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INFORMATION MEMO FOR AMBASSADOR REBECCA E. GONZALES, LESOTHO

FROM: S/GAC – Ambassador Deborah L. Birx, MD

SUBJECT: FY 2019 PEPFAR Planned Allocation and Strategic Direction

We are grateful to you, Ambassador Gonzales, and your Deputy Chief of Mission, Daniel Katz, for your engagement with the PEPFAR team and Government of Lesotho in planning, review and implementation of activities to enhance the impact of PEPFAR's programs. We thank you for your attention to key issues, such as adopting and implementing core policies, facilitating enhanced programmatic performance, investing in data, and holding partners to account. Finally, we are grateful to your incredible PEPFAR staff in country, who continue to work together across agencies to ensure the most effective and efficient use of taxpayer dollars.

We congratulate the team on many key successes during FY 2018. For example, Lesotho continues to make progress toward reaching the 90-90-90 targets (in the wake of last year's LePHIA survey results, UNAIDS' most recent estimate, through the end of 2017, is that Lesotho had reached 80-92-92). Along the HIV treatment cascade, two strong points are especially evident: once people living with HIV (PLHIV) are identified, they are immediately linked to care at a very high rate (95%), and once in care, the retention rate (also 95%) among those patients is equally impressive. It has also been very encouraging to see that as viral load tests have become more readily available, PEPFAR's measured suppression rates across Lesotho mirror UNAIDS' estimate of 92%.

Despite all of the good work that has been done, many challenges remain before Lesotho can reach sustainable epidemic control. In FY 2019 and beyond, improved programmatic and partner performance in a number of areas, and the accelerated implementation of key policies by the Government of Lesotho will accelerate Lesotho's progress path toward ending the spread of HIV.

Programmatic Performance:

Achieving the "first 90" is the biggest challenge, and is the linchpin to overall performance. Last year, only 31,883 PLHIV, compared to a revised target of 50,025 (64%) after PHIA results were available. During COP18, case-finding efforts should remain our biggest focus, and it is critical that they improve. PEPFAR's field team and implementing agencies must work with implementing partners to rapidly expand index testing efforts while simultaneously improving fidelity. All other testing modalities should see improvements in fidelity, and self-testing should be more effectively inserted into every other testing modality.

The planned expansion of viral load testing coverage (just 51% coverage) and improvements in lab systems' effectiveness are two areas within the third 90 measure that lagged significantly during COP17. The expansion of testing services and quality of labs therefore must be scaled up quickly during the remainder of COP18 and completed no later than COP19.

Most dedicated prevention efforts during COP17 have also come significantly short of annual targets and expectations, including VMMC (49% of targets), KP programming (less than 200 total PLHIV identified among FSWs and MSM), and DREAMS (more than 2/3 of those reached only receiving one of the four layered services). Plans to address and mitigate this underperformance are well underway, and rapid improvements during COP18 are expected and necessary.

While more effective and efficient testing practices will require a great deal of the team's focus during COP18 and COP19, the team should be mindful that this increased emphasis should not come at the expense of all of the evident overall successes on the second and third 90s. Instead, they should endeavor to build on the already strong foundations within the second and third 90s that they have established, and make targeted improvements (e.g., with lab systems) where necessary.

Partner Performance:

In general, partners came up substantially short of their targets during COP17, and partner performance needs to improve across the board. Even after targets were significantly revised in the middle of COP17 following last year's publication of the LePHIA results, performance appeared only marginally better.

For example, EGPAF (via CDC and USAID), which handles a significant amount of the testing activities in Lesotho, had testing yields that were too inefficient (i.e., that were too low across testing modalities, gender, and age groups). Their index testing practices were problematic, as it is clear that they conducted too many index tests without fidelity, particularly those given to children. PSI is the other major testing partner and also came up far short of targets, and does not appear to be practicing index testing as prescribed. JHPIEGO, which handles most voluntary medical male circumcisions (VMMC) in Lesotho, performed too few circumcisions (44% of annual target during COP17), and though new data show that their performance improved during COP18 Q1, their annualized rate during the quarter (74% of target) is still too low. Given the lagging performance on key indicators across PEPFAR's major partnerships, the field team and implementing agency representatives should work with partners to improve their delivery of services—with particular attention paid to optimal testing practices and improvements across all modalities, especially index testing and self-testing.

Policies:

We are very pleased that the Government of Lesotho has been quick to adopt most of the critical policies that PEPFAR has promoted as essential to reaching epidemic control. They have also been quick to implement many vital policies, such as test and start. However, after some policies have been adopted, implementation has been slow. Two areas of concern are TB preventive

therapy (TPT) and some components of the differentiated service delivery (DSD) model. We also wish to emphasize that it will be crucial for Lesotho to adhere to the policy transition plan from the TLE to the TLD ARV regimen that has been mapped out.

Summary

The strides already made in the effort to control HIV in Lesotho are commendable, but a number of challenges remain. Given the measurable progress to date, such as how close programs already are to reaching the 90-90-90 targets, and the strength of the PEPFAR field team and their counterparts, with their continued efforts and more efficient practices, Lesotho is well-positioned to be among the first PEPFAR countries to get to the “last mile” and plan for sustained epidemic control.

The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) total planning level for Lesotho for the 2019 Country Operational Plan (COP 2019) is **\$85,000,000**, inclusive of all new funding accounts and applied pipeline.

If you have questions about the priorities and guidance laid out in this letter, please contact your Chair and Program Manager. We are continually grateful for your team’s work on the PEPFAR program, helping us to move towards an AIDS-free generation by supporting the HIV response in Lesotho.

APPENDICES:

- 1. COP 2019 PLANNING LEVEL**
- 2. COP 2019 BUDGETARY REQUIREMENTS & GUIDANCE**
- 3. PAST PERFORMANCE**
- 4. COP 2019 DIRECTIVES**

Subject to COP Development and Approval

APPENDIX 1: COP 2019 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the FY 2018 Q4 POART and performance information, the total COP 2019 planning level is estimated to be comprised as follows:

Table 1. COP 2019 Budget*

| Lesotho | | |
|---|---------------|---------------|
| TOTAL COP 2019 PLANNING LEVEL: \$85,000,000 | | |
| Total Base Budget for COP 2019 Implementation | | \$ 85,000,000 |
| Total COP 19 New Funding | \$ 76,092,461 | |
| <i>of which, VMMC</i> | \$ 4,346,453 | |
| <i>of which, DREAMS</i> | \$ 10,017,660 | |
| Total Applied Pipeline* | \$ 8,907,539 | |
| Total Faith Based Organization (FBO) Initiative Funding (FY 18 Funds) | \$ 7,300,000 | |

*Applied pipeline by agency is provided in the chart below

Table 2. Applied Pipeline**

| Lesotho | |
|---------------------------------------|--------------|
| COP 2019 Applied Pipeline By Agency** | |
| Total Applied Pipeline | \$ 8,907,539 |
| DOD | \$ 135,967 |
| HHS/CDC | \$ 7,346,038 |
| PC | \$ 18,347 |
| USAID | \$ 1,407,187 |

**Based on agency reported available pipeline from EOFY

All planning levels are subject to further adjustment, **based upon appropriations**, further analysis determining the availability of excessive pipeline, and other developments during the course of COP 2018 implementation and the COP 2019 review process. The total spend in the implementation of COP 2019 (FY 2020) may not exceed the total COP 2019 planning level of \$85,000,000.

Central Funding

Lesotho is also receiving \$7,300,000 in Central Funds as a part of the FBO Initiative. FBO funds will be released in two waves:

- First, a portion of this amount will be used to restore funding that was cut between COP17 and COP18. These funds will be immediately released, ahead of the release of the bilateral COP 2019 funds. \$4,723,335 USD should be made immediately available to the

following USAID partners in the following amounts and in COP19 the FBO implementing partners must receive funding appropriate for functioning independent of and without support from the public sector. Specifically, the \$4,723,335 should be programmed with Catholic Relief Services (USAID) to address gaps in funding from the previous year.

- Second, the remainder of these funds will support new activities for communities of faith in raising awareness, HIV case-finding/linkage/retention, and prevention of sexual violence and HIV risk among ages 9-14 years through the CDC \$2,576,665 USD.

Central Funds for the FBO Initiative should be used as soon as possible after receipt, during the current implementation cycle of COP 2018/FY 2019. Each country team should specify the purpose and use of these funds (based on the data and analysis from the recent FBO TDYs) as part of the SDS.

APPENDIX 2: COP 2019 BUDGETARY REQUIREMENTS

Table 3. COP 2019 Earmarks

| Lesotho | |
|---|----------------------|
| COP 2019 EARMARK REQUIREMENTS | |
| Care and Treatment (C&T) | \$ 44,133,627 |
| <i>% of base funds allocated to C&T</i> | <i>58%</i> |
| HKID | \$ 5,326,472 |
| Gender Based Violence (GBV) | \$ 230,250 |
| Water | \$ 550,000 |

Care and Treatment: If there is no adjustment to the COP 2019 new funding level due to an adjustment in applied pipeline, Lesotho's minimum requirement for the care and treatment earmark is reflected in the chart above. Your care and treatment requirement is calculated as the sum of total new FY 2019 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS budget codes, 30% of the total funding programmed to the MTCT budget code, 80% of the total funding programmed to the HLAB budget code, and 30% of the total funding programmed to the HVCT budget code. This minimum care and treatment earmark has been derived based upon a requirement that your country programs a minimum of 50% of all **new FY 2019 Base Funds** to care and treatment of people living with HIV.

HKID Requirement: Lesotho's COP 2019 minimum requirement for the HKID budget code is reflected in the chart above. Your COP 2019 HKID requirement is derived based upon the approved COP 2018 HKID level. The COP 2019 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): Lesotho's COP 2019 minimum requirement for the GBV earmark is reflected in the chart above. Your GBV earmark requirement is calculated as the total **new FY 2019** funding programmed to the GBV cross-cutting code. Your COP 2019 earmark is derived by using the final COP 2018 GBV earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Lesotho's COP 2019 minimum requirement for the water earmark is reflected in the chart above. Your water earmark requirement is calculated as the total **new FY 2019 funding** programmed to the water cross-cutting code. Your COP 2019 earmark is derived by using the final COP 2018 water earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for water can be above this amount; however, it cannot fall below it.

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transition to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal **by agency** by the end of FY20, and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each agency should work with their respective agency HQ to determine their contribution to meeting the agency-level local partner requirement for FY20, as appropriate through their COP 2019 submission.

COP 2019 Applied Pipeline

All agencies in Lesotho should hold a 3 month pipeline at the end of COP 2019 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP 2018 implementation (end of FY 2019) with a pipeline in excess of 3 months is required to apply this excess pipeline to COP 2019, and decrease the new funding amount to stay within the planning level.

The Applied Pipeline amount of \$8,907,539 given by S/GAC as part of the COP 2019 planning level has been calculated to reflect the projected excess pipeline as of the beginning of the COP 2019 implementation cycle (FY 2020), and is the minimum amount that Lesotho must apply as pipeline in the COP 2019 submission. The distribution of new base funds and Applied Pipeline was calculated to ensure 3 months of pipeline remains with mechanisms, based upon the financial data submitted for the FY 2018 Q4 Obligation and Outlay and FY 2018 End of Fiscal Year (EOFY) reports. Expired funds, funds on expired mechanisms, and projected FY 2019 outlays as submitted in the EOFY report were all taken into consideration to inform the projected excess pipeline and the required COP 2019 applied pipeline amount.

Unliquidated obligations on closed mechanisms identified in the FY 2018 EOFY report should be de-obligated in a timely manner. This will continue to be monitored throughout FY 2019 (COP 2018 implementation) and into COP 2019.

APPENDIX 3: PAST PERFORMANCE TRENDS

Table 4. COP 2017/ FY 2018 Outlays versus Approved Budget

| Row Labels | Sum of Approved COP 2017 Planning Level | Sum of Total FY 2018 Outlays | Sum of Over/Under Outlays |
|--------------------|---|------------------------------|---------------------------|
| Lesotho | | | |
| DOD | \$ 620,527 | \$ 657,841 | \$ 37,314 |
| HHS/CDC | \$ 30,050,832 | \$ 26,042,374 | \$ (4,008,458) |
| PC | \$ 717,000 | \$ 655,027 | \$ (61,973) |
| State | \$ 456,717 | \$ (2,480,424) | \$ (2,937,141) |
| USAID | \$ 37,026,964 | \$ 36,406,883 | \$ (620,081) |
| Grand Total | \$ 68,872,040 | \$ 61,281,701 | \$ (7,590,339) |

Lesotho’s total FY 2018 outlay level of \$61,281,701 is under your approved spend level of \$68,872,040 (COP 2017 budget). Within this total, DOD spent above their approved FY 2018 budgets, and CDC, Peace Corps, State, and USAID spent below their approved levels.

Table 5. IP FY18 Outlays

* This table was based off the FY18 EOFY submissions, but edited to reflect OPU’s as of January 15th, 2019. Agencies outlaid to the following Implementing Mechanisms 125% or more in excess of their COP17 approved planning level.

| Mech ID | Prime Partner | Funding Agency | COP17/FY18 Budget (New funding + Pipeline) | Actual FY18 Outlays (\$) | Over/Under FY18 Outlays (Actual \$ - Total COP17 Budget \$) |
|---------|---|----------------|--|--------------------------|---|
| 12098 | Ministry of Health and Social Welfare – Lesotho | HHS/CDC | \$ - | \$ 265,710 | \$ 265,710 |
| 16766 | University Research Corporation, LLC | USAID | \$ - | \$ 1,557,043 | \$ 1,557,043 |
| 16768 | Mothers 2 Mothers | USAID | \$ - | \$ 1,675,023 | \$ 1,675,023 |
| 17549 | JHPIEGO | USAID | \$ 3,312,197 | \$ 4,517,440 | \$ 1,205,243 |

Table 6. COP 2017/ FY 2018 Results versus Targets*

* Financial and target performance data not a one-to-one correlation as program classification expenditures encompass more than those towards indicator/target presented.

| Agency | Indicator | FY18 Result | FY18 Target | % Achievement | Program Classification | FY18 Expenditure | % Service Delivery |
|---------------------------|----------------------------|-------------|-------------|---------------|------------------------|------------------|--------------------|
| HHS/CDC | HTS_TST | 439,260 | 731,311 | 60.06% | HTS | \$ 7,486,833 | 88% |
| | HTS_TST_POS | 15,039 | 61,311 | 24.53% | | | |
| | OVC_SERV | n/a | n/a | n/a | SE for OVC | \$ 0 | n/a |
| | TX_CURR | 80,117 | 99,863 | 80.23% | C&T | \$ 9,097,381 | 86% |
| | TX_NEW | 10,896 | 42,750 | 25.49% | | | |
| | VMMC_CIRC | n/a | n/a | n/a | PREV: CIRC | \$ 0 | n/a |
| | Above Site Programs | | | | | | \$ 1,741,403 |
| Program Management | | | | | | \$ 4,380,234 | |
| DOD | HTS_TST | 7,025 | 3,920 | 179.21% | HTS | \$ 36,858 | 100% |
| | HTS_TST_POS | 124 | 437 | 28.38% | | | |
| | OVC_SERV | n/a | n/a | n/a | SE for OVC | \$ 0 | n/a |
| | TX_CURR | 1,738 | 2,266 | 76.70% | C&T | \$ 274,330 | 100% |
| | TX_NEW | 117 | 342 | 34.21% | | | |
| | VMMC_CIRC | 2,997 | 957 | 313.17% | PREV: CIRC | \$ 334,374 | 100% |
| | Above Site Programs | | | | | | \$ 0 |
| Program Management | | | | | | \$ 178,949 | |
| USAID | HTS_TST | 417,822 | 402,926 | 103.70% | HTS | \$ 3,448,550 | 83% |
| | HTS_TST_POS | 16,710 | 35,531 | 47.03% | | | |
| | OVC_SERV | 36,638 | 88,082 | 41.60% | SE for OVC | \$ 3,652,866 | 69% |
| | TX_CURR | 136,638 | 154,565 | 88.40% | C&T | \$ 9,285,741 | 52% |
| | TX_NEW | 19,284 | 47,554 | 40.55% | | | |
| | VMMC_CIRC | 21,446 | 49,226 | 43.57% | PREV: CIRC | \$ 5,265,954 | 98% |
| | Above Site Programs | | | | | | \$ 2,365,067 |
| Program Management | | | | | | \$ 9,383,906 | |

COP 2017/ FY 2018 Performance

The following sections include more detailed information on programmatic performance, partner performance, and expenditure reporting analysis that should be instructive as plans are formulated to facilitate better performance on key indicators during COP18 and COP19.

Programmatic Performance

- Overall:
 - PEPFAR Lesotho continues to make significant progress towards the 90-90-90 targets (UNAIDS estimated that it had reached 81-92-92 by the end of 2017), but underachieved this past fiscal year against several key annual targets:
 - HIV Testing and testing positive
 - New and current on treatment
 - Voluntary medical male circumcision (VMMC)
 - Expenditures were at or under total spending levels across agencies and implementing partners, and type of service
 - Across program areas, a relatively high portion of PEPFAR's expenditures (almost 70%) are on service delivery
 - Personnel costs currently comprise 37% of PEPFAR's total expenditures in Lesotho, which suggests the team should be actively working to identify prospective local partners who can help to reduce costs without compromising the quality of programs
- Testing:
 - All agencies came up far short of HTS_TST_POS targets
 - Only 31,883 PLHIV were discovered during COP17, compared to annual targets of 97,246 pre-PHIA (33%), or 50,025 post-PHIA (still only 64%)
 - Index testing is the most important means by which to improve overall yield and case-finding, but programmatic data make it clear that index testing is not being practiced properly (e.g., COP17 quarterly yield, even among adults, ranged from just 9% to 12%)
- Treatment and Viral Suppression:
 - Linkage and retention both appear to be strong
 - Most recent national linkage estimate is 95%
 - Current retention proxy estimate is 95%
 - There is however, a clear linkage problem with adolescents (e.g., retention among 15-19 year old females estimated to be only 80% and among males just 61%)
 - Viral load suppression measures have been good (92%+), but the most recent estimates of viral load coverage (51%) reveal that planned coverage expansion is off track
- Prevention:
 - Most prevention efforts during COP17 have also come significantly short of annual targets and expectations, including:
 - VMMC: 49% of targets
 - KP programming: Less than 200 total PLHIV identified among FSWs and MSM
 - DREAMS: More than 2/3 of those reached only receiving one of the four layered services

Partner Performance

- Virtually across the board, partners spent at or below their allocated amounts during COP17
- Performance to targets, however, were too short across too many indicators
- Though results fell short of targets, partners' performance across some key indicators, as a share of results compared to targets actually increased relative to last year (e.g., treatment new achievement ranged from 36%-41% for all partners during COP16, but averaged over 50% during COP17)
- Specific partner issues that warrant observation and correction during COP18:
 - EGPAF (via both CDC and USAID) handles a significant amount of testing activities in Lesotho. Testing yield is too low across testing modalities, gender, and age groups. Their index testing practices are particularly problematic, as it is clear they are conducting too many index tests without fidelity, particularly those given to children
 - PSI is the other major testing partner and also came up far short of targets, and is not practicing index testing as prescribed
 - EGPAF must oversee a much higher level of viral load coverage expansion during COP18 than during COP17, when only 52% of its target was hit
 - JHPIEGO is performing too few circumcisions (44% of annual target in COP17), and though new data show that their performance improved during COP18 Q1, their annualized rate during the quarter (74% of target) is still too low. Without improvement, a new partner may need to be considered for COP19

Subject to COP Development and Approval

APPENDIX 4: COP 2019 DIRECTIVES

Table 7. COP 2019 (FY 2020) Targets

Based on current progress towards epidemic control and funding level, the following FY 2020 treatment targets are recommended for Lesotho:

| Indicator | Pediatric (<15) Treatment Target | Adult Women (15+) Treatment Target | Adult Men (15+) Treatment Target | Treatment Target Total |
|--------------------------------|--|---|---|---------------------------|
| COP 18 (FY 19 Targets) | | | | |
| TX_NEW (New on Treatment) | 1,954 | 26,942 | 16,814 | 45,260 |
| TX_CURR (Current on Treatment) | 12,548 | 171,469 | 118,179 | 302,106 |
| TB_PREV | n/a | n/a | n/a | 132,566 |
| VMMC CIRC | n/a | n/a | n/a | 36,719 |
| COP 19 (FY 20 Targets) | | | | |
| TX_NEW (New on Treatment) | 3,594 | 14,884 | 7,466 | 25,944 |
| TX_CURR (Current on Treatment) | 15,429 | 177,780 | 119,736 | 312,945 |
| TB_PREV | n/a | n/a | n/a | n/a |
| VMMC CIRC | n/a | n/a | n/a | 30,000 |
| National Treatment Coverage | | | | |
| Treatment Coverage | 90% | 90% | 90% | 90% |

^aTargets should be further allocated by age and sex based on disaggregated PLHIV estimates and unmet need for ART.

These targets were developed based on the following assumptions:

- TX_NEW: Targets for TX_NEW assume that 95% of TX_CURR patients are retained from year to year, and that 90% of the TX_NEW target will be retained and thus contribute to the required TX_NET_NEW to achieve the TX_CURR target. Lesotho should consider as they move to Epidemic Control how they can exceed these minimum requirements.
- TX_CURR: TX_CURR targets were generated to move Lesotho to 95-95-95 at the country-level based on preliminary 2018 estimates of PLHIV and ART coverage estimates. In order to achieve this target, the team needs accurate reporting and minimization of loss and mortality.
- TB_PREV: Targets for TB_PREV were calculated using an Excel-based tool that utilized (among other considerations) estimated number of patients expected to be on ART at the start of COP 2019 who would screen negative for TB symptoms, the proportion likely to be ineligible for clinical reasons, the estimated number who would

have already received TPT by the start of COP 2019 and projected enrollment and completion rates.

- VMMC_CIRC: Targets for VMMC were developed based on current coverage, past performance, and available funding for prevention activities.

Although Lesotho has achieved significant progress and is on the path to epidemic control, the COP 2019 strategy must direct PEPFAR’s investment toward the remaining gaps.

COP 2019 Minimum Requirements

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements no later than the beginning of COP19 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs. Failure to meet any of these requirements by FY 2020 will result in reductions to Lesotho’s budget.

Table 8. Minimum Requirements

| Minimum Requirement | OU-Specific Guidance (if applicable in COP18 or COP19) |
|--|--|
| 1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups. | Adopted and fully implemented in Lesotho. |
| 2. Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents. | DSD has been implemented at various stages in different regions and sites. Linkage has been strong across facilities and communities, but supply chain needs to improve to increase % of patients with MMS. It is expected that major, demonstrated progress will be made across all DSD areas that have not yet been fully implemented (i.e., index testing, MMS, TLD, and linkage) by Q3 COP18, or funding C&T at current level will be reduced. |
| 3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine based regimens. | Transition from TLE to TLD is mapped and will soon be underway—updates at regular intervals to track progress must continue. |
| 4. Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established. | Case-finding is the most prominent area that requires immediate improvement on last year’s performance. During COP18, the field team and agencies must work with implementing partners to rapidly expand index testing efforts while simultaneously improving fidelity. |

| | |
|---|---|
| <p>5. TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.</p> | <p>Given the team's struggles with systems challenges, including routine procurement issues and stock outs; inadequate screening and low yields; and difficulties managing MOH relationship and untrained workers, an intensive TA plan from ISMEs and OGAC PQ is planned. Regular progress reports planned to ensure no additional intervention is needed.</p> |
| <p>6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.</p> | <p>COP19 IP work plans need to reflect fidelity to this minimum requirement.</p> |
| <p>7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention.</p> | <p>Refer to COP guidance.</p> |
| <p>8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.</p> | <p>VL scale up activities will continue. Field team has agreed that a target of 90% VL coverage by the end of COP18 is realistic, and will provide regular progress reports. If additional assistance from ISMEs or S/GAC with technical issues, lab quality, or management of partnerships (including MOH) it will be provided. VL coverage of 100% expected during COP19.</p> |
| <p>9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p> | <p>Refer to COP guidance.</p> |
| <p>10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management.</p> | <p>Performance should improve, and the team should ensure that priority age groups are addressed and that all OVC/DREAMS components, including fully layered services, are provided as designed. Progress will be monitored and TA as necessary will be available.</p> |
| <p>11. Evidence of resource commitments by host governments with year after year increases.</p> | <p>S/GAC (led by Lesotho Chair and PPM) will provide a "responsibility matrix" to field team, which will require them to assess current levels of functional and financial responsibilities among three major funders (PEPFAR, GFATM, and GoL) for the various</p> |

| | |
|---|--|
| | elements of HIV-related programs. The completed responsibility matrix form, which can be provided to Chair/HQ reps during RPMs, will provide a baseline for current responsibilities against which evidence of transitioning resource commitments by host governments can be measured in future years. |
| 12. Clear evidence of agency progress toward local, indigenous partner prime funding. | Field team and counterparts will need to identify more prospective local partners over time, particularly to reduce current personnel costs. |
| 13. Scale up of unique identifier for patients across all sites. | Complete during COP19. |

In addition to meeting the minimum requirements outlined above, it is expected that Lesotho will ensure appropriate progress towards viral load management and improved use of efficient testing strategies.

Table 9. Other Requirements

| Requirement | OU Specific Guidance (if applicable in COP18 or COP19) |
|---|---|
| 1. Viral load management: Country policy updated. | As described above, VL scale up activities must continue at a rapid pace. Policy has been informally updated to reflect a target of 90% VL coverage by the end of COP18, and 100% by the end of COP19. If additional assistance from ISMEs or OGAC with technical issues, lab quality, or management of partnerships (including MOH) it will be requested and provided. |
| 2. Screen better and test smarter: Stop over-testing. | Field teams must work with partners to improve testing practices across every testing modality to improve yield and fidelity. Index testing practices should receive the vast majority of efforts, and the field team should insure that IPs appropriately map out sexual partner networks, routinize the notification process, etc. Self-testing should be inserted into every possible testing modality. These more efficient practices will improve performance across testing targets and reduce testing costs. |

COP 2019 Technical Priorities

Tuberculosis

PEPFAR OUs are expected to offer Tuberculosis Preventive Treatment (TPT) as a routine part of HIV care, which means that all care and treatment partners are expected to offer TPT and report on it. Programs are expected to fully scale TPT over the next two years, such that all PLHIV who are on treatment and are eligible for TPT have received a course by the end of COP 2020. Therefore, the TB_PREV targets included in this letter were set as described above under the target table. For COP 2019, the number of patients that are expected to complete a course of TPT in Lesotho is 132,566, approximately half the total number of eligible PLHIV, per the mandate from S/GAC to fully scale TPT over the next two years. COP 2020 TB_PREV targets will cover the remaining 50% of the eligible PLHIV on ART, adjusted upward for those that will be newly enrolled in ART during the COP 2019 implementation period. In order to ensure successful programming, it is expected that, at a minimum, \$742,370 will be budgeted for TPT commodities.

DREAMS

Lesotho is allocated \$10,017,660 funding for DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) programming in COP 2019, of which \$700,000 of your COP19 HVAB budget code needs to be part of your DREAMS programming. This funding is allocated within your COP 2019 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2019 Guidance. All new funding allocated to AGYW prevention programming, including DREAMS, must be allocated to the AGYW Prevention cross-cutting budget code.

As of FY18Q4 Lesotho had achieved less than 50% of targets for OVC_SERV (aged 0-17) and some children experienced severe delays in services received. In addition, Lesotho performed poorly on the percentage of children who know their status or don't require a test based on a risk assessment (42% known status proxy). While dramatic improvements are required in the current fiscal year, the team should describe in the SDS how they will achieve targets and ensure zero breaks in services delivered in FY20.

VMMC

Lesotho is allocated \$4,346,453 funding for VMMC. As with COP 2018, your total COP 2019 allocation to the CIRC budget code is included in your COP funding determined in this letter. VMMC funding must be used exclusively to support the implementation of VMMC programs in males 10 years and older as pursuant with the CIRC budget code guidance, including the minimum package of clinical and prevention services which must be included at every VMMC delivery point, circumcisions supplies and commodities, communication and demand creation, training, and case finding and linkages for high-risk men.

Lesotho's total VMMC target for COP 2019 is 30,000.

Cervical Cancer Screening and Treatment:

Lesotho is allocated \$2,393,040 funding for Cervical Cancer Screening and Treatment programming in COP 2019. This funding is allocated within your COP 2019 planning level and must be used exclusively to reduce morbidity and mortality of women on ART in Lesotho. Per the number of women on ART for the 25-49 year old age band at the end of COP 2017 implementation period, your COP 2019 target for screening HIV positive women for cervical cancer is 46,026 (50% of women 25-49 on treatment).

Addressing Gaps in Epidemic Control, including by Enhancing Engagement with Faith Communities

You have been selected as one of the countries to receive Central Funding support through the FBO and Community Initiative in the amount of \$7.3 million, *in order to accomplish these priority activities, as identified per the FBO TDY visits*. These funds should be used to support case-finding for young adult men, adolescents, and children living with HIV; and to support primary prevention of sexual violence and HIV among children ages 9-14 year old, as explained below.

As one of the countries that posted a reduction between COP17 and COP18 of \$ 4,723,335 in support of FBO partners, you are now receiving \$4,723,335 (part of \$7,300,000) to restore funding for COP18 execution, and these partners must receive full funding for all services provided in COP19, remembering that many FBO clinics are often not subsidized to the same extent as public sector clinics.

These funds should support activities that strengthen primary prevention of sexual violence and HIV among children ages 9-14. As identified during the FBO visits, these activities should include, but not be limited to, convening key stakeholders to facilitate sharing solutions about key sexual and gender-based violence prevention messages by engaging health expertise within religious settings; and building capacity for evidence-based interventions in faith structures (e.g., churches and mosques). Specifically, the \$4,723,335 should be programmed with Catholic Relief Services (USAID) to address gaps in funding from the previous year.

The investments in primary prevention of sexual violence and HIV should include raising awareness among faith and traditional leadership about sexual violence and HIV risk faced by 9-14 year olds; using national-to-local infrastructures to train faith leaders in targeted implementation of evidence-based approaches within faith community infrastructures, including youth, parenting, and men's religious programming, with a focus on community mobilization, changing norms and parenting/caregiver programs (these programs include *Families Matter, Parenting for Lifelong Health, Real Fathers, Coaching Boys Into Men, and SASA! Faith*); and engaging in child safeguarding policy development and implementation through faith and traditional community structures.

You have also been selected as one of the countries to receive additional Central Funding support through the FBO and Community Initiative in the amount of \$ 2,576,665 to increase investments in case-finding for young adult men, adolescents, and children living with HIV. These funds, to be received by CDC, are to be used to engage those who work in high burden areas (including informal settlements) with faith communities, such as local faith-based and traditional networks, local faith-based and traditional organizations, as well as faith and traditional leaders.

The case-finding investments should include the development and/or adaptation and dissemination of new messaging about HIV testing, linkage, and retention (e.g., Test & Start, U=U); building capacity among local faith leaders and faith organizations to create demand for and use of HIV self-tests, along with procurement and targeted distribution of HIV self-tests, engaging champions in faith communities to strengthen linkage and adherence support; and programming on basic HIV education and stigma reduction; and convening key stakeholders to facilitate sharing solutions, assuring inclusion of the contextualized process for accessing health, legal, and social protection referrals.

Some Faith and Community partners support both HIV case-finding/linkage/retention and prevention of sexual violence and HIV risk among ages 9-14 years; in these cases, it may be possible to engage in comprehensive prevention and care by supporting both key FBO priorities.

Any further instructions or questions can be addressed by Chair and PPM.

Other Technical and Programmatic Priorities for Lesotho

First 90:

- Field teams should work with partners to improve testing practices, especially for index testing, e.g., by ensuring that partners appropriately map out sexual partner networks, routinize the notification process, etc.
 - Full scale, faithful implementation of index testing is critical: yields must be above 20% for newly identified positives
 - Self-testing, particularly for finding men, should be incorporated across all testing modalities
 - A need remains to solicit more male contacts
 - PITC practices must be optimized, and volume of testing reduced

Second and Third 90s:

- Viral load coverage and lab quality issues need to be addressed quickly
 - By the end of COP18, VL coverage should be 90%
 - By the end of COP19, VL coverage should be 100%, with acceptable turnaround time and completed Table 6 laboratory investments
- An effort to address any site-level problems at clinics identified as having adherence and retention problems must also take place during COP18

Addressing Partner Performance

- Field teams should work with partners to improve testing practices, especially for index testing, e.g., by ensuring that partners appropriately map out sexual partner networks, routinize the notification process, etc.
- If a partner does not achieve 80% HTC_TST_POS in COP18, a new partner for COP19 may be necessary
- TA from ISMEs and PQ team to assist with problem diagnoses and solutions for IPT, VMMC, and OVC/DREAMS during COP18 is planned, and without evident improvement, additional measures must be considered in advance of COP19

Partner Transitions

- Personnel costs currently comprise 37% of PEPFAR's total expenditures in Lesotho. The field team should be actively working to identify prospective local partners who can help to reduce costs without comprising the quality of programs
- Because such a high portion of PEPFAR's expenditures in Lesotho are currently on service delivery, total donor expenses should come down over time as some programmatic and financial responsibilities gradually shift

Table 6 and Planning for Sustainability

- At this point, only two types of Table 6 investments are sensible in Lesotho—SI and lab system strengthening. Lab investments are admittedly buffeted by government problems, but COP19 remains the year to close out lab investments.
- From COP19 forward, Lesotho should not need many more Table 6 investments—necessary capacity building should be completed, so it will then merely be a matter of maintaining quality of labs, disease surveillance, and health services more broadly.
- During COP18 and in preparation for COP19, as more PLHIV continue to be identified and linked to treatment, and programs get even closer to reaching the 90-90-90 targets, stakeholders should begin to prepare for the evolution of Lesotho's HIV programs to put in place the structures necessary for sustainable epidemic control. This will include consideration of what share of responsibilities the Government of Lesotho can be reasonably expected to handle over time.

COP 2019 Stakeholder Engagement

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups

throughout the development and implementation of COP 2019 remains a requirement for all PEPFAR programs, and as such the COP 2019 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2018 Q4 and FY 2018 APR results and analyses and the convening of an in-country planning retreat with local stakeholders no later than the week of January 28, 2019 in order to introduce and discuss all COP 2019 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2019. In February, initial COP tools will be submitted to S/GAC for review and feedback. S/GAC will provide feedback prior to the in-person meetings in March and April, and teams should reflect the feedback with their revised submissions. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team.

In March, PEPFAR will convene in-person meetings in Johannesburg, South Africa, where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Engagement with all stakeholders is required beyond the meetings and throughout the COP 2019 development and finalization process. As in COP 2018, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2019 Guidance for a full list of requirements and engagement timelines (Section 2.5.3).

Subject to COP Development and Approval