITC at all sites and focusing on community-based testing channels with the highest yield and best linkage to treatment. For treatment, efficiency gains are largely dependent on successful implementation of WHO's optimized service delivery models that include fewer laboratory tests, less frequent clinic visits, extended medication refills, same day treatment initiation, alternative clinic hours, and differentiated models of care for new, stable and unstable patients.

**Table 4.1.1 ART Targets in Scale-up Sub-national Units for Epidemic Control**

SNU	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) <i>TX_CURR</i>	Newly initiated (APR FY 17) <i>TX_NEW</i>	ART Coverage (APR 17)
Maseru	84,532	37,332	30,294	66,639	27,370	80%
Leribe	50,485	18,256	22,132	39,774	16,724	80%
Berea	39,918	15,795	16,139	31,382	14,248	80%
Mafeteng	32,874	9,099	17,200	25,786	12,630	80%
Mohale's Hoek	29,352	9,603	13,879	22,980	11,955	80%
<b>Total</b>	237,161	114,487	99,644	186,562	82,927	80%

**Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Scale-up Districts (FY 16) \***

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Clinical care patients not on ART	-	-	-
TB-HIV Patients not on ART	-	-	-
HIV-positive Pregnant Women	-	-	-
Other priority and key populations	-	-	-
<b>Total</b>			

\* Note: Currently available data do not allow completion of this table with any degree of accuracy.

**Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Scale-up Districts, 15-29**

Target Populations Males 15-29	Population Size Estimate (SNUs)	Current Coverage (FY15)	VMMC_CIRC (in FY17)	Expected Coverage (in FY17)
Maseru	71,480	27,776	781	90%
Leribe	47,320	11,176	9,820	75%
Berea	40,290	7,307	6,562	82%
Mafeteng	32,920	3,986	10,315	71%
Mohale's Hoek	28,894	2,786	8,603	66%
<b>Total/Average</b>	220,904	53,031	36,081	

**Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control**

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
MSM	7,874	80%	6,299
FSW	4,683	80%	3,746
<b>Total</b>	12,557	80%	10,045

**Table 4.1.5 Targets for OVC and Linkages to HIV Services**

	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY17 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target) OVC_KNOWNSTAT*
Maseru	53,031	36,077	-
Leribe	32,249	14,430	-
Berea	24,960	18,889	-
Mafeteng	24,566	9,804	-
Mohale's Hoek	29,627	7,923	-
<b>TOTAL</b>	<b>164,433</b>	<b>89,866</b>	

*\*Targets not required for COP16*

## 4.2 Priority population prevention

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 as a priority population. The DREAMS initiative will support the enforcement of policy and advance national program targets within this population.

In COP16, PEPFAR Lesotho has a target of 43,285 adolescent girls and young women for HIV prevention interventions. PEPFAR Lesotho now has prevalence data and some district population data for men having sex with men (MSM), female sex workers (FSW), and military populations. Therefore, the priority populations addressed in our COP 16 program are MSM, FSW, and the military population. Other populations with weaker prevalence and size estimations, though suspected to have prevalence greater than the general population, include: prisoners, herd boys, migrant workers (textile factories), and disabled persons.

Programming for priority populations will be guided by the data and integrated as much as possible with care and treatment programming. Given the HIV prevalence and risk behaviors of MSM and FSW, the program will be specifically targeted with a comprehensive package of prevention, care and treatment services to identify HIV positive members and link them to care and treatment, health care worker KP training and sensitization, strengthening community-based monitoring systems and linkages to treatment and care, and using information and communication technology (ICT) for outreach and linkages along the cascade. Enhanced risk-reduction interventions, including condoms 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 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.

Priority population communities will be empowered to fully participate in mobilization activities for intensified case-finding and support linkages for enrollment in care and treatment services. These communities in the scale-up districts will be reached through outreach services, condoms, and interpersonal communication activities during the project implementation life cycle to ensure that they access treatment services.

### **4.3 Voluntary Medical Male Circumcisions (VMMC)**

The WHO/UNAIDS recommended VMMC be offered to men in combination with other HIV risk reduction interventions in settings with generalized HIV epidemics and low circumcision coverage. 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 circumcision unmet need and HIV disease burden. In Lesotho, 72% of men aged 15-29 of age live in the five scale-up districts.

In FY 2017, PEPFAR aims to provide surgical and PrePex device direct service delivery to circumcise 38,737 men aged 15 – 29 years. This represents >80% saturation in Berea and Maseru districts. Eighty percent coverage in the remaining scale-up districts will be achieved by September 2018. Technical assistance will be provided for the integration of EIMC in maternal and neonatal child health programs with direct service delivery in Maseru and Berea. Global Fund money will be leveraged for the expansion of services, recruitment of additional manpower, and procurement of equipment and supplies in sustained districts.

Demand creation activities in scale-up districts will include recruitment of additional personnel and mobilizers, transitioning demand creation to year round rather than during winter only, addressing men’s fears regarding pain and HIV testing, strengthening referral linkages from VCT centers and blood donation to VMMC sites, engagement of CBOs as demand creation agents, medical-traditional circumcision collaborations, community mapping to inform targeted demand, advocacy by community leaders, and government leadership.

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, balancing supply and demand, acceptability of PrePex device, and refocusing demand to encourage larger percentage of 15 -29 year olds to access services.

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. Technical assistance focuses on adherence to the WHO minimum package and PEPFAR VMMC technical considerations as well as active referral of clients testing HIV positive at sites to care and treatment. 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.

#### 4.4 Preventing Mother-to-Child Transmission (PMTCT)

The burden of HIV disease among pregnant women in Lesotho is among the highest globally at 21%<sup>18</sup>. The national policy is to eliminate new pediatric HIV infections and improve maternal, newborn, and child health and survival in the context of HIV through the adoption of the WHO PMTCT guidelines that promote the provision of life-long antiretroviral treatment to pregnant and lactating women (Option B+) within MNCH settings. This policy shift provided programmatic gains of a six-fold increase in ART uptake in 2015 among HIV-positive pregnant or lactating women compared to 15% in 2012<sup>19</sup>. PMTCT service provision for pregnant women who access the health facilities has greatly improved. In health facilities, over 90% of pregnant women were tested for HIV at their first ANC visit and 93% of the identified HIV-positive pregnant women received ARVs to prevent mother-to-child transmission of HIV.<sup>20</sup>

However, a major challenge to PMTCT in Lesotho is the low population level coverage of PMTCT service. Only 62% of expected pregnant women know their HIV status and only 64% of all estimated HIV-positive pregnant women are receiving ART<sup>21</sup>.

In COP 2016, PEPFAR will support the national elimination goals to attain epidemic control in the five scale-up districts where over 72% of expected pregnancies in the country are found. PEPFAR support in the sustained response districts of Butha Buthe, Thaba Tseka, Quthing, Mokhotlong, and Qacha's Nek will be limited to providing technical support to the District Health Management Teams (DHMT) to oversee and monitor the quality of PMTCT services to pregnant women currently enrolled on Option B+. Site-level support in the sustained response districts was transitioned to the GOL and DHMT in FY 2016.

The five scale-up districts will be targeted to attain saturation of the PMTCT four pronged approach to service delivery. The PEPFAR PMTCT program will achieve 95% coverage of HIV testing and counseling (HTC) and 95% initiation on Option B+ for HIV-infected pregnant and lactating women identified in FY 2017. This will result in 90% PMTCT coverage. To achieve these targets, PEPFAR Lesotho's strategic shift involves expanding direct service delivery support to improve the package of interventions available for pregnant/lactating women, their children, and partners. Routine opt-out PITC will be provided within MNCH and EID at six weeks and will be expanded to ensure timely initiation on ARVs. COP16 will strengthen training and quality assurance for HIV testing in PMTCT settings and include re-testing and repeat testing during the third trimester, delivery, and postnatal periods to identify those who seroconvert.

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<sup>18</sup> Spectrum 2015

<sup>19</sup> APR 2012 and APR2015 Reports

<sup>20</sup> Ibid

<sup>21</sup> MOH Report 2015

Community outreach will be restructured for intensified case finding using village health workers, community based organizations and mentor mothers. PEPFAR Lesotho will leverage the Vodafone public private partnership (PPP) to mobilize high burden communities for HTC, strengthening linkages for index client testing and couple testing as well as tracking of ARV prophylaxis and EID uptake of HIV-exposed infants delivered outside of hospitals. COP 2016 funds will leverage the ACT and DREAMS initiatives to expand services for adolescent girls and young women (e.g. prevention of Sexual and Gender Based Violence (SGBV)), assisted disclosure, linkages to post-exposure prophylaxis, and STI screening and management.

In line with national policy, the PMTCT service package will support the provision of the mother baby packs, adherence counseling, and cotrimoxazole prophylaxis. Retention of mother-infant pairs will be improved using peer counselors, mentor mothers, and linkage facilitators who will conduct cohort tracking, actively follow-up missed appointments, reduce turnaround time of EID results to caregivers, and support linkage of mothers and newly diagnosed HIV-positive infants to the ART program. Maternal and infant nutrition assessment, counseling and support (NACS) services will continue to be provided for mothers and their infants due to 10%-12% of children under age five classified as severely malnourished and 8% of children under age five classified as moderately malnourished based on weight-for-age<sup>22</sup>. HIV-positive women in the reproductive age attending PMTCT, ART, and care clinics will receive family planning education, counseling, and voluntary access to a wide range of contraceptives based on informed choice in collaboration with UNFPA. Women living with HIV who wish to have children will receive safe pregnancy counseling.

Cohort monitoring using the ANC and the under-five longitudinal registers and collaborative quality improvement will be implemented to monitor retention and effective linkages to care and ART upon final diagnosis of infants. PEPFAR will support sites to implement a filing system that enables more effective retrieval, tracking, and reporting of program beneficiaries so as to address the reporting gaps identified in the SIMS visits. Laboratory monitoring will be strengthened through expansion of the sample transport and local referral network to increase uptake of DNA/PCR and viral load testing. At the DHMT level, PEPFAR will support joint planning, forecasting, and reporting on PMTCT-related commodities, supplies and reagents, (including ARVs, VL, DNA/PCR reagents, rapid test kits (RTKs), and cotrimoxazole). Quarterly program reviews and supportive supervision to monitor the quality of services will be provided in all scale-up districts.

### **Efficiency Analysis**

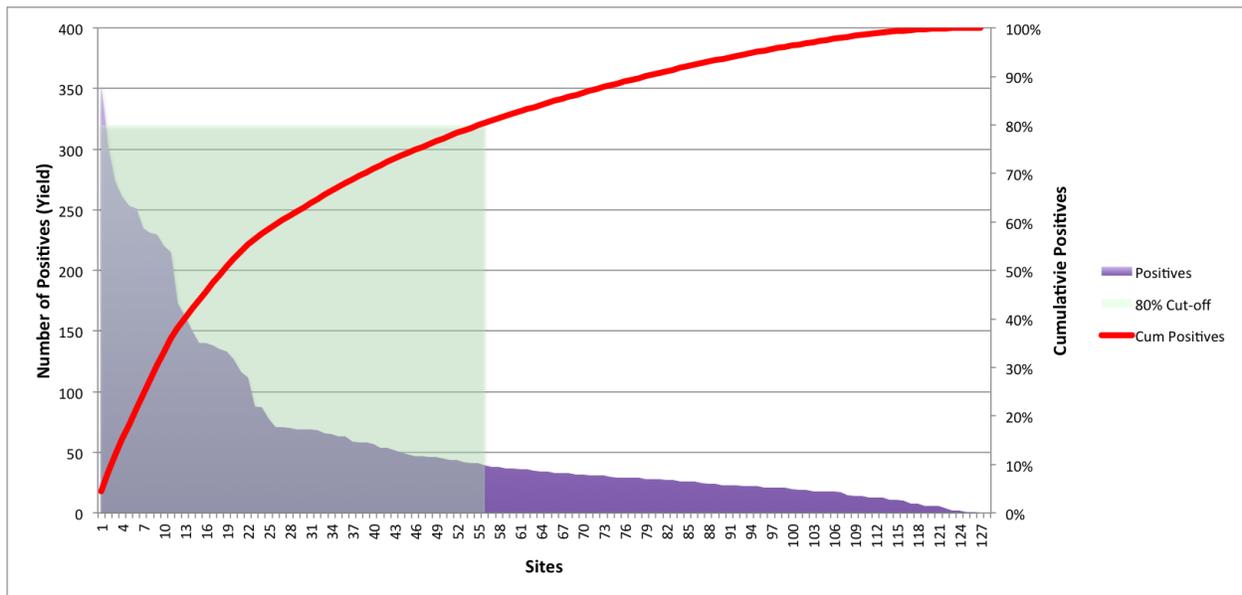
During FY 2015, PEPFAR supported PMTCT services in 185 sites with 126 sites located in the scale-up districts. Four sites in the scale-up districts were transitioned since these sites had 4 or less HIV-positive patients served in 2014.

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<sup>22</sup> KIR/DHS 2014

Site yield analysis of the five scale-up districts showed that 44% (55) of sites identified 80% of the positives and 56% (71) sites identified the remaining 20% of positives. The average positivity rate (weighted against volume) for these sites is 29.1% (range of 9.1% - 99.1%). This 99.1% positivity rate is from Senkatana, a specialized unit for HIV care and treatment services. All new pregnancies identified at this site are usually from patients attending the ART clinic, which results in a high HIV prevalence of 99.1% at the first antenatal clinic.

**Figure 4.4.1 PMTCT Yield by Site and Cumulative Number of Known HIV Positive Pregnant Women**



#### 4.5 HIV Testing and Counseling (HTC)

The PEPFAR Lesotho program aligns itself with the UNAIDS 90/90/90 strategy which emphasizes the need for the identification of PLHIV (the first 90) and link them to care and treatment (the second 90). Though testing rates in Lesotho have improved significantly over the years (12% in 2004, 66% in 2009, and 84% ever tested in 2014), people often test late or are lost within the different stages of the clinical cascade. Poor linkages from HTC to care mean that people may start antiretroviral therapy (ART) when they are already significantly immunocompromised resulting in poor health outcomes and ongoing HIV transmission.

The PEPFAR Lesotho HTC program aims to identify HIV-positive individuals earlier in their infection and track their linkage to treatment services in a cost effective and efficient manner. In FY 2017 PEPFAR will scale up HTC at the facility-level (PITC) and in the community (CBHTC) to ensure identification of HIV early and produce the required number of PLHIV for

ART scale-up. The need for demand creation and targeted community testing cannot be over-emphasized to compliment PITC outcomes.

HTC targets were back calculated to meet the ART numbers required for saturation in the scale-up districts taking into consideration minimal loss throughout the cascade. PEPFAR Lesotho aims to test 773,923 people and enroll 83,293 PLHIV into treatment in FY 2017; 12,638 of these positives are in the Pre-ART program and eligible, leaving the net new positives to be identified at 85,951 to meet the ART targets for epidemic control in the five scale-up districts. These targets include the DREAMS initiative contribution of 61,402 tests and 3,682 positives identified in FY 2017. It is projected that about 85% of the newly identified PLHIV eligible for ART will come from PITC with an average yield of 8% while about 15% will be generated by targeted CBHTC with an average yield of 6%. PITC will be scaled up in outpatient departments, TB clinics and inpatient wards with a goal of reaching individuals attending health facilities. Linkage coordinators will be deployed in all high volume sites to ensure linkages to treatment and to coordinate with community partners on linkages of PLHIV to treatment. The family tree model will be used to track family members of PLHIV in care to the community for testing and linking to treatment.

It is worth noting that as testing coverage increases, the probability of identifying PLHIV in the general population decreases, calling for a systematic review of approaches and strategies that are cost effective. It is expected that financial efficiencies realized from prioritization will avail additional resources for scale-up districts. The HTC program will leverage national and Global Fund HTC (including RTK procurements) resources and Vodafone PPP to identify more PLHIV and link them to care and treatment. While aggressive promotion and scale-up of index patient and family testing may help in identification of PLHIV, especially children and men, innovative strategies will be needed to improve yield at the community level. Focus on specific populations and locations in community testing are some of the strategies that the program will explore to improve identification of PLHIV at the community level. Improving linkage of PLHIV from HTC, especially CBHTC, to care and treatment will be addressed by recruiting linkage facilitators, provision of transport assistance to facilities, and demanding close collaboration between community and clinical partners to track, document, and report linkages of clients.

The DREAMS initiative is an opportunity to address some of the programmatic challenges in two of the five scale-up districts. There is a proposed gender-based violence package of services which includes community engagement and strengthening the National Post Violence Centre in Maseru to address HIV associated stigma and GBV. Under the same initiative, innovative models such as moonlighting and temporary drop-in centers for key populations will be piloted to address stigma associated with public health facilities and improve access to HIV testing and counselling services. Mobility is not only a problem for key populations, but a general population challenge across the country. Maseru and Leribe are two of the five scale-up to saturation districts with the highest density of key populations (MSMs & CSWs). PEPFAR Lesotho intends to advocate for a unique identifier system for clients and patients so that they

can be tracked anywhere along the cascade. The country is also going to receive technical assistance from S/GAC to design a context-specific package of HIV prevention, care and treatment services for key populations in the 5 scale-up districts which will address most of the access and service uptake issues for this group.

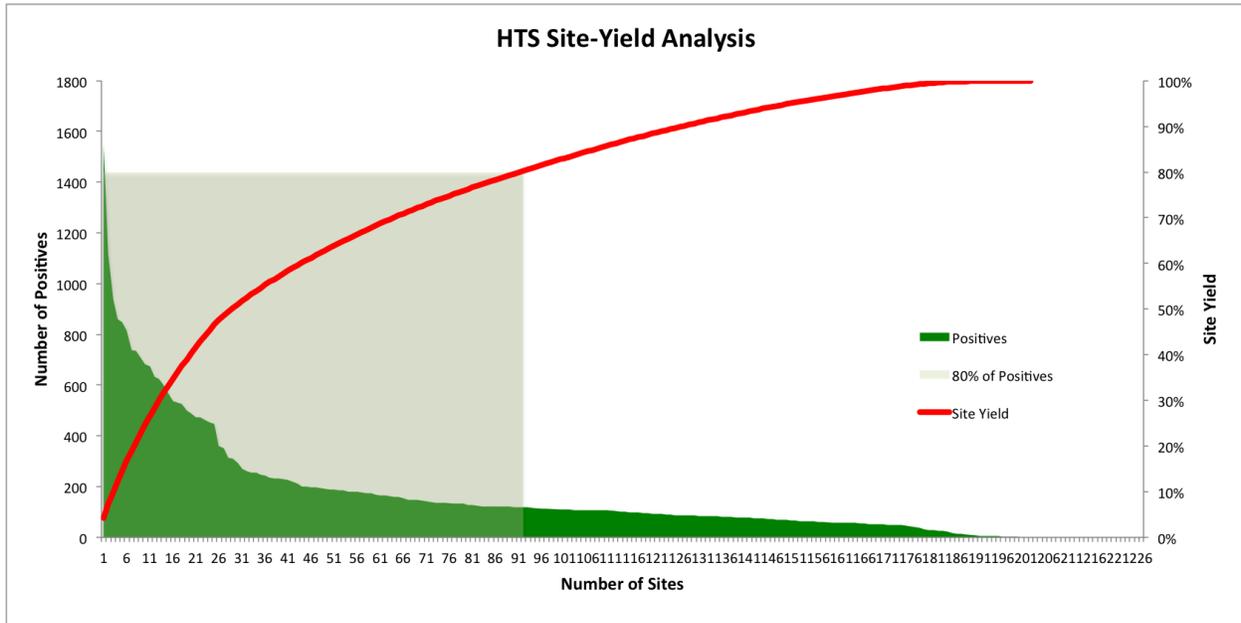
In FY 2017 PEPFAR will focus on the five scale-up districts with the following interventions:

- Scale up Provider Initiated Testing and Counselling in all facilities in the five scale-up districts
- Scale up promising targeted community HTC strategies such as index patient testing to reach high risk populations and link them to treatment.
- Recruit and train service providers to provide quality HIV testing and counseling services (HTS) both at the facility (PITC) and community levels
- Link PLHIV to treatment and track referrals from community to facility in the scale-up districts through engagement of linkage facilitators, provision of transport assistance and revision of data collection tools to track linkages
- Ensure community mobilization and demand creation for the uptake of HTC and other prevention and treatment services
- Implement a robust QI program for HTC services

### **Efficiency Analysis**

PEPFAR Lesotho's pivot in COP15 transitioned out of any site that identified  $\leq 4$  positives in a twelve month period. In FY 2015 PEPFAR supported 202 sites nationally and 139 in the five scale-up districts. Site level analysis demonstrated that 80% of PLHIV came from 43.1% of sites nationally in FY 2015; while in the scale-up districts 80% of positives come from 46.0% of the supported sites.

**Figure 4.5.1 HTC Volume by Site and Cumulative Percentage of Positives Identified at APR15.**



#### 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) in everyone living with HIV at any CD4 cell count. This policy shift is aligned with the National Strategic Plan goal of reducing HIV transmission, morbidity, and mortality in Lesotho. All patients on ART will receive a core package of care and support services.

PEPFAR/Lesotho will support the Ministry of Health to implement major strategic shifts in Care and Support to achieve 80% saturation in scale-up districts that are aligned with the Test and Start policy framework. The goal is to provide a core package of care and support services to 188,474 adults and children on treatment. The COP 2016 Care and Support package is aligned with the PEPFAR Care and Support Prioritization Framework (2014) that defines universal and contextual interventions that include clinical and laboratory monitoring (excluding CD4 testing), cotrimoxazole prophylaxis, enhancing linkage and retention in care, prophylaxis and management of opportunistic infections (OI), screening and management of TB and sexually transmitted infections (STIs), screening and management of Cryptococcal meningitis, provision of voluntary family planning (FP) services, and adherence counselling and support. The Government of Lesotho and Global Fund procure all commodities for care and support services (e.g. OI drugs, the CrAg dipstick test (LFA)).

The GOL has declared an El Nino emergency, as a result of the severe drought that has affected food security and may have effects on treatment adherence. PEPFAR will support nutritional

assessment, education, and counselling support in selected high volume sites to improve treatment outcomes. This will leverage resources from the Global Fund and World Food Program that provide therapeutic and supplementary foods for the treatment of acute and moderate malnutrition. All active Pre-ART patients will be fast-tracked for treatment initiation. PEPFAR will align with the national Test and Start policy that eliminates CD4 testing as a requirement for treatment initiation.

The USG will provide facility-based support through provision of additional human resources (HR), treatment scale up, enhance quality of care, and bridge clinical cascade linkages and retention in care and treatment through adherence counseling. Based on recent SIMS assessments, significant improvements have been made on the filing system of Pre-ART and ART to ensure continued access to care and support services.

The community-based services will include support for identification and tracking of missed appointments through Village Health Workers (VHW) and expert clients at the community level; PLHIV networks to scale-up community ART groups; and mobile technologies 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.

#### **4.7 TB/HIV**

TB is a major cause of morbidity and mortality in Lesotho. In 2015, the WHO estimated TB incidence at 852/100,000 and TB prevalence at 613/100,000, an increase from an incidence of 306/100,000 in 1990 and a reflection of the effect of HIV on TB. The trend in TB notification (new and relapses), shown in Figure 4.7.1, follows the same trend as the estimated incidence. However, there is a gap between the notification and estimated incidence, indicating missed notifications (TB diagnosis and reporting). Notably Lesotho also has high MDR-TB rates; according to the recent 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. A previous history of tuberculosis treatment, being HIV positive, and being between the ages of 45–54 years old were significantly associated with MDR-TB. The HIV prevalence among TB patients is estimated at 74% with 70% of the notified HIV+ patients having been initiated on ART. However, the estimated population level ART coverage for TB/HIV co-infected patients is 34%. High risk groups for TB in Lesotho include children, pregnant women attending ANC, PLHIV, Health Workers, ex-/mine workers, and factory workers that are also predominately migrant, military, and inmates. In 2014, 81% of the TB cases were diagnosed and notified from the five scale-up districts (Maseru (33 %), Leribe (15.7%), Berea (16.5%), Mafeteng (8.2%), and Mohale’s Hoek (8.5%). In 2015, the TB Case Detection Rate (CDR) was estimated at 50%. Lesotho plans to conduct a TB prevalence survey in 2016-17 to better estimate

the extent of TB in the country. This is driven by fact that despite the scale-up of intensified TB case finding (ICF), TB notifications continue to decline every year.

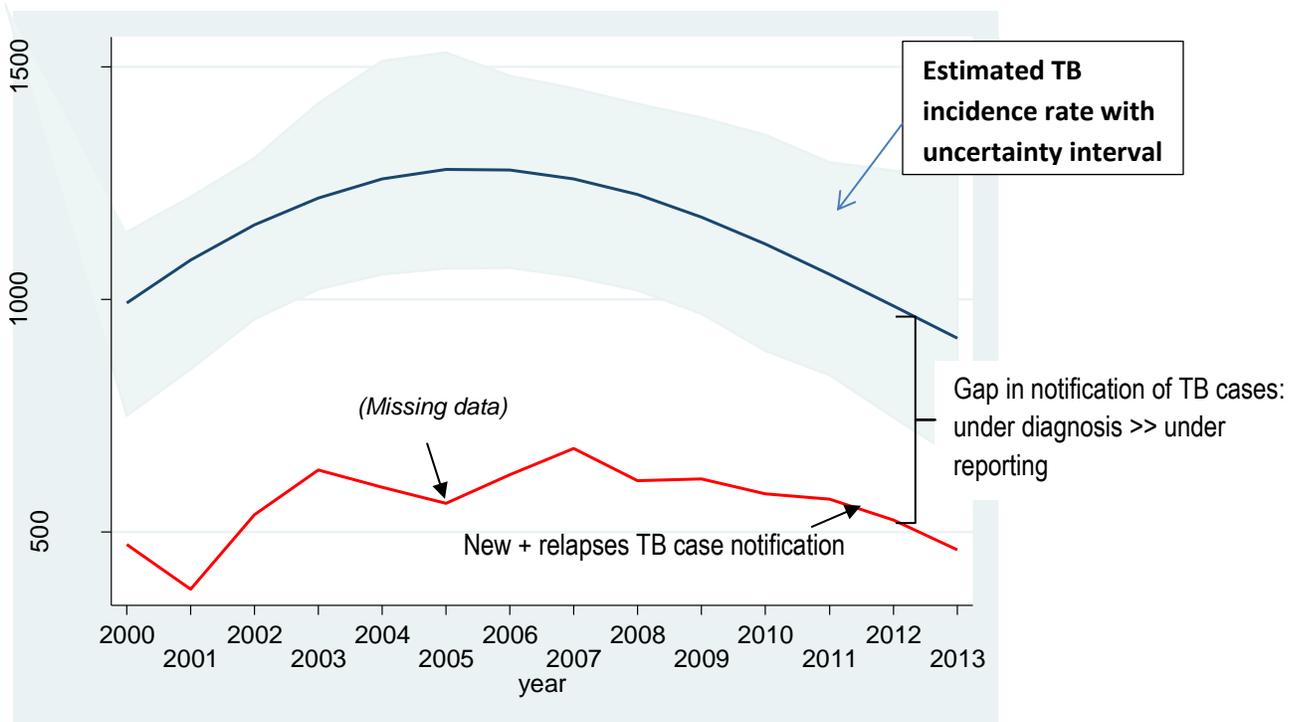
The key priorities for FY 2017 include:

1. In FY 2017, PEPFAR will support integration of TB/HIV care and treatment services in PEPFAR scale-up districts through support for clinical staff to strengthen and improve quality within TB clinics using the one stop approach. This is aimed at achieving effective TB control to contribute to the country's 90/90/90 targets through universal HTC in TB clinics. More timely identification of all PLHIV with TB through improved case detection will help to reach the second 90 faster and early initiation on ART for TB/HIV co-infected individuals reduces mortality, morbidity, and HIV transmission.
2. Support the scale-up of GeneXpert MTB/RIF and improve the early diagnosis of TB among HIV-infected to close the gap between current estimated TB incidence and current notification rates. Lesotho currently has 28 GeneXpert machines (75% in scale-up districts) and PEPFAR will support the implementation of the recently finalized GeneXpert national algorithm that prioritizes HIV infected patients and other high risk groups. USG will continue to provide support for 100% of required cartridges for GeneXpert, estimated at approximately \$600,000.
3. Support ICF activities in ART settings, MNCH settings, correctional services, factory workers, miners and ex-miners, and health care workers. This will include support for tracking systems to ensure complete evaluation of all TB suspects in the register. Linked with care and treatment, PEPFAR will support interventions to improve retention on ART and TB treatment as well as IPT (Mobile technologies, VHW systems, CAGS, basic care package provision). This will leverage the GOL and Global Fund supported ICF activities at community level.
4. Scale up of IPT provision to cover all sites in the scale-up for saturation districts not currently implementing IPT. PEPFAR will support trainings for IPT provision, M&E systems for IPT, supportive supervision, forecasting, and distribution of IPT.
5. Support the implementation of TB infection control measures and site-specific infection control plans in prioritized health facilities, provision of N95 respirators, and coordination of infection control committees.
6. PEPFAR will continue to 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.

7. At the national level, continue to provide technical assistance for review of national plans, guidelines, policies, tools, algorithms, and M&E systems for TB/HIV activities and lastly, provide technical support for the TB prevalence survey.

**Figure 4.7.1: TB case notification (all TB forms new and relapses, red line) and estimated TB incidence rate (WHO), Lesotho, 2000-2013<sup>23</sup>**



#### 4.8 Adult treatment

The GOL adopted the 2015 WHO Test and Start guidelines for the initiation of ART in everyone living with HIV at any CD4 cell count and provision of PrEP to sub-populations at high risk of HIV transmission. This policy shift is 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. Lesotho has a nurse-driven ART program and the GOL procures 70% of ARVs and medications for opportunistic infections (OI) with the remaining 30% supported by the Global Fund. In order to achieve epidemic control and effectively implement the Test and Start policy, key programmatic requirements must be addressed, including (i) revising the national treatment policy, training curriculum, and

<sup>23</sup> Source: TB Epi Analysis Report November 2014

implementation guidelines; (ii) capacity building of service providers; (iii) addressing existing clinical care cascade bottlenecks and weak linkages, mopping up the Pre-ART patients, and low 12-month retention; (iv) implementing cost-effective client-centered service delivery models that enhance timely initiation of treatment, support high patient volumes, and enhance retention in care; and (v) creating community demand to improve treatment literacy and reduce stigma. System-related interventions required for Test and Start include clinical and laboratory monitoring using routine viral load, supply chain management to reduce stock-outs of critical commodities (e.g., test kits and ARVs), enhanced monitoring systems to measure program performance using patient-level data, and additional human resources to meet increased demand for services ( i.e. adherence counseling and retention support, site level reporting, community tracking, and non-facility based ARV distribution).

The Government of Lesotho (GOL) has agreed to adopt Test and Start. PEPFAR Lesotho will use \$11,875,000 in Impact Funds to address programmatic gaps in the HIV clinical cascade that directly affect our ability to achieve COP16 targets. Impact Funds used to support treatment scale-up will free GOL and Global Fund resources for procurement of antiretroviral and other commodities; Lesotho Impact funds will focus on 1) The two aggressive scale districts now become scale-up to saturation and thus increasing treatment targets by approximately 10,000 ART patients, (2) 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 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 54 professional counselors targeting high volume sites in the scale-up districts , (3) Addressing barriers for low rate of treatment initiation by expand case identification and treatment of family members of PLHIV in care, (4) The implementation of alternative models of service delivery at the community level will contribute to a reduction of treatment costs, enhance retention, and decongest high volume health facilities, this includes community delivery ARVs at health posts by community nurse and community counselor teams, (5) Scale of viral load testing to cover 100% of patients currently on ART. During COP 2016, PEPFAR Lesotho aims to saturate treatment services in the five scale-up districts by initiating 83,293 new patients and supporting a total of 188,474 patients on treatment by the end of FY 2017, an increase of 40% from the projected FY 2016 results. In the subsequent year, PEPFAR intends to initiate 9,956 net new on treatment and support 189,729 patients on treatment in the scale-up districts.

To achieve these aggressive targets, PEPFAR Lesotho will build on past gains of providing integrated, family-centered, and comprehensive HIV/AIDS services while shifting from a technical assistance model to a more intensified direct service delivery model. PEPFAR will increase investments in scale-up districts to rapidly expand treatment coverage by offering treatment services to all who are confirmed HIV positive (i.e. Test and Start for all PLHIV).

FY 2016 will serve as a preparatory phase of the implementation of the Test and Start policy. Through USAID/EQUIP, PEPFAR Lesotho is supporting the MOH to conduct a national system readiness assessment that will cover programmatic, financial, and system-related enablers for treatment scale-up. The system readiness assessment is ongoing and the final report will be available in May 2016. In collaboration with WHO, PEPFAR Lesotho will support the MOH to revise the national treatment policy, training curriculum, and implementation guidelines that will be utilized in in-service training of providers in the 120 scale-up sites.

During FY 2017, direct service delivery support will be expanded at the scale-up sites and PEPFAR will utilize the results of the 2014 ART File Audit Assessment and APR 2015 results to set site level program milestones. Sites will 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 by the recruitment of additional human resources 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 (data clerks), and manage site level supply-chain (dispensers). Site level support for treatment enrollment will include enhanced treatment initiation of active Pre-ART patients, rapid initiation of newly diagnosed HIV positives to treatment, increased retention to 85% at 12 months and 75% at 36 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) 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 use of expert clients, PLHIV networks/community-based organizations and VHWs to improve retention through CAGs, 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. PEPFAR Lesotho will 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.

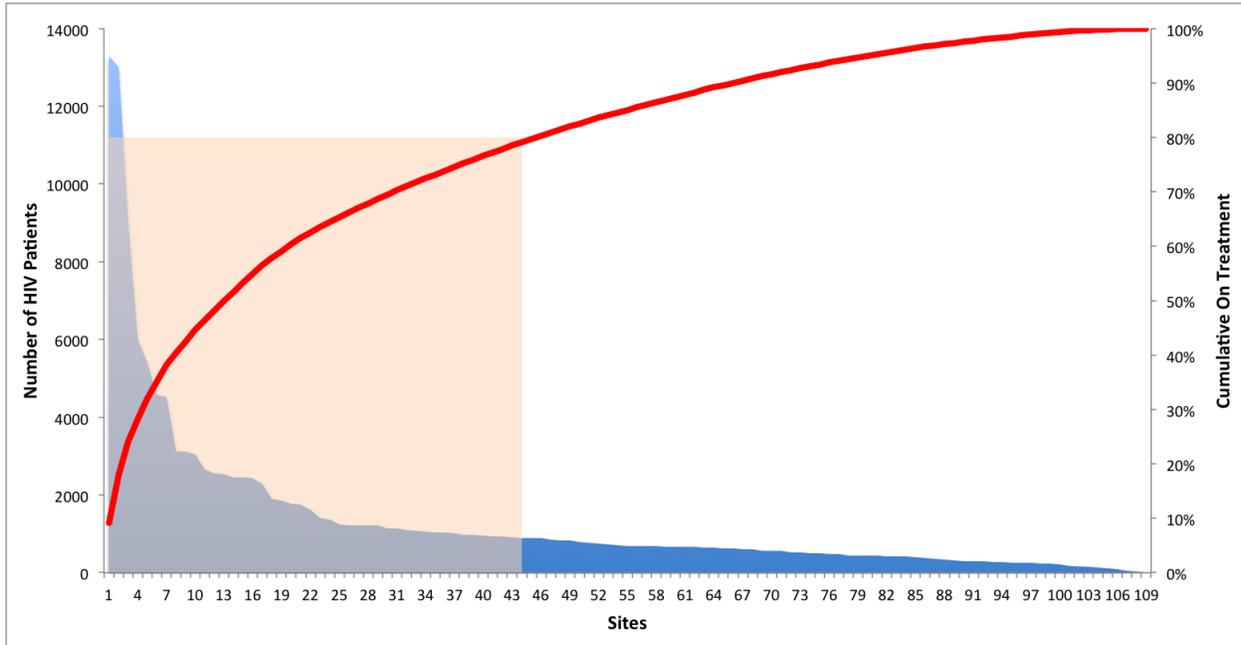
PEPFAR Lesotho will support the MOH to implement the national strategic plan for scale-up of viral load (VL) monitoring. PEPFAR will support the procurement of reagents for VL, collaborate with the MOH to decentralize systems for monitoring and management of treatment failure, and strengthen the sample 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.

During COP16, PEPFAR support in the five sustained response districts will be limited to supporting the DHMT to maintain the quality of services and laboratory monitoring for the ART patients currently enrolled. Sustained response districts will not contribute to the PEPFAR MER results of FY 2017.

### **Efficiency Analysis**

PEPFAR supported ART in 165 sites in 2015 with 108 sites located in the scale-up districts. Patient volume analysis in the scale-up districts showed that 80% of the ART patients were seen in 45% (49) of sites. The average patient volume in the remaining 20% (59) sites in the scale-up districts was 321.

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



#### **4.9. Pediatric Treatment**

PEPFAR Lesotho will utilize COP16 base funds to maintain the gains made by the Accelerating Children’s HIV Treatment (ACT) Initiative to double the number of children receiving treatment and expand pediatric ART coverage in the scale-up for saturation districts by the end of 2017. Pediatric ART coverage has improved from 15% at the start of ACT to 40% at the FY 2015 APR.

The GOL has adopted 2015 WHO guidelines for initiating ART and all HIV-infected children are eligible for treatment. Pediatric ART is provided in all the 120 PEPFAR supported sites in the scale-up districts that provide ART to adults. Significant progress has been made with a number of initiatives targeting pediatric HIV, however coverage remains low. PEPFAR remains committed to meeting 80% coverage for pediatric ART by the end of FY 2017 in Lesotho. Children and adolescents living with HIV are part of the 90/90/90 and epidemic control targets.

Key challenges that remain to be addressed include low testing coverage, especially among the 5-14 age group, limited data for final outcomes for HIV exposed children, and confidence among lower health units in initiating children.

In COP16, PEPFAR will continue to support strategies for scaling-up pediatric HIV treatment including intensified case finding, improved community follow-up and linkages, timely initiation, adherence support, and retention. Identification of HIV-infected children will be enhanced by setting aggressive HTC and EID site level targets to test >80% of all children of HIV-infected women receiving PMTCT as well as care and treatment services for all HIV

exposed infants, children with TB disease, malnutrition, children receiving OVC services, and hospitalized children in high HIV burden districts. In COP16, PEPFAR will intensify pediatric HIV case-finding using index patient testing for children of HIV positives adults currently enrolled into care, saturating all key testing points for identifying HIV-infected children in clinical settings. Linkages, adherence, and retention will be enhanced through longitudinal cohort tracking, follow-up, and timely ART initiation of the mother-infant pairs at facility and community levels. Lesotho has recently revised the tools for tracking and documentation of HIV exposed children and COP16 will support their roll-out and utilization to document final HIV status for HIV-exposed children and accurately measure retention in this cohort.

The PEPFAR program will support the MOH to expand and improve HIV treatment of adolescents living with HIV through the expansion of adolescent corners in high-volume sites.

PEPFAR will continue supporting the MOH to optimize the national pediatric ARV regimens. Salary support for additional human resources will be provided to enhance national level oversight of the pediatric ART program, coordinate district-level pediatric scale-up, mentor healthcare workers, and use expert clients/village health teams to improve case finding, strengthen linkages, and retention. At district level, PEPFAR will continue to provide technical support to the 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 QI tools. Clinical monitoring for children and adolescents will be enhanced through support of the sample transport network, procurement of laboratory reagents, HIV drug resistance (HIVDR) monitoring, and quality assurance/quality control of PITC and EID.

#### **4.10 Orphans and Vulnerable Children (OVC)**

The team used the supplemental data pack to derive targets. The targets were calculated to reach 80% saturation in the five scale-up districts assuming a 25% increase from year one to year two. The historical OVC program served 17,484 clients in the scale-up and 28,457 in the sustained districts. The coverage in scale-up district was low, 10% -37%. The FY 2017 target of 48% coverage will serve 89,866 clients in the scale-up districts (URC: 44,597; DREAMS OVC partner: 37,794; Peace Corps: 4,323; and Small Grants: 1,000).

In line with the legislative guidance, the program will support OVC services and interventions to mitigate the impact of AIDS by building the resiliency in children and families and preventing and treating child and adolescent HIV infection. Lesotho is targeting all OVC, not only orphans as deemed vulnerable by the country. The OVC activities will be implemented in scale-up districts where OVC prevalence is also high. The program will intensify targeting by using a case-finding family centered approach to strengthen linkages and referrals. Using a case management approach, OVC interventions will be located close to clinical services and used as a platform to improve targeting of HIV positive children, adolescents, and their caregivers to access HIV prevention and care and treatment services.

Specifically, this will leverage the scale up efforts of ACT and DREAMS which substantially overlap with both the OVC and care and treatment programs within the five scale-up districts. These Orphans and Vulnerable Children (OVC) will receive support from the PEPFAR Lesotho program to link them to care and ART enrollment. There will be similar linkages across other program efforts as well. ACT and DREAMS will leverage OVC platforms that will use a family based case management approach to identify beneficiaries to be linked to services. OVC partners will also implement DREAMS OVC core package in the non-DREAMS districts.

PEPFAR Lesotho has two new implementing partners for the OVC portfolio who are yet to undergo SIMS assessments. Previous SIMS assessments identified insufficient documentation as an area for improvement. This will be emphasized with the new IPs.

The OVC portfolio will address the following PEPFAR gender analysis recommendations: engage men and boys in taking control of their health, including through addressing gender-based constraints to HIV testing and counseling; implement comprehensive gender-based violence prevention and response programs and services; and integrate gender across all community-based interventions.

Social welfare systems strengthening investments will focus on enhancing the chain of referral and service provision for the management of child related GBV cases. The program will build capacity of the Child and Gender Protection Unit, health workers, and the Sedibeng GBV Center for this purpose. Further, PEPFAR will support district child protection teams for a better-coordinated referral system at district level.

## 5.0 Program Activities in Sustained Support Locations and Populations

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### 5.1. Maintenance package of services in other locations and populations

PEPFAR Lesotho has defined the maintenance package as a core package of services and support that PEPFAR will continue in COP 2016 for HTC, PMTCT, and ART at district level in the sustained response districts. PEPFAR determined that five low HIV burden districts (Butha-Buthe, Mokhotlong, Quthing, Qacha's Nek, and Thaba-Tseka) will not be prioritized for accelerated epidemic control and will receive no site level support. Based on APR 2015 data, these districts serve 19% (23,972) of the total PLHIV receiving ART in Lesotho and have 57 health units. Site level support in these districts was transitioned to the GOL in FY 2016. The sustained districts will only receive above site support at district level.

PEPFAR support will focus on building the capacity of the DHMTs to oversee and monitor the quality of clinical and laboratory services for PLHIV currently enrolled in PMTCT and care and treatment. All PEPFAR support in the sustained districts will be at the above site level. PEPFAR

implementing partners will use a technical assistance model limited to the DHMTs and quarterly joint support supervision. The DHMT will monitor the quality of services through the use of quality assurance (QA) benchmarks that include adherence and retention on treatment. The DHMTs will conduct quarterly support supervision visits to the sites to monitor the QA benchmarks and bi-annual district learning sessions with health unit in-charges will be held. Joint monthly partner and DHMT performance review meetings will be held to address key issues from site support supervision and data validation reports. In these meetings, new QA projects will be identified for rollout in addition to the site-specific QA projects. For sites that have significant quality gaps, the DHMT will be assisted to provide mentorship.

PEPFAR Lesotho will support the two on-going research studies and cohort assessments in the sustained response districts: (i) completion of the final phase of the PMTCT effectiveness cohort assessment in Thaba Tseka and Butha-Butha districts that has been tracking the 18-month MTCT and health outcomes of infants born to PMTCT mothers in the 2014 cohort and (ii) the OVC Special Initiative for early childhood development being implemented in Mokhotlong district primarily for the promotion of HTC and confirmatory HIV testing.

Site level support for HTC, PMTCT, ART, OVC, and VMMC services was transitioned to the GOL in FY 2016. PEPFAR will not support any demand creation for testing. Existing non-PEPFAR supported condom distribution programs will be maintained, but PEPFAR will not support local condom promotion programs. Sustained districts will not contribute to COP16 MER 2.0 targets.

## **5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations**

Discussions took place prior to and during early FY 2016 with GOL, district governments, and other stakeholders (i.e., Global Fund and CSOs) to facilitate the transition of PEPFAR support to priority locations and populations.

PEPFAR support has been transitioned from the low or no yield HTC sites and from PMTCT sites without ART patients in scale-up districts. PEPFAR-supported PMTCT services in the sustained districts have been transitioned to GOL during FY 2016. ART sites in sustained districts have been transitioned to GOL in FY 2016. OVC services in sustained districts have been transitioned to GOL in FY 2016.

VMMC sites in sustained districts have been transitioned to GOL in FY 2016. PEPFAR support has been transitioned out of 127 low yield sites in the scale-up districts to 6 static and outreach sites in the scale-up districts with focused demand creation and active referral of clients testing positive into treatment.

PEPFAR has transitioned specific site and district-level lab activities in the sustained districts, but will continue to provide quality assurance support until there is sufficient level of confidence that this will no longer be necessary. Support is provided at the national-level for supply chain management and for sample transport.

## 6.0 Program Support Necessary to Achieve Sustained Epidemic Control

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### **6.1 Critical Systems Investments for Achieving Key Programmatic Gaps**

In an attempt to identify the systems level investments support critical to reaching 90/90/90 and epidemic control, the PEPFAR Lesotho team utilized sub-national level FY 2016 Q1 program results to identify the three program gaps and stipulate the core activities to resolve the gaps. The three program gaps identified by the team include (i) identifying positives, (ii) improving treatment initiation, and (iii) improving treatment retention in the five PEPFAR scale-up districts.

Table 6.1.1, 6.1.2, and 6.1.3 provides more details and descriptions of each programmatic gap, the associated activities to address the gaps in COP16, and the expected three year outcomes.

### 6.1.1 Programmatic Gap #1: Low number of HIV+ persons identified in 4 of 5 scale-up districts

The PEPFAR Lesotho team utilized HTC program results for FY 2016 Q1 to determine the program gaps in the first 90 of the clinical cascade in the five scale-up districts. In an ideal situation all the five scale-up districts should have been at 25% of the annual targets by the end of quarter one. The MER results show that only Maseru (25%) had achieved the results. The remaining districts achieved the following results: Leribe (13%), Berea (9%), Mafeteng (20%), and Mohale’s Hoek (21%).

Table 6.1.1 Key Programmatic Gap #1: Low number of HIV+ persons identified in 4 of 5 scale-up districts						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16 Activities	Activity Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
1. Inadequate numbers of health workers –Counselors to scale-up high yield HIV testing services:	<ol style="list-style-type: none"> <li>Achieve 80% coverage of HTS in all PITC service points</li> <li>90% of the priority population know their HIV status</li> <li>80% of family members of HIV positive people in care should know their HIV status</li> </ol>	Activity 1 Recruit 44 additional counselors for the 22 high volume sites	\$580,800	HTXS	17401 and 18020	7. Human Resources for Health (Score 5.75)
		Activity 2 Increased supervision and mentorship of counselors				17401 and 18020
		Activity 3. Recruit additional mobilizers for increased uptake of community HIV testing services.	\$258,000	HVCT	17401, 18020, and 18227	7. Human Resources for Health (Score 5.75)
2. Inadequate tracking of bi-directional referrals at facility and community levels	<ol style="list-style-type: none"> <li>90% of all identified HIV positives are successfully linked into care</li> <li>90% of the HIV patients start on ARV are retained on treatment</li> </ol>	Activity 1. Procure mHealth tracking system for bi-directional case referrals	\$450,000	HTXS	17401 and 18020	13. Epidemiological and health data (Score 6.01)
		Activity 2. Train counselors on how to use the mHealth referral system				7. Human Resources for Health (Score 5.75)
<b>TOTAL</b>			\$1,288,800			

### 6.1.2 Programmatic Gap #2: Low numbers of HIV+ persons initiating treatment in all the five scale-up districts

The PEPFAR Lesotho team used treatment initiation program results for FY 2016 Q1 to determine the program gaps in the second 90 of the clinical cascade in the five scale-up districts. In an ideal situation, all five scale-up districts should have been at 25% of the annual targets by the end of quarter one. The MER results show that none of the five scale-up districts achieved the expected results by the end of FY 2016 quarter one. The five districts achieved the following results: Maseru (10%), Leribe (10%), Berea (10%), Mafeteng (12%), and Mohale’s Hoek (10%).

Table 6.1.2 Key Programmatic Gap #2: Low numbers of HIV+ persons initiating treatment in all the five scale-up districts						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16 Activities	Activity Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
1. Inadequate numbers of health workers to link PLHIV to treatment services	<ul style="list-style-type: none"> <li>90% linkage across all service outlets to meet saturation targets</li> </ul>	Activity 1. Recruit 120 linkage coordinators for treatment services and expert patients for CHTS and PITC.	\$1,000,000	HTXS	17401 and 18020	7. Human Resources for Health (Score 5.75)
		Activity 2. Recruit 44 nurses for treatment services.	\$897,600	HTXS	17401 and 18020	7. Human Resources for Health (Score 5.75)
2. Inadequate real-time monitoring of actual linkages along the clinical cascade.	<ul style="list-style-type: none"> <li>100% of the PEPFAR supported sites utilize the unique patient identifier system to track patients.</li> <li>90% of all identified HIV positives are successfully linked into care</li> <li>90% of the HIV patients start on ARV are retained on treatment</li> </ul>	Activity 1. Utilization and initiation of Unique Identifiers for all patients	\$25,000	HVSI	17123	13. Epidemiological and Health data (Score 6.01)
		Activity 2. Utilize mHealth systems to track patients	Funding under 6.1.1: mHealth is funded as a package to address programmatic gaps across the clinical cascade	HTXS	17401 and 18020	13. Epidemiological and Health data (Score 6.01)
		Activity 3. Train Linkage Coordinators and nurses on how to use the mHealth system to track patients initiating treatment.				7. Human Resources for Health (Score 5.75)
<b>TOTAL</b>			\$1,922,600			

### 6.1.3 Programmatic Gap #3: Low number of HIV+ persons retained on treatment in 2 of 5 scale-up districts

The PEPFAR Lesotho team used treatment retention program results for FY 2016 Q1 to determine the program gaps in the third 90 of the clinical cascade in the five scale-up districts. The HTC to treatment linkage target in all five scale-up districts was set at 60% in FY 2016. The MER results show that three of the five scale-up districts achieved the expected results by the end of FY 2016 Q1. The five districts achieved the following results: Maseru (55%), Leribe (72%), Berea (108%), Mafeteng (69%), and Mohale's Hoek (52%).

Table 6.1.3 Key Programmatic Gap #3: Low number of HIV+ persons retained on treatment in 2 of 5 scale-up districts						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16 Activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
1. Inadequate health workers for retention support and reporting	1. Increased 12-month retention at 90% 2. ART patient cohort reports for 12, 24, and 36 months	Activity 1. Recruit 44 adherence counselors to enhance retention	HTXS	\$580,000	17401 and 18020	7. Human Resources for Health (Score 5.75)
		Activity 2. Mentor lower cadres of counselors and clients on treatment literacy				7. Human Resources for Health (Score 5.75)
		Activity 3. Recruit 132 data clerks for cohort monitoring and DHIS2 site level reporting	HTXS	\$500,000	17401 and 18020	7. Human Resources for Health (Score 5.75)
2.Lack of tracking systems for patient transfers: mHealth to enhance retention	1. Increased 12-month retention at 90% 2. ART patient cohort reports for 12, 24, and 36 months	Activity 1. Utilize mHealth to track patients and report retention	HTXS	Funding under 6.1.1: mHealth is funded as a package to address programmatic gaps across the clinical cascade	17401 and 18020	13. Epidemiological and health data (Score 6.01)
		Activity 2. Train adherence counselors and data clerks on how to use the mHealth system.				7. Human Resources for Health (Score 5.75)
3.Inadequate inventory control: system for ARVs and laboratory commodities	1. 90-90-90 achieved by 2017 in the five districts	Activity 1. Align ARV commodity forecasting and ordering with extended and off-site refills	HTXS	\$600,000	17401 and 18020	8. Commodity Security and supply chain (Score 6.32)
		Activity 2. Align laboratory commodities forecasting and ordering with Test and Start requirements/ demands.	HTXS, PDTX, HVTB	\$50,000	17432	8. Commodity Security and supply chain (Score 6.32)
<b>TOTAL</b>				<b>\$1,730,000</b>		

## 6.2 Critical Systems Investments for Achieving Priority Policies

Table 6.2.1 provides the systems barriers, primary outcomes in three years and activities proposed for COP 2016. The content is based on gaps identified in the treatment and prevention cascade and data made available through the SID, Data Pack, PBAC, and other data sources. Table 6.2.2 describes the new service delivery approaches that are proposed.

Table 6.2.1 Test and Start						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16 Activities	Activity Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
1.Lack of adoption of a national policy on Test and Start	1. Lesotho National ART guidelines based on WHO's 2015 ART guidelines (Test and Start)	Activity 1. Implementation of feasibility and readiness assessment for test & start	\$50,000	HTXS	18235	2. Policies and Governance (Score 3.04)
		Activity 2. Revision of National Treatment Guidelines to incorporate test & start procedures	\$25,000	HTXS	17401 and 18020	2. Policies and Governance (Score 3.04)
		Activity 3. Train sites and staff on the new test & start policy, guidelines and SOPs	\$100,000	HTXS		2. Policies and Governance (Score 3.04)
2.Lack of commodity security for ARVs and laboratory commodities in high volume sites	1. 100% of all PEPFAR supported facilities report no stock-outs for all HIV-related commodities.	Activity 1. Recruit pharmacists in high volume sites to ensure ARV commodity security	\$250,000	HTXS	17401 and 18020	7. Human Resources for Health (Score 5.75)
		Activity 2. Support the MOH with direct delivery of lab commodities to high volume sites	\$100,000	HTXS, HVTB	17432	8. Commodity Security and supply chain (Score 6.32)
		Activity 3. Support the MOH transport viral load samples to the nearest laboratory	\$100,000	HTXS, PDTX	17431	6. Service Delivery (Score 4.81)
3.Lack of adequate laboratory infrastructure to rapidly scale-up viral load monitoring	1. Viral load monitoring capacity improved in all the 5 scale-up districts. 2. Routine viral load monitoring coverage increased to 100% and the third 90 targets achieved.	Activity 1. Support the MOH to set-up districts/regional laboratories	\$150,000	HTXS, PDTX	17431	10. Laboratory (Score 4.17)
		Activity 2. Support the MOH recruit laboratory technicians to work in the districts/regional laboratories	\$75,000	PDTX, HTXS	17431	7. Human Resources for Health (Score 5.75)
<b>TOTAL</b>			<b>\$850,000</b>			

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16 Activities	Activity Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
1. Lack of adequately trained health workers for Community Based Care Treatment Support (CBCTS) services	1. 90% of patients initiated on ART in the five districts are retained in Care and Treatment. 2. The five scale-up to saturation districts achieve 80% coverage for pediatric and adult ART. 3. Reduced TB/HIV related mortality	Activity 1. Recruit and train CHWs to implement extended and off-site drug refills	\$200,000	HTXS, PDTX	17401 and 18020	7. Human Resources for Health (Score 5.75)
		Activity 2. Expand CAGs, ART outreaches and mobile clinics in high volume community sites.				6. Service Delivery (Score 4.81)
		Activity 3. Expand supervision, mentorship and monitoring of CHWs in community settings outside health units				6. Service Delivery (Score 4.81)
2. Limited access to HIV and AIDS services due to rigid health facility working hours and service delivery models.	1. 90% of patients initiated on ART in the five districts are retained in Care and Treatment. 2. The five scale-up to saturation districts achieve 80% coverage for pediatric and adult ART. 3. Reduced TB/HIV related mortality	Activity 1. Support the MOH implement flexible working hours, including weekends	\$500,000	HTXS, PDTX	17401 and 18020	6. Service Delivery (Score 4.81)
		Activity 2. Support the MOH implement extended clinic visits (6-12 months for stable patients)				6. Service Delivery (Score 4.81)
		Activity 3. Support the MOH to train staff and CHWs in the new service delivery models.				7. Human Resources for Health (Score 5.75)
3. Lack of a CBCTS patient tracking and monitoring system.	1. 100% of all the community councils submit community facility monitoring reports	Activity 1. Utilize mHealth to track patients and report retention for CBCTS services	\$100,000	HTXS	17401 and 18020	13. Epidemiological and health data (Score 6.01)
		Activity 2. Train CHWs and data clerks on how to use the mHealth system for CBCTS services.				7. Human Resources for Health (Score 5.75)
<b>TOTAL</b>			<b>\$800,000</b>			

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

Table 6.3 includes all other system investments proposed for COP16 not included in either 6.1 or 6.2. The information provided describes how each activity is essential in reaching the 90/90/90 targets or achieving a sustainable national HIV program.

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	Activity	Does the activity address: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
HRH - Systems/Institutional Investments							
1. Human Resources for Health - Nurses	2. Support the Lesotho Nursing Council credential 600 nurses and accredit 121 NIMART sites in the 5 scale-up districts. 3. Annually Monitor HIV and AIDS skills CPD performance for all nurses in the 5 scale-up districts.	<i>1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> 90s</i>	600 nurses working in NIMART sites credentialed to provide same day HIV and AIDS test & start services  121 NIMART sites accredited to provide same day HIV and AIDS test & start services	\$109,873	OHSS	17549	7. Human Resources for Health (Score 5.75)
Inst & Org Development							
1. Civil Society Capacity strengthening	2. Six (6) community based organizations strengthened to provide CBCTS services 3. Six (6) local community based organizations strengthened in Monitoring and evaluation and reporting	<i>1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> 90s</i>	100% (six) of the local community based organizations strengthened to provide CBCTS services in the 5 scale-up districts.	-	-	Centrally Funded Mechanism: AIDSFREE	6. Service Delivery (Score 4.81)
Laboratory							
1. Support Laboratory Quality system and Biosafety: Continuous Quality Improvement (CQI) and	1. Strengthening the implementation of Continuous Quality Improvement (CQI) and Proficiency Testing (PT) program in clinical laboratories and Point of	<i>First 90:</i> Implementation of quality assured HIV diagnosis (HIV RT and EID) contributes to first 90 targets.  <i>Second 90:</i> Provision	Standardized and quality assured laboratory services (EID, VL and TB diagnosed) and tests are provided.  All 18 clinical laboratories are certified by ASLM	\$217,364	HLAB, HVCT, HVTB, HTXS, PDTX, PDCS, MTCT	17431 and 17432	10. Laboratory (Score 4.17)

<p>Proficiency Testing (PT) program</p>	<p>Care (POC) sites</p> <ol style="list-style-type: none"> <li>2. National Lab QA program supports facilities by developing/revising guidelines and SOPs</li> <li>3. Preparation and distribution of quality control and proficiency panels for key diagnostic and monitoring tests in 18 hospitals and 216 health centers</li> <li>4. Quarterly site visit and supportive supervision of 11 district hospital laboratories.</li> <li>5. Prepare certification and accreditation of national reference lab and National Blood Bank.</li> <li>6. Implement QA plan in HIV testing including role out HIV Rapid Testing Quality Improvement Initiative (RTQII)</li> <li>7. Support Strengthening of Laboratory Management Towards Accreditations (SMLTA) and certify 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</li> </ol>	<p>of quality laboratory HIV and diagnostic services ensures access to treatment.</p> <p><b>Third 90:</b> Increasing access to quality routine VL contributes to achieving the third 90.</p> <p><b>Sustained epidemic control:</b> Building sustainable local accredited laboratory facility contributes to sustain epidemic control.</p>	<p>using WHO SLIPTA check list by ASLM</p> <p>National Reference Laboratory accredited</p>				<p>10. Laboratory (Score 4.17)</p>
<p>2. Sample transport referral system</p>	<p>8. Strengthen the local referral networks through tiered lab services:</p>	<p><b>First 90:</b> Increases access to EID and contributes to</p>	<p>Local capacity developed and effective sample transport and referral</p>	<p>\$340,000</p>	<p>HVTB, HBHC, HTXS, PDCS,</p>	<p>17431 and 17432</p>	<p>10. Laboratory (Score 4.17)</p>

	<p>national, district and health levels</p> <p>9. Support sample transport and referral testing services</p> <p>10. Strengthen sample tracking and results reporting system with the reduction in turnaround time.</p>	<p>identifying infants to link to treatment.</p> <p><b>Second 90:</b> Increase access to TB and OI diagnosis and link them to care and treatment.</p> <p><b>Third 90:</b> Will increase access to VL monitoring of patients on ART.</p> <p><b>Sustained Epidemic Control:</b> Strengthening the local referral network will increase access to disease monitoring, care and treatment.</p>	<p>network established</p> <p>Functional sample tracking and reporting system in place where samples are tracked and results accessed at facility and reference laboratory levels</p>		PDTX, MTCT, HLAB		
3. Laboratory Information (LIS) and M&E System	<p>11. Support the maintenance of electronic based LIS implemented in reference and 18 clinical laboratories.</p> <p>12. Interface referral test result reporting system (SMS printers) with LIS.</p> <p>13. Establish national database for test repository, analyze and report on quarterly basis laboratory data, monitoring and evaluation.</p>	<p><b>1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> 90s:</b> Implementation of standardized and efficient lab result recording and reporting is critical to scale up services and monitor performance for planning and decision making. This contributes to achieve 90/90/90 targets. In addition, the availability of quality data also contributes to epidemic control.</p>	<p>Quality data generated and used for planning and decision making</p>	\$100,000	HLAB, HVTB, HTXS, PDTX, MTCT, HVSI	17431 and 17432	10. Laboratory (Score 4.17)
4. Human Resource and Training Support	<p>14. Recruit, train, and retain lab technologists and data clerks to support HIV diagnostic and monitoring testing services.</p> <p>15. Assess the training needs and prepare and/revise in-training curriculum.</p> <p>16. Conduct refresher training</p>	<p><b>1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> 90s:</b> Trained and skilled laboratory personnel and counselors are critical to scale up and provide quality care which contributes to achieving first, second and third 90.</p>	<p>Gaps in HR addressed, trained and qualified personnel deployed at hospital and reference laboratories</p>	\$180,000	HLAB, HVTB, HTXS, PDTX, PDCS, MTCT, OHSS	17431 and 17432	10. Laboratory (Score 4.17)

	on biosafety, laboratory quality management system, laboratory operation HIV diagnosis, (EID/VL, TB diagnosis).						
5. Laboratory equipment procurement and maintenance system	<p>17. Make an inventory and purchase critical lab equipment.</p> <p>18. Develop and/or revise guidelines and SOPs for maintenance services for major lab equipment.</p> <p>19. Implement preventive and routine maintenance.</p> <p>20. Development and enforcement of service contract with manufacturers or vendors for Roche Cobas, GeneXpert, MGIT, CD4 Machines (FacsCount/FacsCaliber), VL machines, Biosafety cabinet).</p>	<i>1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> 90s:</i> The availability of standardized and functional lab equipment plays a major role in timely provision of diagnostic and monitoring tests for achieving 90-90-90.	National equipment management and maintenance system.	\$220,000	HLAB, HVTB, HTXS, PDTX, PDCS, MTCT	17431 and 17432	10. Laboratory (Score 4.17)
6. Lab diagnostic and monitoring reagents and supplies	<p>21. Quantification and procurement of reagents and consumables for TB &amp; HIV diagnosis and patient monitoring and distribution to sites</p> <p>22. Lab testing performed for TB and HIV diagnosis of patients, and monitoring of patients on care and ART</p> <p>23. Scale up of services through decentralization of VL monitoring at two regional laboratories</p>	<p><i>First 90:</i> Increases access to EID and contributes to identifying infants to link to treatment.</p> <p><i>Second 90:</i> increase access to TB and HIV diagnosis and link them to care and treatment.</p> <p><i>Third 90:</i> will increase access to VL monitoring of patient on ART</p> <p><b>Sustained Epidemic Control:</b> Strengthening the local capacity in lab supply management system</p>	<p>Local capacity developed in quantification and distribution of laboratory commodities established</p> <p>Sustainable TB and HIV and treatment monitoring tests are provided with no interrelation of services</p>	\$5,639,180	HVTB, HTXS, PDCS, PDTX, MTCT, HLAB	17431 and 17432	8. Commodity Security and Supply Chain Laboratory (Score 4.17)

		will enable to increase access to disease monitoring, care and treatment.					
Strategic Information							
1. Review of the current EMR system	MOH has asked for PEPFAR's support to review the EMR for overall quality, ease of use, and applicability to the healthcare system. Outcome of this review will be either: <ol style="list-style-type: none"> <li>Changes to the current EMR system to improve use</li> <li>Abandonment of current system in favor of more user friendly system</li> </ol>	<i>1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> 90s</i>	<ol style="list-style-type: none"> <li>Decision on which EMR to support in Lesotho</li> <li>Develop of EMR system with Lesotho specific indicators</li> <li>Increased use of EMR in facilities</li> </ol>	\$25,000	HVSI	17123	13. Epidemiological and Health Data (Score 6.01)
2. DHIS2	<ol style="list-style-type: none"> <li>Rollout of DHIS2 to site level</li> </ol>	<i>1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> 90s</i>	<ol style="list-style-type: none"> <li>Availability of site level indicators</li> <li>Improved timeliness and quality of data reported</li> <li>Better understanding of both overall HIV epidemic and the success of PEPFAR and MOH in achieving targets</li> </ol>	\$736,640	HVSI	17123	13. Epidemiological and Health Data (Score 6.01)
Systems Development							
1. Commodity Security and Supply Chain	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: <ol style="list-style-type: none"> <li>Quantification, forecasting and supply planning for HIV and AIDS including ARVs and laboratory commodities.</li> <li>Appropriate warehousing</li> </ol>	<i>1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> 90s</i>	<ol style="list-style-type: none"> <li>120 sites in the five scale-up to saturation districts have 100% commodity security for all Test and Start commodities.</li> </ol>	\$2,000,000	OHSS, HTXD,	18048	8. Commodity Security and supply chain (Score 6.32)

	<ul style="list-style-type: none"> <li>and inventory control for all HIV and AIDS commodities</li> <li>3. Establish a functional LMIS for HIV and AIDS commodities</li> <li>4. Review current SCM SOPs and re-engineer process for efficient procurement of HIV and AIDS commodities for Test and Start.</li> </ul>						
<b>TOTAL</b>							\$9,543,057

\*Reference Appendix C for a list of activity types that fit in each category.

## 7.0 Staffing Plan

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The PEPFAR Lesotho team conducted an initial 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 team began in COP15 and is continuing to implement in COP16. The following factors were key in the staffing analysis undertaken by PEPFAR Lesotho: the administration and management burden of the PEPFAR business practices (such as SIMS, POART, COP, and SID) and the programmatic pivot the PEPFAR Lesotho program has taken in order to meet the FY 2017 ART targets in the five scale-up to saturation districts. This programmatic pivot cannot continue without finalizing the COP15 staffing recruitment as COP 2016 continues to require more active, hands-on management of PEPFAR partners, as well as more frequent and multi-layered engagement with GOL, the newly established NAC, and the Global Fund.

As of April 2016, PEPFAR Lesotho will have three vacant positions: one with USAID, one with CDC, and one with Department of State. For USAID, the candidate has been identified and will begin work on May 2<sup>nd</sup>. For CDC, the candidate has been identified and is undergoing medical and security clearances. For Department of State, recruitment will occur through the month of April with the aim of getting someone on board by the end of May 2016.

In COP16, PEPFAR Lesotho is proposing one additional position: an interagency Site Improvement and Monitoring System (SIMS) Coordinator. The SIMS Coordinator will lead interagency implementation of the SIMS program within the PEPFAR Coordination Office. The SIMS Coordinator will coordinate the planning for SIMS visits, including motor pool requests for the visits, preparation of the tools, and communication with the implementing partner. The SIMS Coordinator will work with each PEPFAR agency to ensure it is fulfilling its required SIMS visits and reporting requirements each quarter. Currently, the PEPFAR Lesotho team is finalizing the position description with hopes that the position can be classified and begin recruitment by FY 2017.

Factors that may change the cost of doing business in the next cycle include the additional staff position and guidance shift to allocated time spent on partner management to the HVMS budget code. During FY 2017, the PEPFAR Coordinator position is expected to shift to an LNA position within the Department of State. The USAID Regional HIV/AIDS Program (RHAP) has also increased the ICASS costs for PEPFAR Lesotho. In addition, the growing SIMS requirements may result in an increase in ICASS costs due to use of motorpool and driver staff time.

# APPENDIX A

**Table A.1 Program Core, Near-core, and Non-core Activities for COP 16**

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	<p><b>OVC</b></p> <ul style="list-style-type: none"> <li>Establishing and facilitation of linkages and referral systems</li> <li>Registration of vulnerable children</li> <li>Parenting programs</li> </ul> <p><b>ADULT AND PEDIATRIC TREATMENT</b></p> <ul style="list-style-type: none"> <li>Offer Test and Start to all PLHIV</li> <li>Same-day ART initiation if ready for treatment</li> <li>Mop-up Pre-ART initiation on treatment</li> <li>Enhance treatment initiation of HIV positive family members of patients currently on ART</li> <li>Adherence counseling and support</li> <li>Multi-month dispensing of ART for stable patients</li> <li>Expanded clinic visits to 1,3,6,12 months based on patient category i.e. newly initiated on treatment, stable or unstable</li> <li>Home-based and weekend delivery of ART</li> <li>Quality improvement along the HIV Clinical Cascade</li> <li>Facility linkage coordinators to enhance intra- and inter-facility linkages and facility-community referrals linkages</li> <li>mHealth technology for SMS reminders on appointments, lab results and treatment and prevention literacy.</li> <li>Active community follow-up using the appointment registers and tracking tools</li> <li>Community Adherence Groups</li> <li>Strengthen the ART filing system to enable active tracking and reporting of patient-level data</li> <li>Training of clinicians in Viral Load monitoring of ART and result interpretation</li> </ul> <p><b>ADULT AND PEDIATRIC CARE AND SUPPORT</b></p> <ul style="list-style-type: none"> <li>Prevention and treatment of opportunistic infections (e.g. Cotrimoxazole prophylaxis, Cryptococcal meningitis)</li> <li>PHDP Services i.e. STI screening and management, voluntary FP services,</li> <li>Condoms, and adherence counseling and support</li> </ul> <p><b>TB/HIV INTEGRATION:</b></p> <ul style="list-style-type: none"> <li>Intensify TB case finding among PLHIV in ART clinics, MNCH, correctional facilities, factories, mines, and health care facilities.</li> <li>TB diagnosis with GeneXpert to increase TB notification rates</li> </ul>	<p><b>ADULT AND PEDIATRIC TREATMENT</b></p> <ul style="list-style-type: none"> <li>Hepatitis B screening and management</li> <li>Cervical cancer screening and management for women living with HIV/AIDS</li> </ul> <p><b>TB/HIV INTEGRATION:</b></p> <ul style="list-style-type: none"> <li>Address TB in high-risk groups (i.e., children, contacts of index clients, prisoners, migrants, minors, and factory workers)</li> <li>Regional issues for TB and HIV treatment on cross-border management to maintain screening and cross-border referrals for TB and ART clients</li> </ul> <p><b>NUTRITION SERVICES FOR PLHIV (NACS)</b></p> <ul style="list-style-type: none"> <li>Therapeutic and supplementary feeding services of moderately malnourished PLHIV</li> <li>Policy and guideline development for nutrition in HIV</li> <li>Commodity procurement of therapeutic and supplementary foods (this is provided by the Global Fund and World Food Program)</li> </ul> <p><b>PMTCT AND EID</b></p> <ul style="list-style-type: none"> <li>Risk reduction counseling and re-testing within MNCH</li> <li>Integration of FP within ART and MNCH settings</li> <li>Training and mentorship of health workers in PMTCT</li> <li>Integrated TB/HIV services in MNCH settings</li> <li>Postnatal care to improve mother baby pair follow-up</li> </ul> <p><b>VMMC</b></p> <ul style="list-style-type: none"> <li>Focused age pivot (15-29yrs.) demand creation</li> </ul>	<p><b>ADULT AND PEDIATRIC TREATMENT</b></p> <ul style="list-style-type: none"> <li>Task sharing for nurse-led ART service delivery</li> <li>Support to Village Health Workers to escort patients to treatment services</li> </ul> <p><b>ADULT AND PEDIATRIC CARE AND SUPPORT</b></p> <ul style="list-style-type: none"> <li>Home-based care</li> <li>Psychosocial support</li> <li>CD4 testing and procurement of reagents and supplies commodities</li> </ul> <p><b>TB/HIV INTEGRATION:</b></p> <ul style="list-style-type: none"> <li>Procurement of anti-TB drugs</li> <li>Procurement of additional GeneXpert Machines</li> </ul> <p><b>PMTCT AND EID</b></p> <ul style="list-style-type: none"> <li>Task sharing for nurse-led ART service delivery in MNCH/PMTCT</li> <li>Support to Village Health Workers to escort patients to treatment services</li> <li>Procurement of RTKs, ARVs, Cotrimoxazole, OI drugs, amphotericin B, fluconazole, therapeutic and supplementary foods</li> <li>Expand the range of FP services provided to WLHIV</li> </ul> <p><b>VMMC</b></p> <ul style="list-style-type: none"> <li>DSD EIMC in districts with &gt;60% adolescent/adult coverage</li> </ul> <p><b>LABORATORY</b></p> <ul style="list-style-type: none"> <li>Major renovations/ construction of labs</li> </ul> <p><b>BLOOD SAFETY</b></p> <ul style="list-style-type: none"> <li>Human Resources</li> <li>Infrastructure and Policy</li> <li>Collection and screening of blood for HIV, HBV, HCV and Syphilis</li> <li>Storage and distribution</li> <li>Appropriate clinical use of blood</li> <li>Donor recruitment, notification and linkage</li> </ul>

- Detect and treatment all MDR cases early
- IPT provision in all scale up sites
- Test and Start for HIV-positive TB patients.
- TB infection control (IC) measures at site level including provision of N95 respirators, and coordination of TB IC committees.
- Quality Improvement of TB prevention and treatment cascade i.e. TB intensive case finding cascade, monitoring of gene GeneXpert implementation, TB infection control in care settings
- Ensure engagement and retention of all PHLIV through mobile technology such as SMS reminders in scale-up districts
- Active community follow-up for TB contact tracing, case identification and DOTS

#### **NUTRITION SERVICES FOR PLHIV (NACS)**

- Nutrition assessment, categorization of adults and children on ART
- Growth monitoring of all children living with HIV
- Counseling of care givers on optimal infant and young child feeding
- Nutrition equipment procurement
- Job aides for nutrition

#### **PMTCT AND EID**

- Increasing uptake of HTS services for pregnant and lactating mothers and their partners
- Option B+ to HIV-positive pregnant women and lactating mothers in ANC, labor and delivery
- ARV prophylaxis to HIV exposed infants (HEI)
- Support VL monitoring for pregnant and lactating mothers on ART
- EID testing by 8 weeks of age and ensure receipt of results by care givers
- Cotrimoxazole prophylaxis to PMTCT mothers and their HEI
- Adherence support and counseling for pregnant and lactating mothers on ART.
- Community demand creation for ANC-1 and PMTCT uptake
- Community linkages and referral for ART for pregnant and lactating mothers
- Collaborative quality improvement along the PMTCT-EID cascade
- Active follow-up of mother-infant pairs at community level
- Additional HR to improve service delivery

#### **VMMC**

- DSD at six static sites and outreach/mobile services; Scale-up PrePex services; HIV+ referrals to treatment and care

#### **HTC**

- Implement 'HTC triage' at OPD to improve coverage for

#### **LABORATORY**

- Minor renovation or refurbishment of lab
- Procurement of ancillary equipment e.g. centrifuges
- Implementation of SLMTA: Site level mentorship and supervision

#### **BLOOD SAFETY**

- Technical assistance to assess and improve quality management systems with the goal of attaining national blood service-specific accreditation

	<p>HTC</p> <ul style="list-style-type: none"> <li>• Implement routine opt-out HIV testing in priority settings (ART, MNCH/PMTCT, TB, nutritional corners, OVC settings, and pediatric inpatient wards)</li> <li>• Develop family tree using OVC child and pediatric patients for index testing both in community &amp; facility settings</li> <li>• Site improvement monitoring and supervision</li> <li>• Link testing and counseling with clinical and community interventions, improve referrals to TB and STI screening, management, FP services, psychosocial support, and ART</li> </ul> <p><b>LABORATORY</b></p> <ul style="list-style-type: none"> <li>• Sample collection, HIV rapid testing, and TB diagnosis.</li> <li>• Facility based equipment maintenance services.</li> <li>• EQA/PT support for HIV rapid test AFB, GeneXpert TB, and CD4 tests.</li> <li>• Hiring critical lab staff including lab data clerks to support lab services at hospital and health center labs.</li> </ul>		
Sub-national level	<ul style="list-style-type: none"> <li>• Effective integration of PMTCT, treatment and child survival activities.</li> <li>• Referrals will be supported through active linkages between clinics, NGOs, and community-based organizations to support case finding, treatment retention, and adherence.</li> <li>• Data collection that monitors clients in community care reach, test, treat, and retention</li> <li>• In-service training and mentorship of service providers on the new WHO policy guidelines</li> <li>• Data validation of HIV clinical cascade results</li> <li>• Support supervision of the HIV prevention, care and treatment services</li> <li>• Decentralization of systems for the management of treatment failure</li> <li>• Integrate quality improvement along the clinical cascade</li> <li>• Quarterly learning sessions with all stakeholders</li> <li>• Support the national transport for EID and VL</li> <li>• Coordination of VMMC services</li> <li>• Strengthen EID services and address bottle necks</li> <li>• Design adolescent specific HTC outreaches in selected locations</li> <li>• Support all districts and sites to improve the quality of services through institutionalized QI approaches</li> <li>• Develop family tree using OVC child and pediatric patients for index testing both in community &amp; facility settings</li> <li>• Viral load and EID testing at regional lab</li> </ul>	<ul style="list-style-type: none"> <li>• Data sharing</li> <li>• Policy dissemination to sites and stakeholders at district level</li> <li>• Quarterly program performance reviews with national stakeholders and implementers</li> <li>• School and community campaigns; Strengthened referrals from HCT to VMMC sites; School and community campaigns; Medical-Traditional circumcision collaborations; Male sexual partners characterization of AGYW</li> <li>• Mentorship, supervision, and in-service training</li> </ul>	<ul style="list-style-type: none"> <li>• EIMC TA</li> <li>• Pre-Service Training</li> <li>• Renovation/construction of regional labs or blood banks</li> </ul>
National level	<ul style="list-style-type: none"> <li>• M&amp;E</li> <li>• Access to government cash grants</li> <li>• Policy revision to adopt the 2015 WHO treatment and TB guidelines</li> <li>• Updating training curricular and job aides</li> <li>• Procure additional GeneXpert cartridges in scale-up districts</li> <li>• TB surveillance and M&amp;E systems for TB/HIV activities.</li> <li>• Data quality assurance of HIV/AIDS prevention, care and</li> </ul>	<ul style="list-style-type: none"> <li>• Data sharing</li> <li>• National coordination of the HIV/AIDS response through the HIV, TB, PMTCT, and pediatrics technical working groups</li> <li>• Pre-service training on comprehensive HIV prevention, care and treatment services</li> <li>• FP compliance training for USG</li> </ul>	<ul style="list-style-type: none"> <li>• Procurement of RTKs, ARVs, Cotrimoxazole, OI drugs, amphotericin B, fluconazole, therapeutic and supplementary foods</li> <li>• Distribution of therapeutic and supplementary foods at facility and community levels (World Food Program)</li> <li>• Integration of EIMC in MNCH</li> </ul>

- treatment data
- Surveillance on drug resistance
- Rollout the national Quality Improvement strategy and implementation plan
- Support the national Quality Improvement coordination technical working group
- Integrate quality improvement along the clinical cascade
- Quarterly learning sessions with all stakeholders
- Quarterly program performance reviews with national stakeholders and implementers
- Retention cohort analyses for the care and treatment program
- Support the national transport for EID and VL
- Procurement of supplies and equipment
- Waste management
- Establish a know your status campaign and conduct community mobilization for pediatric care and treatment
- Refresher training of counselors on pediatric HTC counseling
- In service training and mentorship
- Support the review and adoption of guidelines
- Recruitment of counsellors, linkages facilitators/coordinators, IPC agents/Mobilizers, HTC coordinators
- Referral testing support: Viral load and EID testing
- TB culture and drug resistance testing

- personnel, IPs and MOH
- Task shifting/sharing policy
- Support the development of tools to effectively track linkages to treatment services
- Support MOH to roll out referral and linkages SOPs
- Provide TA for specialized counselling for different population groups (e.g. children, young people, couples and key populations)
- Procurement of RTKs for emergency stock outs
- Development of national strategic plan for laboratory equipment maintenance program.
- Development of national strategic plan, guidelines and SOPs.

- Training of midwives in EIMC
- Procurement of condoms and lubricants
- Procurement of CD4 machines
- Blood Safety
- Infrastructure and policy

**Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16**

	<b>Core Activities</b>	<b>Near-core Activities</b>	<b>Non-core Activities</b>
HTC: General	<ul style="list-style-type: none"> <li>Scale up targeted outreach HTS for priority populations and locations</li> <li>Scale up evidence-based and promising HTC strategies to improve identification of PLHIV in the community</li> <li>Develop family tree using OVC child and pediatric patients for index testing both in community &amp; facility settings</li> </ul>		
HTC: Pediatrics and adolescents	<ul style="list-style-type: none"> <li>Establish a know your status campaign and conduct community mobilization for pediatric care and treatment</li> <li>Strengthen EID services and address bottle necks</li> <li>Design adolescent specific HTC outreaches in selected locations</li> </ul>		
HTC: PITC	<ul style="list-style-type: none"> <li>Implement ‘HTC triage’ at OPD to improve coverage for HTC</li> <li>Implement routine opt-out HIV testing in priority settings (ART, MNCH/PMTCT, TB, nutritional corners, OVC settings, and pediatric inpatient wards)</li> </ul>		
HTC: Referral and linkages	<ul style="list-style-type: none"> <li>Track and report linkages of PLHIV to treatment service.</li> <li>Link testing and counseling with clinical and community interventions, improve referrals to TB and STI screening, management, FP services, psychosocial support, and ART</li> </ul>	<ul style="list-style-type: none"> <li>Develop tool to effectively track linkages to treatment services</li> <li>Support MOH to roll out referral and linkages SOPs</li> </ul>	
HTC: Capacity building and quality improvement	<ul style="list-style-type: none"> <li>Site improvement monitoring and supervision</li> <li>Refresher training of counselors on pediatric HTC counseling</li> <li>In service training and mentorship</li> <li>Support all districts and sites to improve the quality of services through institutionalized QI approaches</li> </ul>	<ul style="list-style-type: none"> <li>Provide TA for specialized counselling for different population groups (e.g. children, young people, couples and key populations)</li> </ul>	
HTC: Policy guidance		<ul style="list-style-type: none"> <li>Support the review and adoption of guidelines</li> </ul>	<ul style="list-style-type: none"> <li>Reducing HIV/AIDS-related stigma and discrimination at all levels</li> <li>Ensuring a supportive legal and policy framework within which the response is scaled up, including safeguarding the human rights of people seeking services</li> </ul>
HTC: HRH	<ul style="list-style-type: none"> <li>Recruitment of counsellors, linkages facilitators/coordinators, IPC agents/Mobilizers, HTC coordinators</li> </ul>		
HTC: PSM/commodities		<ul style="list-style-type: none"> <li>Procurement of RTKs for emergency stock outs</li> </ul>	<ul style="list-style-type: none"> <li>Procurement of condoms and lubricants</li> </ul>
Adult and Pediatric Treatment	<ul style="list-style-type: none"> <li>Offer Test and Start to all PLHIV</li> <li>Same-day ART initiation if ready for treatment</li> <li>Mop-up Pre-ART initiation on treatment</li> </ul>	<ul style="list-style-type: none"> <li>National coordination and oversight of the HIV/AIDS response through the HIV, TB, PMTCT, and pediatrics technical working groups</li> </ul>	<ul style="list-style-type: none"> <li>Task sharing for nurse-led ART service delivery</li> </ul>

	<ul style="list-style-type: none"> <li>• Enhance treatment initiation of HIV positive family members of patients currently on ART</li> <li>• Adherence counseling and support</li> <li>• Multi-month dispensing of ART for stable patients</li> <li>• Expanded clinic visits to 1,3,6,12 months based on patient category i.e. newly initiated on treatment, stable or unstable</li> <li>• Home-based and weekend delivery of ART</li> <li>• Quality improvement along the HIV Clinical Cascade</li> <li>• Facility linkage coordinators to enhance intra- and inter-facility linkages and facility-community referrals linkages</li> <li>• mHealth technology for SMS reminders on appointments, lab results and treatment and prevention literacy.</li> <li>• Active community follow-up using the appointment registers and tracking tools</li> <li>• Community Adherence Groups</li> <li>• Strengthen the ART filing system to enable active tracking and reporting of patient-level data</li> <li>• Training of clinicians in Viral Load monitoring of ART and result interpretation</li> <li>• In-service training and mentorship of service providers on the new WHO policy guidelines</li> <li>• Data validation of HIV clinical cascade results</li> <li>• Support supervision of the HIV prevention, care and treatment services</li> <li>• Decentralization of systems for the management of treatment failure</li> <li>• Integrate quality improvement along the clinical cascade</li> <li>• Quarterly learning sessions with all stakeholders</li> <li>• Support the national transport for EID and VL</li> </ul>	<ul style="list-style-type: none"> <li>• Pre-service training on comprehensive HIV prevention, care and treatment services</li> <li>• Policy dissemination to sites and stakeholders at district level</li> <li>• Quarterly program performance reviews with national stakeholders and implementers</li> <li>• FP compliance training for USG personnel, IPs and MOH</li> </ul>	<ul style="list-style-type: none"> <li>• Procurement of RTKs, ARVs, Cotrimoxazole, OI drugs, amphotericin B, fluconazole, therapeutic and supplementary foods</li> <li>• Distribution of therapeutic and supplementary foods at facility and community levels (World Food Program)</li> <li>• Support to Village Health Workers to escort patients to treatment services</li> </ul>
Adult and Pediatric Care and Support	<ul style="list-style-type: none"> <li>• Retesting (for confirmation prior to ART initiation) for HIV + individual</li> <li>• Prevention and treatment of opportunistic infections (e.g. Cotrimoxazole prophylaxis, Cryptococcal meningitis)</li> <li>• PHDP Services i.e. STI screening and management, voluntary FP services,</li> <li>• Condoms, and adherence counseling and support</li> </ul>	<ul style="list-style-type: none"> <li>• Hepatitis B screening and management</li> <li>• Cervical cancer screening and management for women living with HIV/AIDS , procurement of supplies and equipment</li> </ul>	<ul style="list-style-type: none"> <li>• Home-based care</li> <li>• Psychosocial support</li> <li>• CD4 testing and procurement of CD4 reagents and commodities</li> </ul>
TB/HIV Integration	<ul style="list-style-type: none"> <li>• Intensify TB case finding among PLHIV in ART clinics, MNCH, correctional facilities, factories, mines, and health care facilities.</li> <li>• TB diagnosis with GeneXpert to increase TB notification rates</li> <li>• Detect and treatment all MDR cases early</li> <li>• IPT provision in all scale up sites</li> <li>• Test and Start for HIV-positive TB patients.</li> <li>• TB infection control (IC) measures at site level</li> </ul>	<ul style="list-style-type: none"> <li>• Procurement of additional GeneXpert Machines</li> <li>• Address TB in high-risk groups (i.e., children, contacts of index clients, prisoners, migrants, minors, and factory workers)</li> <li>• Regional issues for TB and HIV treatment on cross-border management to maintain screening and cross-border referrals for TB and ART clients</li> </ul>	<ul style="list-style-type: none"> <li>• Procurement of anti-TB drugs</li> </ul>

	<ul style="list-style-type: none"> <li>including provision of N95 respirators, and coordination of TB IC committees.</li> <li>Quality Improvement of TB prevention and treatment cascade i.e. TB intensive case finding cascade, monitoring of gene GeneXpert implementation, TB infection control in care settings</li> <li>Ensure engagement and retention of all PHLIV through mobile technology such as SMS reminders in scale-up districts</li> <li>Active community follow-up for TB contact tracing, case identification and DOTS</li> </ul>		
Nutrition Services for PLHIV (NACS)	<ul style="list-style-type: none"> <li>Nutrition assessment, categorization of adults and children on ART</li> <li>Growth monitoring of all children living with HIV</li> <li>Counseling of care givers on optimal infant and young child feeding</li> <li>Nutrition equipment procurement</li> <li>Job aides for nutrition</li> </ul>	<ul style="list-style-type: none"> <li>Therapeutic and supplementary feeding services of moderately malnourished PLHIV</li> <li>Policy and guideline development for nutrition in HIV</li> <li>Commodity procurement of therapeutic and supplementary foods (this is provided by the Global Fund and World Food program)</li> </ul>	
Prevention	<ul style="list-style-type: none"> <li>Increasing uptake of HTS services for pregnant and lactating mothers and their partners</li> <li>Option B+ to HIV-positive pregnant women and lactating mothers in ANC, labor and delivery</li> <li>ARV prophylaxis to HIV exposed infants (HEI)</li> <li>Support VL monitoring for pregnant and lactating mothers on ART</li> <li>EID testing by 8 weeks of age and ensure receipt of results by care givers</li> <li>Cotrimoxazole prophylaxis to PMTCT mothers and their HEI</li> <li>Adherence support and counseling for pregnant and lactating mothers on ART.</li> <li>Community demand creation for ANC-1 and PMTCT uptake</li> <li>Community linkages and referral for ART for pregnant and lactating mothers</li> <li>Collaborative quality improvement along the PMTCT-EID cascade</li> <li>Active follow-up of mother-infant pairs at community level</li> <li>Additional HR to improve service delivery</li> <li>Rollout the national Quality Improvement strategy and implementation plan</li> <li>Integrate quality improvement along clinical cascade</li> <li>Quarterly learning sessions with all stakeholders</li> <li>Retention cohort analyses for care and treatment</li> </ul>	<ul style="list-style-type: none"> <li>Risk reduction counseling and re-testing within MNCH</li> <li>Integration of FP within ART and MNCH settings</li> <li>Training and mentorship of health workers in PMTCT</li> <li>Integrated TB/HIV services in MNCH settings</li> <li>Postnatal care to improve mother baby pair follow-up</li> <li>National coordination of the HIV/AIDS response through the PMTCT, and pediatrics technical working groups</li> <li>Pre-service training on comprehensive HIV prevention, care and treatment services</li> <li>FP compliance training for USG personnel, IPs and MOH</li> <li>Quarterly program performance reviews with national stakeholders and implementers</li> </ul>	<ul style="list-style-type: none"> <li>Task sharing for nurse-led ART service delivery in MNCH/PMTCT</li> <li>Support to Village Health Workers to escort patients to treatment services</li> <li>Procurement of RTKs, ARVs, Cotrimoxazole, OI drugs, amphotericin B, fluconazole, therapeutic and supplementary foods</li> <li>Expand the range of FP services provided to women living with HIV</li> </ul>
Prevention : Key Pops	<ul style="list-style-type: none"> <li>Interpersonal communication (IPC) address risk assessment, self-efficacy and empowerment, violence, condom use</li> <li>Negotiation and promotion of regular HIV/STI testing.</li> <li>Condom promotion and provision.</li> </ul>	<ul style="list-style-type: none"> <li>Support CBO capacity building</li> <li>Community mobilization</li> <li>Monitoring and Evaluation</li> <li>Coordination of CSO interventions</li> </ul>	

	<ul style="list-style-type: none"> <li>• HTC promotion and provision</li> <li>• Mapping of key population hotspots such as popular meeting areas including social gatherings, bars, hotels, restaurants in communities where CSW and MSM frequent</li> <li>• Sensitization of health care workers and service providers and establishment of a coordinating committee for linkages and referrals.</li> </ul>		
Laboratory diagnosis and Monitoring supplies	<ul style="list-style-type: none"> <li>• National Quality Assurance program: Continuous Quality Improvement (CQI) and Proficiency Testing (PT) program.</li> <li>• Laboratory diagnosis and monitoring support: Qualification procurement and distribution supplies of reagents and supplies for HIV, VL, EID, CD4, OI, TB culture, and drug susceptibility tests.</li> <li>• Sample transport and referral network</li> <li>• Human Resource: In-service training technologists, lab data clerks and sample transporters.</li> <li>• Supervision and mentorship</li> </ul>	<ul style="list-style-type: none"> <li>• Implementation of SLMTA: laboratory accreditation.</li> <li>• Rapid Testing Quality Improvement Initiative (RTQII)</li> <li>• Infrastructure maintenance: Minor targeted renovations e.g. painting, sinks, windows, air conditioning system, biosafety cabinet, reconfiguration of lab work flow, bench top to improve biosafety and quality of services.</li> <li>• National strategic plan for laboratory equipment</li> <li>• Implement GIS to map the test site locations and transport routes to monitor quality improvement.</li> </ul>	<ul style="list-style-type: none"> <li>• Major renovations/ construction of labs</li> <li>• Procurement of reagents and supplies for chemistry/ hematology tests</li> <li>• Pre-service training</li> </ul>
Blood Safety		<ul style="list-style-type: none"> <li>• Technical assistance to assess and improve quality management systems with the goal of attaining national blood service-specific accreditation</li> </ul>	<ul style="list-style-type: none"> <li>• Human Resources</li> <li>• Infrastructure and Policy</li> <li>• Collection and screening of blood for HIV, HBV, HCV and Syphilis</li> <li>• Storage and distribution</li> <li>• Appropriate clinical use of blood</li> <li>• Donor recruitment, notification and linkage</li> </ul>
OVC Program/system support	<ul style="list-style-type: none"> <li>• Ensure effective integration with existing or planned child focused community and home based activities such as PMTCT, treatment and child survival.</li> <li>• Establishing linkages and referral systems between community and clinic based programs.</li> <li>• Identification and registration of vulnerable children</li> <li>• Data and information flow between the community councils, district and national headquarters</li> <li>• Improving M&amp; E for interventions</li> <li>• Parenting and family support interventions</li> <li>• Community caregiver support</li> <li>• Create and enhance access and linkages to government supported cash grant programs</li> <li>• Mobilizing child protection committees</li> <li>• Ensure facilitation of referral to care, and services like HTC, PMTCT and pediatric care and treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• Support MOSD in ensuring a child- focused, family centered approach to health and nutrition through ECD and school based programs</li> <li>• Community mobilization</li> <li>• Monitoring and Evaluation</li> <li>• Support to community councils</li> <li>• Coordination of CSO interventions</li> <li>• Early childhood development programs building strong beginnings</li> <li>• Inform macro – level initiatives, through advocacy and policy dissemination.</li> </ul>	
VMMC	<ul style="list-style-type: none"> <li>• Focus DSD at six static sites and outreach services</li> <li>• Scale-up PrePex services</li> <li>• Procurement of supplies and equipment</li> <li>• HIV+ referrals to treatment and care</li> </ul>	<ul style="list-style-type: none"> <li>• Focused age pivot (15-29yrs.) demand creation</li> <li>• School and community campaigns</li> <li>• Task shifting/sharing</li> <li>• Strengthened referrals from HCT to VMMC sites</li> <li>• Medical-Traditional circumcision collaborations</li> </ul>	<ul style="list-style-type: none"> <li>• EIMC TA</li> <li>• DSD EIMC in districts with &gt;60% adolescent/adult coverage</li> <li>• Integration of EIMC in MNCH</li> <li>• Training of Midwives in EIMC</li> </ul>

**Table A.3 Transition Plans for Non-core Activities**

Transitioning Activities	Type of Transition	Funding in COP 16	Estimated Funding in COP 17	# of IMs	Transition End date	Notes
Task sharing for nurse-led ART service delivery	N/A	\$0	\$0		N/A	National policy framework already implemented
Procurement of RTKs, ARVs, Cotrimoxazole, OI drugs, amphotericin B, fluconazole, therapeutic and supplementary foods	N/A	\$0	\$0	N/A	N/A	Funded by the GOL and Global Fund
Distribution of therapeutic and supplementary foods at facility and community levels (World Food Program)	N/A	\$0	\$0	N/A	N/A	Procured by the GOL and Global Fund
Home-based Care	Fully transitioned to GOL	\$0	\$0	N/A	N/A	Services transitioned to the GOL
Psychosocial support	Fully transitioned to GOL					Services transitioned to GOL in FY 2016
CD4 testing and procurement of reagents and supplies	Shift from routine CD4 monitoring to VL monitoring	\$106,200	\$50,000	1	N/A	National Treatment Guideline revision to adopt VL testing as the routine test to be provided for ART monitoring
Support to Village Health Workers to escort patients to treatment services	N/A	\$0	\$0	N/A	N/A	Funded by the GOL and Global Fund
Expand the range of FP services	N/A	\$0	\$0	N/A	N/A	Funded by the USAID/UNFPA mechanism to Lesotho
EIMC TA	DSD EIMC in Maseru and Berea districts	\$85,230	\$190,000	1	09/01/2017	Maseru and Berea adolescent/adult VMMC coverage >60% at end of FY 16
Mass community campaigns for testing and counselling	Immediate		\$0.0	1	APR15	Testing and counseling will no longer use untargeted mass campaigns for HTS in FY17, this stopped in FY15 due to low yield & high cost. There are no funds allocated to this activity in COP16
Procurement of reagents and supplies for chemistry/ hematology tests	To be fully transitioned to GOL	\$0	\$0	N/A	End of FY16	New guidelines require very limited lab test for HIV services
Pre-service training	Transitioned to GOL	\$0	\$0	N/A	End of FY15	
Blood Safety	To be fully transitioned to GOL	\$0	\$0	N/A	End of FY16	
Procurement of CD4 machines	Immediate	\$60,100	\$0.0	1	FY16	As the country fully adopts Test and Start, the use of CD4 as a criteria for enrollment will be de-emphasized
<b>Totals</b>						

## APPENDIX B

### B.1 Planned Spending in 2016

**Table B.1.1 Total Funding Level**

Applied Pipeline	New Funding	Total Spend
\$10,231,319	\$40,843,681	\$51,075,000

**Table B.1.2 Resource Allocation by PEPFAR Budget Code**

PEPFAR Budget Code	Budget Code Description	Amount Allocated (Pipeline + New Money)
MTCT	Mother to Child Transmission	\$943,803
HVAB	Abstinence/Be Faithful Prevention	-
HVOP	Other Sexual Prevention	\$851,143
IDUP	Injecting and Non-Injecting Drug Use	-
HMBL	Blood Safety	-
HMIN	Injection Safety	-
CIRC	Male Circumcision	\$3,636,679
HVCT	Counseling and Testing	\$4,702,182
HBHC	Adult Care and Support	\$2,452,702
PDCS	Pediatric Care and Support	\$1,120,994
HKID	Orphans and Vulnerable Children	\$2,991,455
HTXS	Adult Treatment	\$19,475,490
HTXD	ARV Drugs	-
PDTX	Pediatric Treatment	\$3,132,721
HVTB	TB/HIV Care	\$3,457,712
HLAB	Lab	\$763,882
HVSI	Strategic Information	\$1,865,161
OHSS	Health Systems Strengthening	\$830,803
HVMS	Management and Operations	\$4,850,271
<b>TOTAL</b>		<b>\$51,075,000</b>

## B.2 Resource Projections

Program Area	Beneficiary Type	Site Type (Scale-up, Maintenance, Transition)	SNU (default national) National SNU1 (if available) SNU2 ...	Unit Cost Applied	Source / Justification/ Other Notes (e.g., differed from EA UE result by X)
FBCTS	Adult Pre-ART	Scale-up to Saturation SNUs	5 Scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$0	No UEs were applied for Adult Pre-ART
	Peds Pre-ART	Scale-up to Saturation SNUs	5 Scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$0	No UEs were applied for Peds Pre-ART
	Adult ART	Scale-up to Saturation SNUs	5 Scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$95.06	The original UE of \$21.79 was adjusted to \$95.06 to account for personnel increases as a result of the scale-up in the five scale-up to saturation districts. SI, program management, travel/transport all kept level while maintaining historic percentages.  <b>Personnel Costs:</b> UE costs calculated to account for additional health staff required to scale-up treatment services at facilities.  <b>Source:</b> UE Modification tool
	Peds ART	Scale-up to Saturation SNUs	5 Scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$148.07	The original UE of \$24.79 was adjusted to \$148.07 to account for personnel increases as a result of the scale-up in the five Scale-up to saturation districts and the higher cost associated with treating children. SI, program management, travel/transport all kept level while maintaining historic percentages.  <b>Personnel Costs:</b> UE costs calculated from the taking the adult ART personnel cost as the base and adjusting to account for the higher costs associated with pediatrics: salaries are 20% greater for pediatric counselors, staff to patient ratios are lower, pediatric patients have more clinical visits and each visit requires more staff

					support. <b>Source:</b> UE Modification tool
CBCTS	CBCTS Beneficiaries	Scale-up to Saturation SNU's	5 Scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$67.52	The original UE of \$90.39 was based on the PEPFAR Small Grants program historic expenditure. This UE cannot be related to the new CBCTS activities that will be implemented in COP16.  <b>Personnel:</b> The UE was calculated to account for new community based health staff who will deliver health services at community health posts.  <b>Travel &amp;Transport:</b> The UE includes costs for maintenance, fuel, rescue services, and equipment associated with transportation methods. Transport refunds for referral tests and community tracking.  <b>Source:</b> UE Modification Tool
	Pregnant Women Tested	Scale-up to Saturation SNU's	5 Scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$11.17	The original UE of \$13.60 was adjusted to \$11.17 to account for HIV test kits that will be procured by the Global Fund to meet the scale-up in the five scale-up to saturation districts.  <b>Source:</b> UE Modification Tool
PMTCT	Women receiving ARV prophylaxis	Scale-up to Saturation SNU's	5 scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$95.06	The original UE of \$21.79 was adjusted to \$95.06 to account for personnel increases as a result of the scale-up in the five scale-up to saturation districts. SI, program management, travel/transport all kept level while maintaining historic percentages.  <b>Personnel Costs:</b> UE costs calculated to account for additional health staff required to scale-up treatment services at facilities.  <b>Source:</b> UE Modification tool
	Pregnant Women on Option B+	Scale-up to Saturation SNU's	5 scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$0	No UEs were applied for Pregnant Women on Option B+

	Infants Tested	N/A	N/A	N/A	N/A
	Infants on Care	Scale-up to Saturation SNU	5 scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$179.07	The original UE of \$2121.93 was adjusted to \$179.07 to account for the costs of EID and care for all HIV exposed infants and treatment of confirmed HIV positive infants in the five scale-up to saturation districts.  <b>Source:</b> UE Modification tool
VMMC	Males Circumcised	Scale-up to Saturation SNU	5 scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$155.74	This unit cost of \$155.74 from EA 2015 was maintained <b>Source:</b> 2015 EA Navigation Tool
	HTC PITC	Scale-up to Saturation SNU	5 scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$4.95	The original UE of \$2.20 was adjusted to \$4.95 to align it with COP15 UE  <b>Source:</b> UE Modification tool
	HTC VCT	Scale-up to Saturation SNU	5 scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$26.78	This unit cost of \$26.78 from EA 2015 was maintained.  <b>Source:</b> 2015 EA Navigation Tool
	HTC CBTC	Scale-up to Saturation SNU	5 scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$18.92	The original UE of \$19.91 was adjusted to \$18.92 to align it with COP15 UE  <b>Source:</b> UE Modification tool
	Other HTC	Scale-up to Saturation SNU	5 scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$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 scale-up to saturation districts.  <b>Source:</b> UE Modification tool
OVC	OVC All Care	Scale-up to Saturation SNU	5 scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$62.17	The original UE of \$162.35 was adjusted to \$62.17 to account for changes in the program activities and a well-defined package for the five scale-up to saturation districts.  <b>Source:</b> UE Modification tool
PP-PREV	Prevention Priority Populations	Scale-up to Saturation SNU	5 scale-up to saturation Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	\$0	No UEs were applied for PP-PREV
Key Populations Prevention	KP-PWID	N/A	N/A	N/A	N/A
	KP-FSW	Scale-up to Saturation SNU	Maseru	\$87.53	Source: The unit cost of \$87.53 is cited from Futures International website for a similar FSW

					<p>program in South Africa. The target for KP-FSW is the 75% of the national target from the size estimate study.</p> <p><b>Source:</b>  <a href="http://policytools.futuresinstitute.org/UC/">http://policytools.futuresinstitute.org/UC/</a></p>
	KP-MSMTG	Scale-up to Saturation SNU's	Maseru	\$87.53	<p>The unit cost of \$87.53 is cited from Futures International website for a similar FSW program in South Africa. The target for KP-FSW is the 75% of the national target from the size estimate study.</p> <p><b>Source:</b>  <a href="http://policytools.futuresinstitute.org/UC/">http://policytools.futuresinstitute.org/UC/</a></p>

# APPENDIX C

## Systems Investments for Section 6.0

Included Activities	Excluded Activities
<b>Human Resources for Health (HRH): Systems/Institutional Investments</b>	
<p>In-service training systems support and institutionalization; HRH performance support/quality other HRH activities not classified as above</p> <ol style="list-style-type: none"> <li>1. Support the Lesotho Nursing Council credential and accredit NIMART sites in the 5 scale-up districts.</li> <li>2. Monitor HIV and AIDS skills CPD performance for all nurses in the 5 scale-up districts.</li> </ol>	<p>Pre-service training.; HRH policy planning and management; HR assessments and information systems;</p>
<b>Human Resources for Health (HRH): Personnel Costs for Service Delivery</b>	
<p>In-service training; all HRH support at sites and community across all program areas</p> <ol style="list-style-type: none"> <li>1. Recruit 44 additional counselors for the 22 high volume sites.</li> <li>2. Recruit additional mobilizers for increased uptake of community HIV testing services.</li> <li>3. Recruit 121 Linkage Coordinators for treatment services and expert patients for CHTS and PITC.</li> <li>4. Recruit 44 nurses for treatment services.</li> <li>5. Recruit 44 adherence counselors to enhance retention</li> <li>6. Mentor lower cadres of counselors and clients on treatment literacy</li> <li>7. Recruit 132 data clerks for cohort monitoring and DHIS2 site level reporting</li> <li>8. Recruit logisticians at high volume sites to manage ARVs and laboratory commodities</li> <li>9. Train Linkage Coordinators and nurses on how to use the mHealth system to track patients initiating treatment.</li> <li>10. Train adherence counselors and data clerks on how to use the mHealth system.</li> <li>11. Support the MOH recruit laboratory technicians to work in the District/Regional Laboratories.</li> <li>12. Recruit and train CHWs to implement extended and off-site drug refills</li> <li>13. Support the MOH to train staff and CHWs in the new service delivery models.</li> <li>14. Assess the training needs and prepare / revise laboratory in-service training curriculum;</li> <li>15. Conduct refresher training on biosafety, laboratory quality Management System</li> </ol>	<p>N/A</p>
<b>Governance</b>	
<ol style="list-style-type: none"> <li>1. Implementation of feasibility and readiness assessment for test &amp; start.</li> <li>2. Revision of National Treatment Guidelines to incorporate test &amp; start procedures</li> <li>3. Train sites and staff on the new test &amp; start policy, guidelines and SOPs</li> </ol>	<p>N/A</p>
<b>Systems Development</b>	
<p>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:</p> <ol style="list-style-type: none"> <li>1. Quantification, forecasting and supply planning for HIV and AIDS including ARVs and laboratory commodities.</li> <li>2. Appropriate warehousing and inventory control for all HIV and</li> </ol>	<p>N/A</p>

<p>AIDS commodities</p> <ol style="list-style-type: none"> <li>3. Establish a functional LMIS for HIV and AIDS commodities</li> <li>4. Review current SCM SOPs and re-engineer process for efficient procurement of HIV and AIDS commodities for Test and Start.</li> </ol>	
<b>Institutional and Organizational Development</b>	
<ol style="list-style-type: none"> <li>1. Program and operations capacity building for CBCTS community based organizations.</li> <li>2. Monitoring and evaluation capacity building</li> </ol>	N/A
<b>Strategic Information</b>	
<ol style="list-style-type: none"> <li>1. Support the review of the current EMR system</li> <li>2. Expand DHIS2 to site level</li> </ol>	N/A
<b>Laboratory</b>	
<ol style="list-style-type: none"> <li>1) Laboratory Quality Assurance and Biosafety program <ul style="list-style-type: none"> <li>• Make an inventory and purchase critical lab equipment</li> <li>• National Lab QA program supports facilities by developing/revising guidelines and SOPs</li> <li>• Preparation and distribution of quality control and proficiency panels for key diagnostic and monitoring tests in 18 hospitals and 216 health centers</li> <li>• Quarterly site visit and supportive supervision of 11 district hospital laboratories.</li> <li>• Prepare certification and accreditation of national reference lab and National Blood Bank.</li> <li>• Implement QA plan in HIV testing including role out HIV Rapid Testing Quality Improvement Initiative (RTQII)</li> <li>• Support Strengthening of Laboratory Management Towards Accreditations (SMLTA) and certify 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</li> </ul> </li> <li>2) Strengthening Laboratory Strengthening Laboratory Information (LIS) and M&amp;E System <ul style="list-style-type: none"> <li>• Support the maintenance of electronic based LIS implemented in reference and 18 clinical laboratories.</li> <li>• Interface referral test result reporting system (SMS printers) with LIS</li> <li>• Establish national database for test repository, analyze and report on quarterly basis laboratory data, monitoring and evaluation</li> </ul> </li> <li>3) Human resource and training support; <ul style="list-style-type: none"> <li>• Assess the training needs and prepare /revise in-training curriculum</li> <li>• Conduct refresher training on biosafety, laboratory quality Management System</li> </ul> </li> </ol>	<p>Vehicles, equipment and furniture, construction and 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</p>