



## **FY 2015 Lesotho Country Operational Plan (COP)**

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on [www.PEPFAR.gov](http://www.PEPFAR.gov), reflect the approved FY 2015 COP for Lesotho.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

**Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.**

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.
- 3) *Sustainability Index and Dashboard*

**Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on [www.PEPFAR.gov](http://www.PEPFAR.gov) in the “FY 2015 Country Operational Plan Budget and Target Report.”**

**Lesotho**

**Country Operational Plan (COP) 2015**

**Strategic Direction Summary**

August 5, 2015

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## Goal Statement

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The Country Operational Plan 2015 for Lesotho is set in the context of the broader PEPFAR Lesotho Strategic Framework 2015-2020. COP FY2015 describes the programmatic pivot required in order to increase the number of eligible people receiving anti-retroviral therapy (ART) with the goal to achieve 80% coverage in the five districts most burdened by HIV by September 30, 2018. Increasing ART coverage will prevent both morbidity and mortality of the people living with HIV (PLHIV) and will help avert new infections. This will require greater collaboration with the Government of Lesotho (GOL) and the Global Fund to successfully achieve this goal. PEPFAR Lesotho has worked with a number of stakeholders in order to develop the 2015 COP.

Lesotho has the one of the highest highest HIV incidence rates in the world, yet has low HIV treatment coverage. To reach epidemic control – the point at which new HIV infections have decreased and fall below the number of AIDS-related deaths – will not be possible at the current pace. Therefore, COP 2015 investments are focused on achieving 80% coverage of ART in five districts.

A minimum package of care, treatment, and support services has been established for PEPFAR-supported patients in all remaining districts of Lesotho. The sustained package is described in section 5.0, along with PEPFAR Lesotho’s objective of maximizing efficiencies and programing to overcome bottlenecks and leakages across the clinical cascade and accelerate ART uptake in the scale-up districts.

The comparative strength of the PEPFAR program is that it has implementing partners at the service delivery point that can improve program quality. Implementing partners will increase HIV diagnosis, enhance linkages to care, hasten initiation of treatment, and foster adherence and retention. Building upon the ACT and DREAMS initiatives, PEPFAR Lesotho will prioritize scale-up in high-burden districts through direct community and site support. 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 profile

Lesotho has a total population of 1,916,574 people, 52% of whom are women and 36% are under 15 years of age. The country is divided into ten administrative districts. The country is classified a Lower Middle Income country with a Human Development Index of 0.486<sup>1</sup> and a Gross National Income (GNI) per capita of \$1,500<sup>2</sup>. Seventy-three percent of the population resides in rural areas. The lowland districts of Maseru, Mafeteng, Mohale's Hoek, Leribe and Berea are the residence for 70% of the total population.

The data provided on Lesotho's HIV epidemic throughout COP 2015 is based on official demographic information from Lesotho's Bureau of Statistics (BOS). UNAIDS spectrum EPP estimates were based on the UN Population Division projections that showed a higher total population for Lesotho. The total population is now estimated at 1.9 million (down from 2.1 million). These MOH and UNAIDS revisions have resulted in the projected number of PLHIV decreasing from 360,000 to 310,000<sup>3</sup>. This is not evidence of a reduction in prevalence, but a revision of PLHIV projections<sup>4</sup>.

Despite these changes, Lesotho continues to have one of the highest HIV prevalence among people 15-49 years, with prevalence stabilizing at 23.4% [CI: 22.1% to 24.8]. HIV remains in the top ten causes of outpatient consultations and inpatient mortality. However, recent modeling shows a significant reduction in incidence over the last 10 years from 2.8% [CI: 2.6 – 3.0] in 2004 to 2.0% [CI: 1.9 – 2.2] in 2014<sup>5</sup>, bringing the trend more in line with other southern African countries.

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

Available funding for the GOL program is only half of the projected requirement of \$557 million for 2015-2018. This funding shortfall is compounded by critical barriers to supply, demand and access to HIV services that cannot be addressed in isolation. The barriers are 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.

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<sup>1</sup> <http://hdr.undp.org/en/data>

<sup>2</sup> <http://data.worldbank.org/country/lesotho>

<sup>3</sup> <http://aidsinfo.unaids.org/>

<sup>4</sup> The 2014 UNAIDS HIV epidemiological estimates were not released until June 2014, so provisional SPECTRUM estimates were used to plan the Lesotho COP 2015

<sup>5</sup> Estimates are based on preliminary SPECTRUM estimates in 2014 for persons 15-49 years of age.

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	1,916,574	100	344,297	18%	344,602	18%	653,332	34%	574,342	30%	BOS, 2014 <sup>6</sup>
Prevalence (%)		15.5%		2.9%		2.9%		24.9%		19.9%	Spectrum, 2014 <sup>7</sup>
AIDS Deaths (per year)	8,025		525		550		3,350		3,600		Spectrum, 2014 <sup>8</sup>
PLHIV	297,00		10,000		10,000		162,500		114,500		Spectrum, 2014 <sup>9</sup>
Incidence Rate (Yr)		1.15%		0.8%		0.8%		1.27%		1.03%	Spectrum, 2014 <sup>10</sup>
New Infections (Yr)	18,630										Spectrum, 2014 <sup>11</sup>
Annual Births	50,900	100%									Spectrum, 2014 <sup>12</sup>
% >= 1 ANC visit	N/A	95%	n/a	n/a			n/a	n/a			KIR/DHS, 2014 <sup>13</sup>
Pregnant women needing ARVs	11,820	23% <sup>14</sup>									Spectrum, 2014
Orphans (maternal, paternal, double)	118,370		38,835		38,835		20,350		20,350		Spectrum, 2014
TB cases (Yr)	18,090		n/a		n/a		n/a		n/a		Spectrum, 2014
TB/HIV Co-infection	13,234	73%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Spectrum, 2014
Males Circum-cised <sup>15</sup>	160,443	100%			22,457 <sup>16</sup>	14%			137,986 <sup>17</sup>	86%	BOS population projections, 2014

<sup>6</sup> Lesotho National and Sub-national Population Projections, Bureau of Statistics and UNFPA, 2010

<sup>7</sup> Preliminary SPECTRUM Projection for 2014, MOH and UNAIDS, 2015.

<sup>8</sup> Final Spectrum estimates would round this to 8,000 to show the lack of precision in the estimates, but we have rounded to 8,025 so that the disaggregates sum to the total. We have done this for several estimates (e.g., # PLHIV by age and sex).

<sup>9</sup> Total number of PLHIV has been scaled to 297,000 which was the Spectrum estimate when populating the data pack. It has since increased to 298,855. Disaggregates may not sum to the total due to rounding.

<sup>10</sup> Local estimates from Spectrum which may differ slightly from final UNAIDS estimates

<sup>11</sup> Ibid

<sup>12</sup> Ibid

<sup>13</sup> MOH, Demographic and Health Survey: Key Indicators 2014, March 2015

<sup>14</sup> 11,820 HIV+ pregnant women / 50,900 births

<sup>15</sup> Traditional circumcisions excluded

<sup>16</sup> APR 2012-2014 results for 0-14 years

<sup>17</sup> BOS 2014, 15-59 males equals 520,702 multiplied by KIR/DHS 2014 26.5% of men 15-59 reporting medical circumcision

											KIR/DHS, 2014; APR, 2012-2014
<b>Key Populations</b>											
Total MSM*	10,845										Lesotho estimate <sup>18</sup>
MSM HIV Prevalence	31.1%										Maseru population <sup>19</sup>
Total FSW	5,986										Lesotho estimate <sup>20</sup>
FSW HIV Prevalence	73.3%										Maseru Population <sup>21</sup>
Total PWID	N/A										
PWID HIV Prevalence	N/A										
Military*											
<i>*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.</i>											

<sup>18</sup> Sweitzer, S. Rolfe, J. Ketende, J. Grosso. A. Baral, S. Examining Factors Associated with HIV-related Risk Behaviors, HIV Prevalence, and Population size Estimates of Two Key Populations—Men who have Sex with Men (MSM) and Female Sex Workers (FSW)—in Lesotho, October 2014. [PSI publication]

<sup>19</sup> Ibid

<sup>20</sup> Ibid

<sup>21</sup> Ibid

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%) <sup>22</sup>	Total PLHIV (#) <sup>23</sup>	In Care (#) <sup>24</sup>	On ART (#) <sup>25</sup>	Retained on ART 12 Months (#) <sup>26</sup>	Viral Suppression 12 Months	Tested for HIV (#) <sup>27</sup>	Diagnosed HIV Positive (#) <sup>28</sup>	Initiated on ART (#)
Total population	1,916,574	23.2%	297,000	205,699	106,384	90,426	n/a	588,549	69,067	21,850 <sup>29</sup>
Population less than 15 years	688,899	2.9%	20,000	14,635	4,824	4,100	n/a	69,776	2,914	1,396
Pregnant Women	55,100	25.9% <sup>30</sup>	12,900	31,754	7,754 <sup>31</sup>	5,583 <sup>32</sup>	n/a	25,348	3,743	3,480
MSM <sup>33</sup>	10,845	31.1%	3,372	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FSW <sup>34</sup>	5,986	73.3%	4,388	n/a	n/a	n/a	n/a	n/a	n/a	n/a
PWID	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	

<sup>22</sup> SPECTRUM Projection for 2014; MOH and UNAIDS, 2015

<sup>23</sup> Ibid

<sup>24</sup> MOH, ART Report as of APR14, 2014

<sup>25</sup> Ibid

<sup>26</sup> Calculated from data pack based on 15% LTFU

<sup>27</sup> MOH, HTC Report as of APR 2014 (excludes EID 11,518 tested within 12 months)

<sup>28</sup> Ibid

<sup>29</sup> MOH, ART New Enrollment Report as of APR 14, 2014

<sup>30</sup> MOH, ANC HIV Sentinel Surveillance Report 2013, 2015

<sup>31</sup> MOH, PMTCT Report as of APR 2014 (HIV tested among all newly identified positives only and initiated among newly identified only)

<sup>32</sup> EGPAF, Roll-out of Option B+ Assessment, 2015

<sup>33</sup> Sweitzer, S. Rolfe, J. Ketende, J. Grosso. A. Baral, S. Examining Factors Associated with HIV-related Risk Behaviors, HIV Prevalence, and Population size Estimates of Two Key Populations—Men who have Sex with Men (MSM) and Female Sex Workers (FSW)—in Lesotho, October 2014. [PSI publication.]

<sup>34</sup> Ibid

The distribution of HIV in Lesotho varies by district, population, gender, and age. In 2009, based on estimates from the UNAIDS 2014 sub-national report for Lesotho, HIV prevalence across districts ranged from 14.7 – 27.1%. HIV prevalence was highest in Maseru district [78,735 individuals] and lowest in Butha Buthe [11,957 individuals].<sup>35</sup> Leribe and Berea were the second and third highest burden districts, with 23.4% [47,194 individuals] and 21.2% [37,302 individuals] respectively.<sup>36</sup>

HIV prevalence in individuals under 15 years is 3%, but for those 15+ there are differences with HIV prevalence at 34% for women and 30% for men. Divorced/separated and widowed individuals have higher prevalence (50.5% and 59.9%, respectively).<sup>37</sup> HIV prevalence also varies by age with the highest prevalence among people aged 30-39 years (40%).<sup>38</sup> Prevalence was higher in urban (27.2%) compared to rural (21.1%) areas.<sup>39</sup>

## 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 Account, Clinton Foundation and the World Bank. Twenty-eight percent of the funding in 2014 came from domestic resources while 72% came from international sources.<sup>40</sup> The country projects to increase their allocation to HIV to 40% in subsequent years under the willingness to pay clause of the Global Fund concept note.

Of the existing domestic resources for the national HIV/AIDS response, the highest allocation area was care and treatment including laboratory services that accounted for 71%, followed by impact mitigation with 24%. All other areas made up the remaining 5% of the funding envelope. Impact mitigation predominately accounted for support to vulnerable children through the Ministry of Social Development. From results of the Lesotho Resource Mapping conducted in 2014, approximately \$8,000,000 (27%) of domestic HIV and AIDS resources were invested in multi-sectorial response. Table 1.2.1 and 1.2.2 detail program area funding. Of note, the GOL is supporting 47% of clinical care and treatment.

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 be more focused targeting the most affected or high-risk populations groups.

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<sup>35</sup> Data pack, April 17<sup>th</sup> v15.

<sup>36</sup> Ibid

<sup>37</sup> Lesotho DHS 2009.

<sup>38</sup> Ibid

<sup>39</sup> Ibid

<sup>40</sup> MOH, Resource Mapping 2013/14

**Table 1.2.1 Investment Profile by Program Area<sup>41</sup>**

Program Area	Total Expenditure	% PEPFAR	% GF	% GOL	% Other
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>42</sup>**

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GOL	% Other
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%	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>

**Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives [prospective]**

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	0	0	N/A	0	N/A
USAID TB	0	0	N/A	0	N/A
USAID Malaria	0	0	N/A	0	N/A
Family Planning	0	0	N/A	0	N/A
NIH	0	0	N/A	0	N/A
CDC NCD	0	0	N/A	0	N/A
Peace Corps	0	0	N/A	0	N/A
DOD Ebola	0	0	N/A	0	N/A
MCC	0	0	N/A	0	N/A
Private Sector	\$9,000,000	\$6,000,000	N/A	\$3,000,000	Vodafone Foundation Consortium
PEPFAR Central Initiatives	\$13,800,000		9		ACT Initiative
<b>Total</b>	<b>\$22,800,000</b>	<b>\$6,000,000</b>	<b>9</b>	<b>\$3,000,000</b>	

<sup>41</sup> Ibid

<sup>42</sup> Source: MOH Resource Mapping 2013/14

### **1.3 National Sustainability Profile**

The PEPFAR team completed a draft Sustainability Index Dashboard (SID) to assist with identifying areas of weakness which are critical to the HIV and AIDS response and attainment of epidemic control in Lesotho. Of the fifteen sustainability elements five were classified as unsustainable (Red), six scored partially unsustainable (Yellow), four scored partially sustainable (Light Green), and none scored sustainable (Green). With 11 of the 15 elements scoring either unsustainable or partially unsustainable the Lesotho HIV response requires urgent measures to change the course towards sustainable epidemic control.

The elements that scored either unsustainable or partially unsustainable included quality management (Red), resource commitments (Red), allocative efficiency (Red), technical efficiency (Red), public access to information (Red), epidemiological data (Yellow), performance data (Yellow), human resources for health (Yellow), supply chain management (Yellow), oversight and stewardship (Yellow), and policies, laws and regulations (Yellow).

Based on the partnership framework PEPFAR Lesotho has historically invested in three of these elements (human resources for health, supply chain management, and epidemiological data). In COP 2015, 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 2015, the PEPFAR team will engage the MOH to seek independent management and executive authority for commodity and supply chain management of HIV drugs, laboratory diagnostics, and other commodities. While the USG investments will go towards supply chain management systems strengthening, it is assumed that both the Global Fund and the Government of Lesotho will continue procuring adequate HIV commodities. In addition, COP 2015 has scaled up high-impact access and demand investments throughout the continuum of response. PEPFAR will scale-up demand for HIV services by ensuring that PLHIV know their HIV status either through PITC or CBTC and are linked to treatment services. In addition, treatment access will be expanded through HRH capacity for VMMC, OVC, HCT, PMTCT, FBCT and CBCT services in scale-up districts.

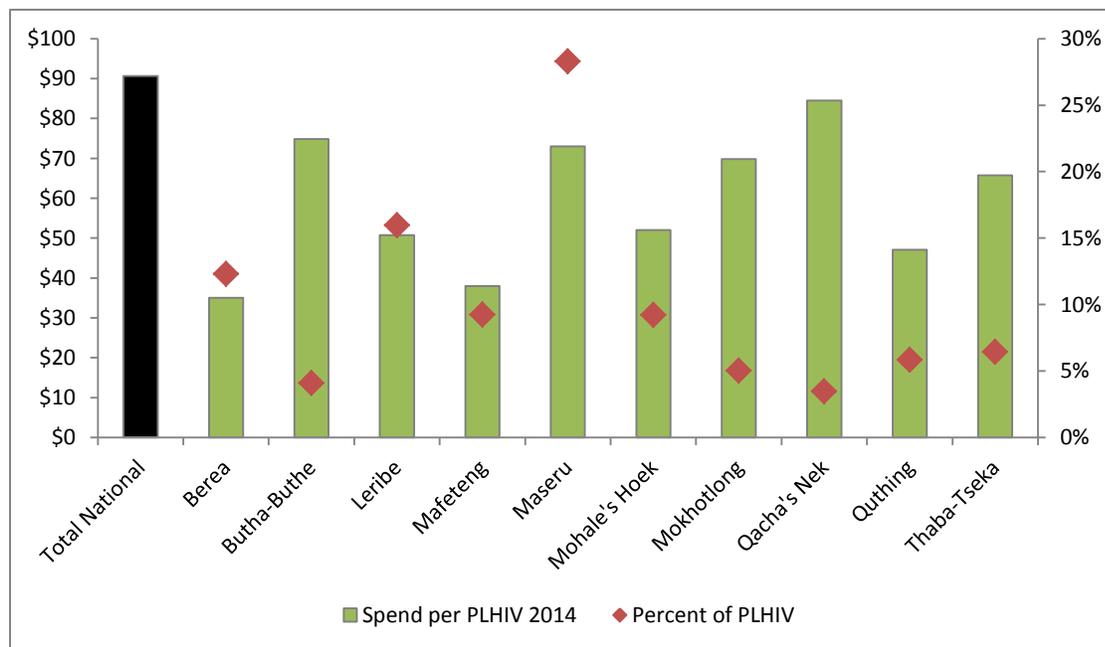
### **1.4 Alignment of PEPFAR investments geographically to disease burden**

PEPFAR's 2014 total expenditures were reasonably aligned to the geographic distribution of the disease burden with a few exceptions. Improved alignment of resources to disease burden is a key consideration for COP 2015; the PEPFAR team will make appropriate changes based on findings.

PEPFAR spent on average \$90 per PLHIV in Lesotho in 2014 (Figure 1.4.1). Spending per PLHIV at the district level varied from \$35 in Berea to \$84 in Qacha's Nek with an average of \$59 spent at the site level and an additional \$31 per PLHIV spent at the national level. There are several issues that puts this variation in context including different service delivery models across PEPFAR clinical partners; different cost drivers across SNU's related to distance, remoteness, and lower densities of PLHIV; and different levels of investment by the GOL and Global Fund across districts.

The PEPFAR team’s efforts to program with national reach in 2014 led to higher expenditures in places with lower disease burden. This is because it costs more to operate a 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 2014 Expenditure per PLHIV**



Further analyses of PEPFAR investments in 2014 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. Analyses of 2014 expenditures were carefully considered in the geographic prioritization exercise described in section 3.0. Figure 1.4.2 illustrates how expenditures have changed from 2013 to 2014 across SNUs; this figure demonstrates some planned and executed shifts in a few key districts, namely Maseru and Leribe.

Figure 1.4.2 Total PEPFAR 2013 & 2014 Expenditures and Percent of PLHIV by SNU by Fiscal Year

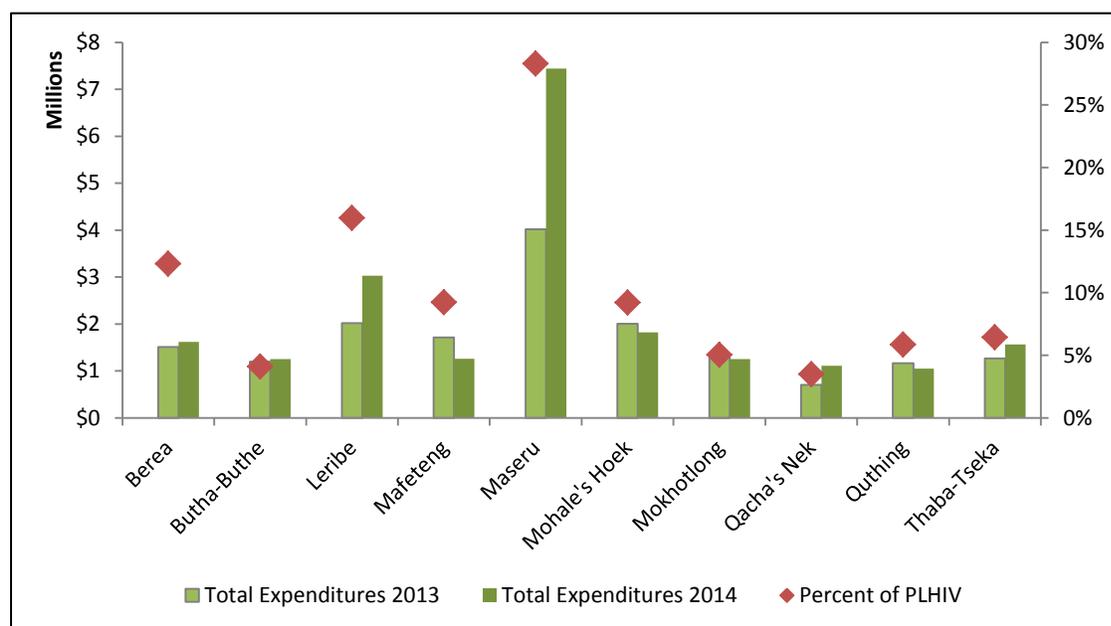


Table 1.4.2 Summary of Unmet Need, including Total PLHIV,<sup>43</sup> Percent PLHIV, and Coverage of Total PLHIV for ART by SNU

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	78,735	27%	33,722	43%	45,013	22,059	29,266
Leribe	47,194	16%	19,070	40%	28,124	14,171	18,685
Berea	37,302	13%	11,952	32%	25,350	17,042	17,890
Mafeteng	30,908	10%	10,454	34%	20,454	12,500	14,272
Mohale's Hoek	28,211	9%	7,835	28%	20,376	11,451	14,734
Quthing	19,151	6%	4,014	21%	15,137	9,090	11,307
Thaba Tseka	18,119	6%	6,354	35%	11,765	6,274	8,141
Mokhotlong	14,822	5%	4,338	29%	10,484	6,380	7,519
Butha Buthe	11,957	4%	6,213	52%	5,744	1,803	3,352
Qacha's Nek	10,602	4%	2,432	23%	8,170	4,033	6,049
<b>National</b>	<b>297,000</b>	<b>100%</b>	<b>106,384</b>	<b>36%</b>	<b>190,616</b>	<b>104,803</b>	<b>131,216</b>

<sup>43</sup> Data pack, April 17th v15.

## 1.5 Stakeholder Engagement

The PEPFAR Lesotho team's engagement with host country government representatives has been limited due to the February 28, 2015 national elections and delays in forming the current, seven-party ruling coalition. As we forge a more robust relationship with the new administration, Ambassador Harrington has taken the lead in engaging with the new Prime Minister, Deputy Prime Minister, Minister of Health and others on the need for increased leadership on HIV/AIDS issues. During a meeting on April 13, the Ambassador briefed the Health Minister on the core elements of PEPFAR 3.0 and COP 2015 including the decision to focus scale-up in prioritized districts.

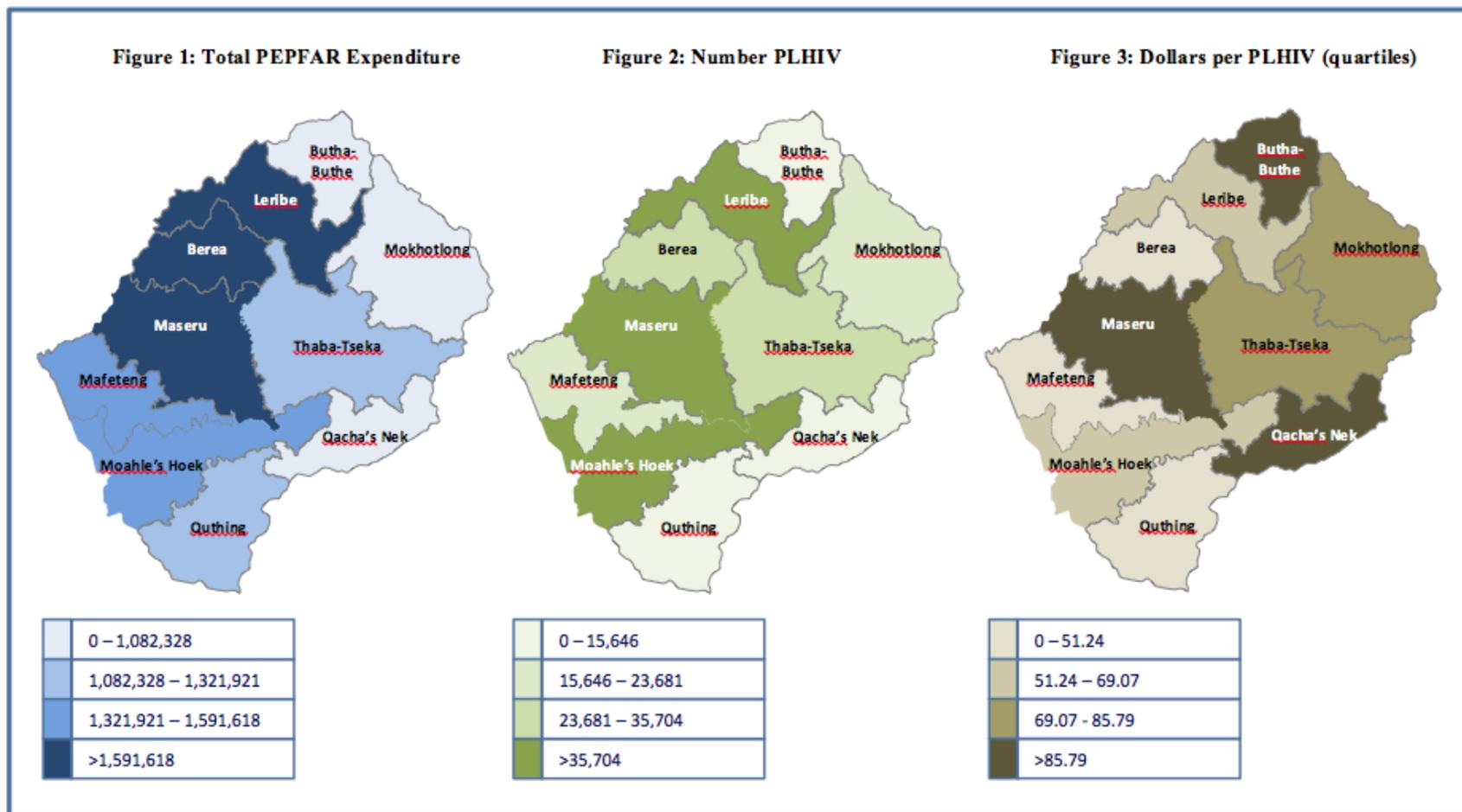
Although the post-election delays have prevented a multi-stakeholder engagement meeting, the PEPFAR team undertook technical consultations with MOH counterparts including the Director General and Department Directors. These consultations focused primarily on the COP 2015 investment approach of ART saturation for scale-up districts. The team presented the data driving PEPFAR's geographic prioritization decisions. Also discussed were how PEPFAR support to service delivery in sustained districts would be managed, maintaining a mutually agreed upon package of support and service quality assurance. The response from the MOH was positive; further dialogue was planned on ACT and DREAMS initiatives.

The PEPFAR team held a consultative meeting with local civil society on April 21, 2015. A discussion was held and committee formed to develop an engagement strategy in line with the guidance, as well as a presentation and dialogue on PEPFAR Lesotho's COP15 proposal.

The PEPFAR team engaged as far as possible with the Global Fund and other health donors during the course of COP 2015 planning through bilateral meetings. COP development took place at the same time as the development of the Global Fund concept note. PEPFAR reviewers in the field and in Washington raised concerns about the levels of funding dedicated to ART and other commodity procurements as well as limited coordination with PEPFAR programming in other areas. As a result, the USG declined to provide an immediate endorsement to the GOL proposal. Subsequently PEPFAR Lesotho endorsed the concept note noting the need for the GOL to meet their willingness to pay commitment to allocate an additional \$10 million for ARV procurement. Further concerns on the remaining 10-20% ARV shortfall, programmatic alignment to ACT and DREAMS initiatives, and synergies with the PEPFAR program given the current development and review of COP15 will need to be addressed. It is expected that these issues will be addressed concurrently with the TRP review and grant making process. The Lesotho PEPFAR team requested the Global Fund and other donors' programs to be supportive of COP 2015 activities.

The PEPFAR team was constrained in holding open and free dialogue with stakeholders due to serious data challenges and fragmented analytical tools. Much time was spent by the team to populate, update, and identify and correct analytical tool errors in order for PEPFAR Lesotho to be able to present a cohesive and robust data set.

Figure 1.3.2 Total expenditure, PLHIV, and Expenditure per PLHIV by District



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

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PEPFAR Lesotho undertook an analysis of the PEPFAR Lesotho program in the context 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 to the technical approaches to maximize our impact. Though the majority of clinical services are provided within GOL health centers, PEPFAR Lesotho is the primary donor at the site/service delivery level for PMTCT, HTC, care and treatment, TB/HIV, and the laboratory, strategic information and supply chain management systems. Therefore given the projected scale-up, the plan has retained core service delivery support and quality assurance components for these interventions.

Given the need for scale-up of treatment activities, blood safety, aspects of OVC programming, and cross-cutting central policy formulation/dissemination not targeted to priority populations have been identified as non-core and will end in 2016. The core and near-core activities have also been geographically focused to scale-up districts and 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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PEPFAR is currently operational in all ten districts. In order to reach 80% ART coverage nationally, an additional 131,216 patients will need to be initiated on ART. This will require scale-up in other programs such as HTC, PMTCT, community outreach, priority and key population interventions, and HSS. The investments required to achieve saturation nationally are in excess of currently available resources.

Based on PEPFAR guidance, the care and treatment allocation will increase significantly in FY16 in order to achieve the proposed targets. Due to the increase in the care and treatment allocation, HSS, HTC and VMMC allocations will have to remain level or decrease. PEPFAR Lesotho will not have the resources to fill the total unmet need for effective saturation of combination prevention. Neither the Global Fund nor the GOL currently have the necessary resources as demonstrated by the \$31.4 million funding gap in 2015/16 and \$61.4 million funding gap in 2017<sup>44</sup>.

Given this budget constraint, PEPFAR Lesotho has chosen to focus its activities in a set of scale-up districts and on a sub-set of priority populations. PEPFAR Lesotho will focus on five districts for scale-up, three to saturation (Maseru, Berea and Leribe) and two districts for aggressive scale-up (Mafeteng and Mohale's Hoek) that represent 75% of the national HIV disease burden. PEPFAR Lesotho has calculated the program can support scale-up for 44,197 new patients in five districts in the next year given the planned spending level and targeting for ART using the clinical cascade. Assuming that 64,452 additional patients are added on ART by the end of 2018, PEPFAR Lesotho could support the GOL to achieve epidemic control (80% of total PLHIV enrolled in ART) in the five districts. The remaining five districts (Butha Buthe, Thaba Tseka, Quthing, Mokhotlong, and Qacha's Nek) will receive a package of services to sustain passive enrollment via HIV testing and counseling that includes technical assistance for essential laboratory services for PLHIV as well as quality assurance and quality improvement to ensure patients continue to receive quality services.

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<sup>44</sup> Global Fund concept note submission, April 20, 2015

In accordance with PEPFAR’s realignment to focus resources geographically and programmatically, Peace Corps will further align PEPFAR-funded volunteer placements in areas with a high burden of HIV—with consideration of all safety and security regulations. The program will mobilize youth and young mothers to link to key services as well as build HIV knowledge.

## 4.0 Program Activities for Epidemic Control in Priority Locations and Populations

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### 4.1 Targets for priority locations and populations

In alignment with Lesotho’s NSP, we plan to reach 80% ART coverage in scale-up districts by 2018. PEPFAR Lesotho will support reaching this target by geographical prioritization in five districts with the highest burden and unmet need among PLHIV. Priority populations within these districts will be MSM, FSW and the military population. Eligible members of these populations will be prioritized within the target of 44,197 new naïve ART clients that will result in the goal of 126,925 current on ART by the end of FY2016. This represents an increase in coverage from 37% as of December 2014 to 52% (Table 4.1.1). We anticipate continuing to increase our assistance at a similar pace through 2017-18 to assist Lesotho in reaching the full 80% coverage target for PLHIV.

Data systems are poor in Lesotho and lack the ability to measure the number of PLHIV actively enrolled in care (pre-ART and ART). A recent patient file audit revealed the attrition among those in pre-ART was greater than 80%. Therefore the number of individuals in care is mostly represented by the number of individuals currently on treatment. Lesotho projects to have 98,657 current on treatment at the end of 2015 in the five scale-up districts. Using those individuals as baseline, Lesotho targets to reach the undiagnosed through targeted HTC, PMTCT, TB, and VMMC HIV testing. PMTCT and TB groups are test and treat in Lesotho. To account for attrition of PLHIV on ART, this represents a target of 44,197 newly initiated on ART in 2016 in the five scale-up districts.

Lesotho is an Option B+ country. The goal in 2016 is to test 95% of pregnant mothers in scale-up districts and enroll 95% of those testing HIV-positive into ART programs which is expected to yield an additional 7,663 newly initiated women on ART. EID access will be expanded to cover 99% of HIV-exposed infants (9,294) and all confirmed HIV-positive infants will be linked to treatment.

PEPFAR Lesotho’s support to Lesotho’s national and district-level targets will also occur via innovative service delivery models as well as focused routine technical assistance. PEPFAR Lesotho aims to reach 2,079 FSW and 3,379 MSM.

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

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SNU	Total PLHIV	Expected current on ART (2015)	Additional patients required for 80% ART coverage	Target current on ART (in FY16) <i>TX_CURR</i>	Newly initiated in FY 16 <i>TX_NEW</i>
Berea	37,302	13,118	16,724	20,897	10,913
Leribe	47,194	22,949	14,806	28,413	9,726
Mafeteng	30,908	12,580	12,146	16,148	4,198
Maseru	78,735	40,581	22,407	48,355	15,027
Mohale's Hoek	28,211	9,429	13,140	13,112	4,333
<b>Total</b>	<b>222,350</b>	<b>98,657</b>	<b>79,223</b>	<b>126,925</b>	<b>44,197</b>

**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	n/a	n/a	3,986
TB-HIV Patients not on ART	8,553	2,994	3,592
HIV-positive Pregnant Women	33,137	4,647	3,680
Other priority and key populations	545,934	55,898	32,939
<b>Total</b>	<b>587,624</b>	<b>63,539</b>	<b>44,197</b>

**Table 4.1.3 VMMC Coverage and Targets by Age Bracket**

Target Populations	Population Size Estimate (priority SNUs)	Current Coverage (date)	<i>VMMC_CIRC</i> (in FY16)	Expected Coverage (in FY16)
Males 15-29	217,105 <sup>45</sup>	44% <sup>46</sup>	18,391	52%
<b>Total/Average</b>	<b>217,105</b>	<b>44%</b>	<b>18,391</b>	<b>52%</b>

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

Target Populations	Population Size Estimate (priority SNUs)	Coverage Goal (in FY16)	FY16 Target
MSM	4,224	80%	3,379
FSW Military <sup>47</sup>	2,599	80%	2,079
<b>Total</b>	<b>6,823</b>	<b>80%</b>	<b>5,458</b>

**Table 4.1.5 Targets for OVC and Pediatric HIV Testing, Care and Treatment**

<sup>45</sup> BOS population projections for 2015

<sup>46</sup> BOS population projections for 2015 multiplied by circumcision coverage for 15-29 year olds in 2015

<sup>47</sup> Presenting a size estimate would compromise the safety of this population

	<b>Estimated # of Children PLHIV (&lt;15)</b>	<b>Target # of active OVC (FY16 Target) OVC_SERV</b>	<b>Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target) OVC_ACC</b>	<b>Target # of children tested (FY16 Target)</b>	<b>Target # of children on ART (FY17 Target)</b>
Berea	2,600	7,138	3,564	52,000	2,080
Leribe	3,200	9,222	4,604	62,525	2,501
Mafeteng	2,200	6,953	3,507	42,925	1,717
Maseru	5,400	15,165	7,571	107,025	4,281
Mohale's Hoek	1,800	8,472	4,230	32,975	1,319
<b>TOTAL</b>	<b>15,200</b>	<b>46,950</b>	<b>23,476</b>	<b>297,450</b>	<b>11,898</b>

## 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 for this population.

The team did not have any targets for priority populations in FY2015 however 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 COP 15 are MSM (10,845), FSW (5,986) 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 individuals and link them to care and treatment. 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 donated condoms from a USAID centrally funded mechanism.

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

Their 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 priority geographic areas 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)**

While surveys indicate that 52% to 59% of Basotho men report being circumcised, many men reporting circumcision attended initiation school where incomplete circumcisions are often performed. Results from surveys may therefore overestimate circumcision coverage in Lesotho.

VMMC services in Lesotho were previously designed to reach 80% coverage among the age group 10-49 years. The national strategic plan was to conduct 250,000 VMMC over 5 years. As of July 2015, 100,000 VMMC had been conducted at 17 fixed and 81 outreach sites.

In COP 15, the USG plans to conduct VMMC in the five scale-up districts focusing on males 15-29 years of age. The goal is to reach 80% coverage in this age group by 2017-2018. Based on available funding, 18,391 VMMC can be accomplished with COP 15 base funding. VMMC in sustained districts and in other age groups will be the responsibility of the Government of Lesotho.

PEPFAR Lesotho provides direct service delivery and technical assistance on VMMC. The package of services for adolescents and adults includes risk reduction counseling, HIV testing, screening and treatment of STIs, active referral for HIV-positive clients to care and treatment services, surgical removal of foreskin, and management of adverse events. Services are offered in fixed, mobile and outreach sites both routinely and during campaigns for intensified service delivery. Technical assistance includes technical guidance for EIMC, targeted demand creation, and quality assurance/quality improvement. In addition, the coordination of the national and district level VMMC services with supply chain management, forecasting and leveraging Global Fund resources is an essential part of sustainability planning. All VMMC interventions are core activities; there is no plan to transition until we reach saturation.

Currently the Global Fund grant provides the kits and supplies for VMMC services. PEPFAR contributes only gap filling items at the site level for service provision.

The SIMS visits conducted to the VMMC sites in Lesotho have shown no major issues with quality, M&E or accountability. All sites visited have exceeded expected results. The team will continue with the existing M&E, quality improvement, quality control and SIMS activities to ensure quality of services and accountability.

Community mobilizers and traditional leaders are targeted as key role players for community mobilization and demand creation for VMMC services in Lesotho. The VMMC program supports the community engagement implementation plan for VMMC services. The engagement plan will facilitate mobilization, training and full participation for VMMC and EIMC services in scale-up districts.

Communities in scale-up districts will be reached with VMMC services through the outreach services for Intensified Service Delivery (ISD). ISD will be organized during specific times of the year in collaboration with the district health offices, local leaders, peer educators and community mobilizers to reach communities in scale-up districts.

#### 4.4. Preventing Mother-To-Child Transmission (PMTCT)

The burden of HIV disease among pregnant women in Lesotho is among the highest globally at 25.9%<sup>48</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 2013 PMTCT guidelines that promote the provision of life-long antiretrovirals to pregnant and lactating women (Option B+) within MNCH settings. Programmatic gains of this policy shift was the six-fold increase in ART uptake in 2014 among HIV-positive pregnant or lactating women compared to 15% in 2012<sup>49</sup>. Facility-level uptake of PMTCT services has greatly improved with over 90% of pregnant women tested for HIV at the first ANC visit and 93% of the identified HIV-positive pregnant women receiving ARVs to prevent mother-to-child transmission of HIV.<sup>50</sup>

The major challenge to PMTCT in Lesotho is the low population level coverage of PMTCT services despite demonstrated improvements in the uptake of MNCH services. Uptake of the first and fourth ANC visits are at 95% and 74% respectively, and delivery supported by a skilled provider is 74%.<sup>51</sup> However using population-level data instead of facility-level data shows only 62% of pregnant women have been tested for HIV in an antenatal care setting, and only 64% of all estimated HIV-positive pregnant women are receiving ART.

In COP 2015, 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 for PMTCT in the districts of Butha Buthe, Thaba Tseka, Quthing, Mokhotlong, and Qacha's Nek will be transitioned to the GOL during FY 2016. Implementing partners will transition 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+. Resources required to support these patients have been factored into the sustained budget for the remaining areas.

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 FY2016. This will result in 90% PMTCT coverage. To achieve these targets, PEPFAR Lesotho's strategic shift is to expand direct service delivery support so as to improve the package of interventions available for pregnant/lactating women, their children and partners. Routine opt-out Provider Initiated Testing and Counseling (PITC) will be provided within the MNCH and EID at six weeks and will be expanded to ensure timely initiation on ARVs. Training and quality assurance for HIV testing in PMTCT settings will be strengthened and include retesting and repeat testing during the third trimester, delivery, and postnatal periods to identify those who seroconvert.

Community outreach will be restructured for intensified case finding using village health teams or community based organizations and mentor mothers. The Vodafone PPP will be leveraged to mobilize communities for HTC, strengthening linkages for index client testing and couple testing as well as birth

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<sup>48</sup> LDHS, 2009.

<sup>49</sup> APR 2012 and APR2014 Reports

<sup>50</sup> Ibid

<sup>51</sup> LDHS, 2014

registration to track ARV prophylaxis and EID uptake of HIV-exposed infants delivered outside of hospitals. Community services will also be leveraged by the proposed DREAMS initiative as it supports the prevention of Sexual and Gender Based Violence (SGBV) through assisted disclosure and 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>52</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 HEI 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/specimen transport network so as to increase uptake of DNA/PCR, CD4, 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, CD4/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***

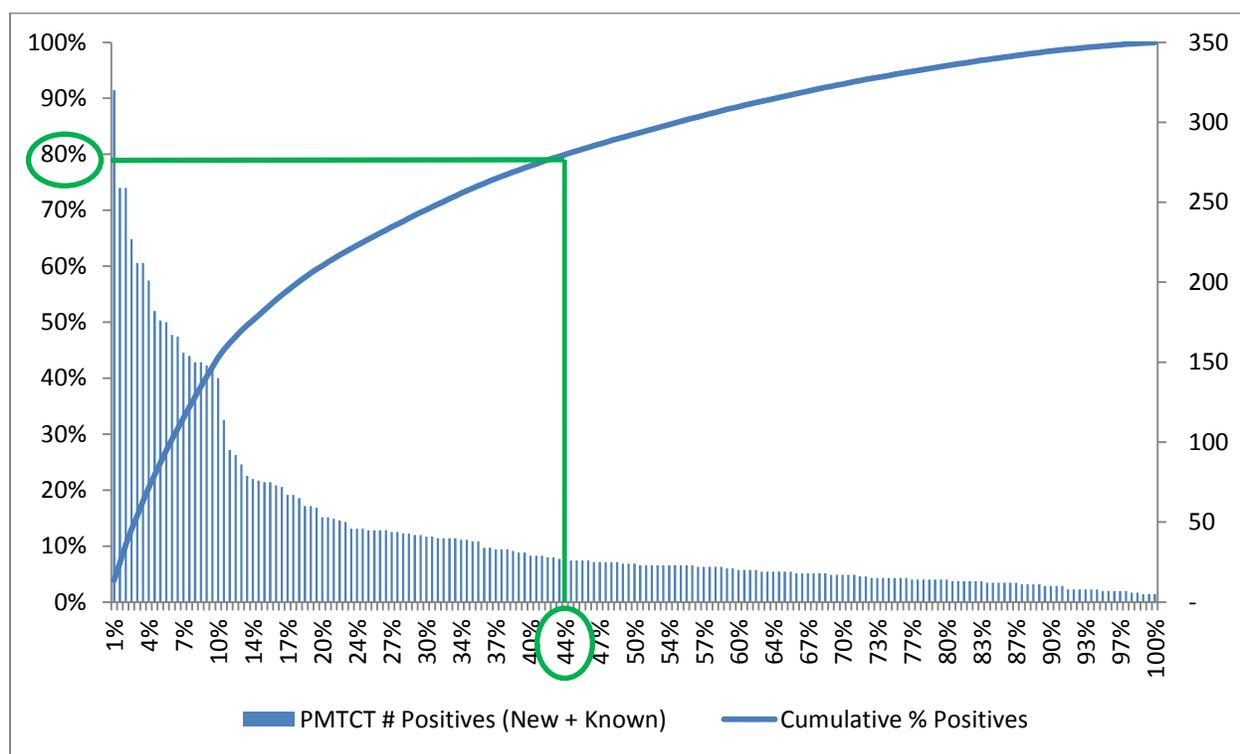
PEPFAR supported PMTCT services in 182 sites in 2014 with 131 sites located in the scale-up districts. Six sites in the scale-up districts were transitioned since these sites had 4 or less HIV-positive patients served in 2014. As shown in the figure below, 44% of sites identified 80% of the positives at the national level.

Yield analysis of the five scale-up districts showed that 44% (54) of sites identified 80% of the positives and 57% (71) sites identified the remaining 20% of positives. The average positivity rate (weighted against volume) for these sites is 24.7% (range of 6.9% - 57.1%). Sixty percent (42/71) of low volume sites have positivity rates below the average.

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<sup>52</sup> KIR/DHS 2014

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



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

People reach HIV treatment, care, and the full range of prevention options through the gateway of HIV testing and counselling (HTC). 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. 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 goal for the PEPFAR HTC program is to identify HIV-positive individuals earlier in their infection and track their linkage to clinical and prevention services as appropriate. In FY2014 PEPFAR will scale up HTC at the facility-level (PICT) as well in the community (CBHTC). The HTC results rose significantly in FY2014 to 386,807 from 98,422 in FY2012 and 138,886 in FY2013. In the five scale-up districts the FY2014 HTC coverage was 289,277 with a 12.7% HIV positive yield. PICT had a better yield at 13.3% than CBHTC (9.9%) and improved linkages to care and treatment for PLHIV. However to support epidemic control, identify HIV early and produce the required number of PLHIV for ART scale-up, there is a continued need for demand creation and targeted CBHTC.

HTC targets were back calculated using historical program data for linkage and yield. PEPFAR aims to test 545,934 in FY16 to meet the ART scale up targets for epidemic control in the scale-up districts. It is projected that 70% of the newly identified PLHIV eligible for ART will come from PICT while about 30% will be generated by CBHTC. These targets are much higher than the FY13 results as they are necessary for epidemic control. 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 in these districts. While aggressive promotion and scale-up of index patient and family testing may help in clinical settings, innovative strategies will be needed to improve yield at the community level. Improving linkage of PLHIV from HTC, especially CBHTC, to care and treatment will be addressed by recruiting linkage facilitators and demanding close collaboration between community and clinical partners to track, document and report linkages of clients. Stigma and discrimination, high mobility of key populations and gender-based violence are some of the challenges facing uptake of HTC and other HIV services.

The DREAMS initiative is an opportunity to address some of these programmatic challenges in two of the five scale up districts. There is a proposed gender-based violence package of services which include (but are not limited to) 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 three '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 picked anywhere along the cascade and the system to mitigate the loss due to mobility. 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.

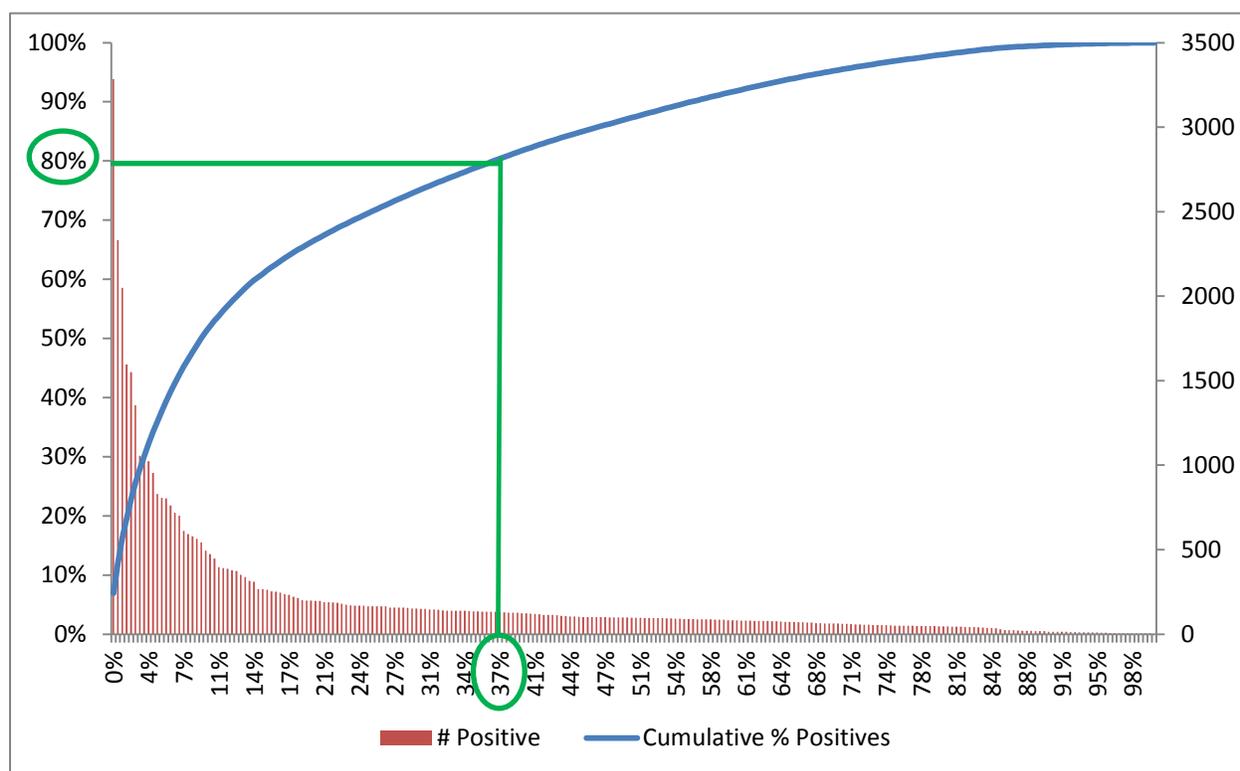
In FY16 PEPFAR will focus on the five scale-up districts with the following interventions:

- 1) Recruit and train service providers to provide quality HIV testing and counseling services both at the facility (PICT) and community levels
- 2) Link PLHIV to care and treatment and track referrals from community to facility in the scale-up districts
- 3) Ensure community mobilization and demand creation for the uptake of HTC and other prevention, care and treatment services
- 4) Carefully select a mix of HTC strategies that will reach underserved, key and priority populations in the five districts to maximize yield and ensure high rate of linkages to care, treatment and other high impact services
- 5) Implement a robust QI program for HTC services

### ***Efficiency Analysis***

Previously PEPFAR supported 238 HTC sites nationally. Site level analysis demonstrated 80% of PLHIV coming from 37% of sites. Yield analysis of the five scale-up districts showed that 35% (57) of sites identified 80% of the positives. The average positivity rate (weighted against volume) for these sites was 13.6% (range of 1.6% - 49.3%).

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



#### 4.6 Facility and community-based care and support

USG provides facility-based support for HIV services through both government health facilities and the Christian Health Association of Lesotho (CHAL). In addition the government has engaged private sector providers through an MOU to deliver HIV, TB and SRH services. Previously USG provided site support through technical assistance including mentorship and transfer of skills to health care workers, supportive supervision, quality improvement, monitoring and support for reporting systems for HIV/TB care and treatment, PMTCT and limited direct service provision. To achieve 80% saturation in the prioritized PEPFAR districts calls for a major care and treatment strategic shift. USG will support the initiation of 108,649 adults and children on antiretroviral treatment by the end of FY17 (FY 2016 - 44,197; FY 2017 - 64,452). The interventions to expand the number of people receiving care and treatment in the scale-up districts are based on the Lesotho sustainability profile and the Core/Near Core priorities.

In FY16, the USG will provide facility-based support through provision of human resources to support ART enrollment and quality of care, HRH to support linkage and retention in care and treatment, adherence counselling for ART and support for quality improvement initiatives to improve patient outcomes. Based on recent SIMS assessments, gaps have been noted in the provision of pre-ART leading to high attrition rates in this group. USG in collaboration with GOL and GF will provide support for roll-out of a pre-ART package in scale-up districts. The package will include management and prophylaxis of opportunistic infections (OI), management of sexually transmitted infections (STIs), provision of family

planning (FP) services, monitoring of CD4 counts, treatment literacy in preparation of ART, and adherence counselling and support. Defaulter tracking of patients on pre-ART will be strengthened and pre-ART and ART patient monitoring tools will be printed. Pediatric nutritional assessment, education, and counselling support will be intensified and staff in high volume sites will be trained to ensure quality. Additionally in FY2016 USG will provide support to develop new and strengthen existing clinical and community M&E tools and registers to monitor and evaluate community and clinical outcomes and linkages to care, treatment and OVC programs. This support will link the national and district level SI support for HMIS.

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. WHO estimates the incidence at 916/100,000 and prevalence 613/100,000, an increase from 548/100,000 in 1990 and a reflection of the effect of HIV on TB. The trend in TB notification (new and relapses) follows the same trend as the estimated incidence. There however 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 Drug Resistance Survey conducted in 2009 the overall MDR-TB rate was 5.1% -- 3.1% for new cases and 12.6% for previously treated patients. The HIV prevalence among TB patients is estimated at 74% and 70% of the notified HIV-positive patients have been initiated on ART, but 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, current and former mine workers, factory workers who are predominately migrant, military, and inmates. In 2013, 81% of the TB cases were diagnosed and notified from the five scale-up districts (Maseru (38%), Leribe (14%), Berea (13%), Mafeteng (9%), and Mophale's Hoek (7%)). In 2013, the TB Case Detection Rate (CDR) was 50% and Treatment Success Rate (TSR) 71%<sup>53</sup>. Lesotho adopted the ARV consolidated guidelines in 2013, ensuring that all TB/HIV co-infected patients receive ART as soon as possible.

The key priorities for FY 2016 include:

1. PEPFAR will support integration of TB/HIV care and treatment services in scale-up districts through support for clinical staff to strengthen and improve the 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 patients will reduce mortality, morbidity and HIV transmission.

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<sup>53</sup> WHO, Global TB Report 2014

2. Support for the scale-up of GeneXpert MTB/RIF and improving early diagnosis of TB among HIV-infected individuals will close the gap between estimated TB incidence and current notification rates. Lesotho currently has 20 GeneXpert machines (75% in prioritized districts) and the PEPFAR will support the implementation of the recently finalized GeneXpert national algorithm that prioritizes HIV-infected patients and other high risk groups. Additional support for the provision of GeneXpert cartridges in the scale-up districts will be availed.
3. Support intensified TB case finding activities among PLHIV in ART settings, MNCH settings, correctional facilities, factories, and among miners, 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, support interventions to improve retention on ART and TB treatment as well as IPT (mobile technologies, VHW systems, CAG, basic care package provision).
4. Scale-up IPT provision to cover all sites in the scale-up districts not currently implementing IPT. PEPFAR will support trainings for IPT provision, M&E systems for IPT, support supervision, forecasting and distribution of IPT.
5. Support the implementation of TB infection control measures and site specific IC plans in prioritized health facilities, provision of N95 respirators and coordination of IC 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. This includes implementation of revised TB/HIV MER indicators both in TB and HIV settings; TB/HIV cascade analysis; data quality assurance systems; and strengthening use and ownership of data for program planning, management and evaluation at district- and facility-levels.
7. At national level continue to support review of national guidelines, policies, tools, algorithms and M&E systems for TB/HIV activities.

#### **4.8 Adult Treatment**

The Kingdom of Lesotho adopted the 2013 WHO guidelines and rolled out revised national ART guidelines in 2014 for the expanded treatment eligibility to CD4 <500 cells/ml and lifelong treatment for TB/HIV co-infected, pregnant and lactating women, and children under five years of age irrespective of CD4 count. 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 63% of ARV and medications for opportunistic infections (OI) with the remaining 37% supported by the Global Fund. In order to achieve epidemic control, programmatic bottlenecks need to be addressed including a low 12-month retention rate of 75%; weak linkages along the clinical care cascade; recurrent stock outs of critical commodities (e.g., test kits and CD4 reagents); inadequate monitoring systems to measure program performance using patient-level data; shortage of skilled personnel coupled with limited capacity of the MOH to absorb critical positions (such as lay counselors); and limited data on the uptake of ART among some priority populations who have an HIV prevalence above the national average (i.e., FSW, MSM, factory workers and miners).

PEPFAR Lesotho aims to saturate treatment services in the five scale-up districts by initiating 44,197 new patients and support a total of 126,925 patients on treatment by APR 2016, an increase of 29% from the projected APR 2015 results. In the subsequent year, PEPFAR intends to initiate 64,452 on treatment and support 169,997 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 service delivery model. PEPFAR will increase investments in scale-up districts to rapidly expand treatment coverage by targeting eligible pre-ART patients, children and adolescents through the ACT initiative, pregnant and lactating women and identified key populations.

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 2014 results as a baseline to set site level program milestones. Service quality will be strengthened by the recruitment of additional human resources to provide services to adults and children living with HIV to attain >90% uptake of CD4 assessments of pre-ART patients; increase the mean CD4 count at initiation, increase retention to 80% at 12 months and 70% at 36 months; and attain viral load suppression in at least 90% of patients on treatment or Option B+. The clinical care cascade linkages will be strengthened linkages) through: (i) recruitment of site-level Linkage Facilitators and Adherence Counselors to provide pre-ART initiation counseling, track missed appointments, and enhance intra- and inter-facility linkages and (ii) community level support of Village Health Teams (VHT), expert clients and PLHIV networks/community-based organizations to improve retention through Community ART Groups (CAGs), and mobile technologies to facilitate linkages and retention in care. As the prime clinical partners do not have staff in the community, local Civil Society Organizations will be sub-grantees and supported to create demand, enhance retention and advocate for program accountability within the health center catchment communities.

National, district, and facility-level teams will be supported to scale-up and sustain collaborative quality improvement initiatives to improve patient outcomes, retention, enhance provider skills, and monitor progress of implementation using patient level data. 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. As the ART program matures, PEPFAR will engage with MOH to decentralize systems for treatment failure monitoring and management of ART resistance. Stakeholder discussions on pharmacovigilance systems are ongoing.

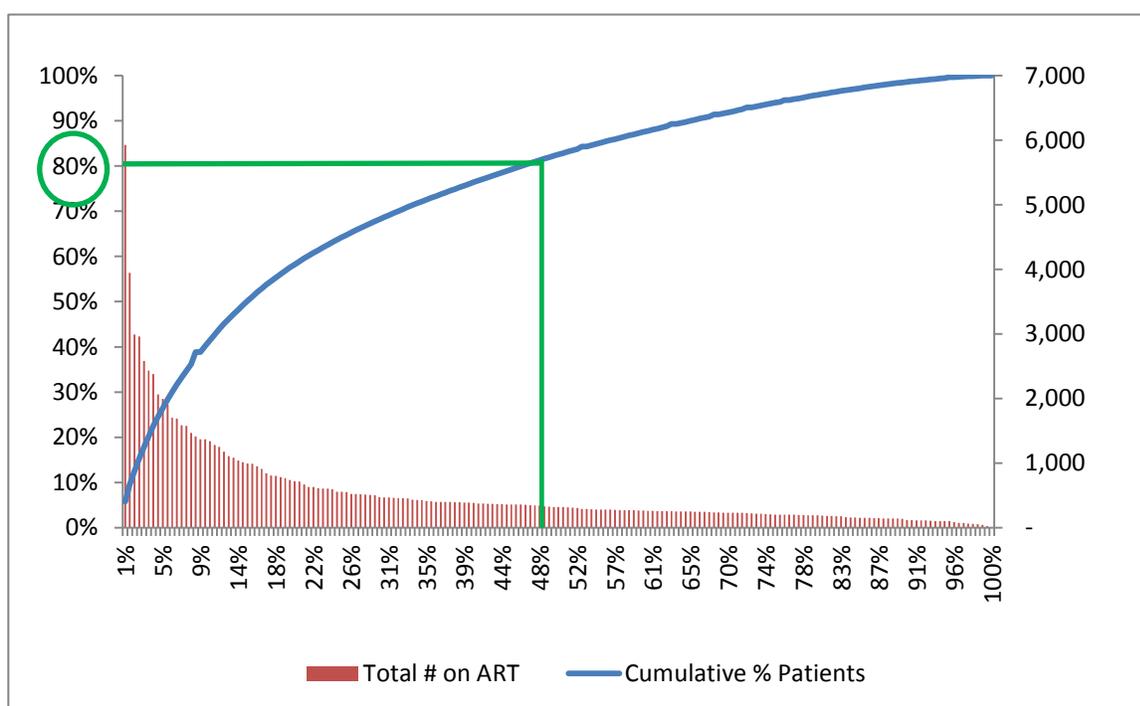
PEPFAR Lesotho is working with the MOH and other stakeholders to develop a national strategic plan for scale-up of viral load (VL) monitoring. PEPFAR will support the procurement of reagents for CD4 and VL; collaborate with the MOH to decentralize systems for monitoring and management of treatment failure; and strengthening of the sample transport network for EID, VL, and CD4. 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 and in-service training for nurses on clinical management.

PEPFAR supported 23,351 ART patients in 57 sites located in the sustained districts (APR 2014). During COP 15, support in these districts will be limited to supporting the DMHT to maintain the quality of services including laboratory monitoring for the ART patients currently enrolled while transitioning site level activities to the GOL by 2016.

### Efficiency Analysis

PEPFAR supported ART in 185 sites in 2014 with 129 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 48% (61) of sites. The average patient volume in the remaining 20% (67) sites in the scale-up districts was 228 (range of 22 to 360).

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



### 4.9. Pediatric Treatment

Lesotho is implementing the new guidelines of initiating ART for all children under age five years and eligible older children and adolescents with CD4 <500/ml. Pediatric ART is provided in 86% (159) of all PEPFAR supported sites providing ART to adults. The pediatric treatment gap in Lesotho is still wide with children on ART accounting for only 4.7% of the total number of people on ART; 21% of all children who need treatment were enrolled in 2014. The main challenges to expansion of pediatric HIV services are related to human resource shortages, stock outs of rapid test kits which interrupt case identification, high loss to follow-up along the pediatric clinical care cascade, and limited access to adolescent treatment services.

PEPFAR Lesotho will utilize COP 15 base funds and the Accelerating Children's Treatment (ACT) Initiative funding to double the number of children receiving treatment (14,574) and expand pediatric ART coverage in five scale-up districts by the end of 2017-2018.

The PEPFAR strategies for scaling-up pediatric HIV treatment includes 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 adults receiving PMTCT, care and treatment services as well as HIV-exposed infants, children with TB disease, malnutrition, children receiving OVC services and hospitalized children in high HIV burden districts. 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. 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.

Health systems level support in COP 15 will include the procurement of pediatric ARVs to meet the accelerated scale-up targets. PEPFAR will continue supporting the MOH to optimize the national pediatric ARV formulary. Salary support for additional human resources for health 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 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 monitoring, and quality assurance/quality control of PITC and EID.

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

USG will align its OVC portfolio with the GOL National Strategic Plan for Vulnerable Children (NSPVC) 2010-2017 and the NSP for HIV/AIDS.

The team used the supplemental data pack to derive targets. The targets were calculated to reach 80% saturation in the scale-up districts assuming a 25% increase from year 1 to year 2. Historically the OVC program served 17,484 clients in scale-up districts and 28,457 in sustained districts. The coverage in scale-up districts was low (10%-37%). The FY2016 target of 48% will serve 46,950 OVC.

The team proposes an alternative approach to set targets for OVC. This will leverage the scale-up efforts of ACT and DREAMS that will have a substantial overlap with both the OVC and care and treatment programs within the scale-up districts. For example for ACT, 32,500 OVC are targeted for HTC in FY2016. Among the OVC tested, 4% prevalence is assumed based on the Lesotho DHS yielding approximately 1,300 HIV-positive OVC. These OVC will receive support from the PEPFAR Lesotho program to link to care and ART enrollment. There will be similar linkages across other programs as well.

The goals of the program are strengthening: 1) GOL systems to coordinate the OVC response; 2) community-based care and support services and referrals to clinical settings for OVC and their families; and 3) capacity of families and communities to provide care and support services for OVC. The OVC Situation Analysis and Strategic Plan recognized that care and support services for OVC are fragmented and poorly coordinated. A key priority for the portfolio is referrals and linkages for OVC service delivery through the Ministry of Social Development (MOSD). USG has been providing leadership and management training to national and district level staff of MOSD and civil society organizations. The focus will now shift to district level and will target auxiliary social workers and community council teams to improve coordination and linkages to health services. USG in collaboration with Ministry of Education and Training will scale up Early Childhood Development (ECD) interventions as an entry point to pediatric testing, care, and treatment. Gender norms and gender based violence (GBV) interventions will be integrated in the OVC platforms, especially those targeting adolescent girls and young women. USG will collaborate with the Ministry of Gender and Youth, Sport and Recreation to disseminate messages on gender equality and GBV prevention.

USG OVC programs primarily implement activities at community/household levels making them well placed for linkages to the continuum of response. The program will use the MOH two-way referral tool and district directories to facilitate linkages between communities and health facilities. Community OVC platforms will be used to identify children and household members for testing and treatment adherence support. Community support groups, caregiver/ grandmother groups, women's savings and lending groups, and ECD centers are examples of such platforms to be used as entry points for PMTCT awareness raising, pediatric testing and care and treatment.

Lessons learned and evidence gathered from the implementation science initiative on ECD will further inform programming around health outcomes for children. The OVC program will support economic strengthening through sustainable livelihoods, a strategy recommended in the NSPVC to strengthen capacity of families and communities. The NSP for HIV/AIDS also recommends mitigating social and economic impacts of HIV on affected households and individuals as an enabling strategy for national priorities. USG partners will provide sub-grants to local CBOs and women's groups to support household economic strengthening and food security activities. Community groups will be trained in small business skills and savings and lending group management. The program will leverage the GOL Cash Grants Program to provide beneficiaries with small business skills training and link them to interventions such as GBV prevention, HIV prevention and care and treatment.

## Program Activities to Sustain Support in Other Locations and Populations

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### **5.1. Sustained package of services in other locations and populations**

PEPFAR Lesotho has defined the sustained package as a core package of services and support that PEPFAR will continue in COP 2015 for HTC, PMTCT, and ART in low burden locations. 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 only the sustained package. These districts serve 22% (22,717) of the total PLHIV receiving ART in Lesotho and have 57 health units.

PEPFAR support will focus on building the capacity of the District Health Management Teams (DHMT) to oversee and monitor the quality of services for PLHIV currently enrolled in PMTCT and care and treatment. PEPFAR implementing partners will provide technical support to the DHMT to set site- and district-level targets for combination prevention aligned to PEPFAR supported ART passive enrollment. The DHMT will define Quality Improvement (QI) benchmarks for monitoring site-level quality of care that includes, but not limited to, adherence, retention, and routine laboratory testing including one viral load (or 2 CD4 tests) per year. The DHMT will conduct quarterly support supervision visits to the sites to monitor the QI benchmarks and bi-annual district learning sessions with health unit in-charges will be held. In addition, the DHMT will hold monthly data validation exercises to monitor data accuracy, completeness, and timely reporting and the DHMT will use these results to compute the clinical care cascade at district and/or site levels. 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 QI projects will be identified for rollout in addition to the site-specific QI projects. For sites that have significant quality gaps the DHMT will be assisted to provide mentorship.

PEPFAR will not support any demand creation for testing. Outside of passive testing and linkage to care in PMTCT and ART sites, PEPFAR support for HTC and VMMC will be transitioned to GOL in these districts.

OVC currently served with core interventions in these districts, primarily promotion of HTC and confirmatory HIV testing, will be supported in Mokhotlong district only where the OVC Special Initiative for early childhood development is being implemented. The current OVC program is ending at the end of FY15. An exit and sustainability plan is already in place to ensure a transition of core and non-core OVC activities to community organizations and GOL. Existing non-PEPFAR supported condom distribution programs will expected to be maintained, but PEPFAR will not support local condom promotion programs.

The expected volume of patients needing the minimum package of services in these areas has been calculated by district and overall (Table 5.1.1).

**Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Districts**

<b>Sustained Volume by Group</b>	<b>Expected result APR 15</b>	<b>Expected result APR 16</b>	<b>Percent increase (decrease)</b>
HIV testing in PMTCT sites	11,011	8,074	(26%)
HTC (only sustained ART sites in FY 16)	104,815	68,485	35%
Current on care (not yet initiated on ART)	26,150	19,189	(27%)
Current on ART	41,535	59,720	44%
OVC	20,353	20,353	0%

## **5.2 Plans for centrally supported sites and redirecting PEPFAR support to priority locations and populations**

PEPFAR support to the 15 low or no yield HTC sites and PMTCT sites without ART patients will be discontinued immediately. With respect to PMTCT, PEPFAR-supported services in districts outside of the priority areas will be transitioned to GOL during FY 2016.

Most ART sites will be maintained in sustained districts during FY 15, with a plan to transition all sites/patients to GOL in FY 16. Discussions have been begun with GOL, district governments, and other stakeholders (i.e., Global Fund and CSOs) to facilitate this transition. Support currently provided at the national-level for supply chain and sample transport network will be maintained. By the end of FY 16, PEPFAR will transition specific site and district-level lab activities in areas outside of the scale-up districts to GOL.

## 6.0 Program Support Necessary to Achieve Sustained Epidemic Control

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### 6.1 Laboratory strengthening

The goal is to strengthen laboratory services to provide quality-assured and integrated services to meet HIV prevention, care and treatment targets. The implementation will be aligned with the national laboratory strategic plan (2013/14-2017/18), PEPFAR Lesotho's strategic plan (2015-2019) and PEPFAR's goal of achieving an AIDS-free generation. Support will focus at site level to increase access to HIV/TB diagnosis and treatment monitoring services through decentralization and introduction of point of care and cost-effective technologies in PEPFAR priority health facilities and districts. Above site and district level support will focus on providing technical assistance to build capacity in laboratory management for effective coordination, monitoring and evaluation of laboratory services.

In order to strengthen Lesotho's laboratory infrastructure for improved access, quality, and coverage of HIV, TB and OI diagnostic testing and monitoring of patients on HIV care and treatment, PEPFAR Lesotho will focus on the following core activities:

1. Laboratory quality program for HIV testing, TB diagnosis, Early Infant Diagnosis (EID), CD4, viral load and toxicity monitoring
2. Support for laboratory equipment maintenance
3. Laboratory Information System (LIS) and M&E system
4. Training and supervision of laboratory personnel to conduct TB testing, HIV rapid testing, CD4 testing, EID and VL testing
5. Sample transport network and referral testing services
6. Procurement of reagents and testing consumables for TB and HIV diagnosis and patient monitoring

PEPFAR Lesotho has been supporting two reference laboratories (National Reference Laboratory and TB Reference Laboratory), 18 clinical laboratories in 10 districts, and 216 health centers providing HIV rapid testing including 26 sites offering CD4 point of care testing. In FY16, direct service delivery (DSD) will be provided to 10 clinical laboratories and 2 reference laboratories and Technical Assistance-Service Delivery Improvement (TA-SDI) support to 119 health centers in five scale-up districts. Technical support to non-scale-up districts will be limited to national and DHMT levels for the EQA/PT program. All major technical support in sustained districts will be transitioned to the Government of Lesotho.

The laboratory services ensure patients are tested. Patients are provided quality care by supporting monitoring tests. Increasing access to lab tests will also contribute to scale-up of HIV care and treatment services. The targets are the facilities that provide laboratory services which are primarily based on PEPFAR's scale-up districts and populations: district hospital laboratories and health centers that provide diagnostic and patient monitoring support. Resources for lab support will be coordinated with GF and GOL funding while PEPFAR's focus will be ensuring

access to quality services by supporting policy and guideline development, training, sample transport, referral networks, equipment maintenance, and laboratory information and M&E systems. To ensure uninterrupted testing services, PEPFAR will also support procurement of laboratory reagents and essential equipment. PEPFAR will cover 100% of the required reagents and supplies for EID, GeneXpert, and cryptococcal meningitis screening (CrAg LFA test) and 50% of viral load and CD4 monitoring reagents in the five scale-up districts.

The resources will be determined based on MOH Resource Mapping in 2014, PEPFAR expenditure analysis, planned population coverage in PMTCT, HTC, pediatric/adult care and treatment services, as well as based on the need for patient monitoring using the recently adopted ART guidelines. There are still challenges that are anticipated in meeting the laboratory monitoring targets especially CD4 and VL due to limited resources as shown by MOH Resource Mapping in 2013/14. With regard to data, laboratory data can be generated at facility, district and national levels as a result of PEPFAR support for the LIS. The laboratory services are primarily at facility levels and provide services to patients that have access to those facilities. In addition, point of care tests (HIV rapid test and CD4) could be provided at community levels to link clients to care and treatment service. In order to minimize duplication of funding and improve efficiency and cost-effectiveness and maximize impact, data from the PEPFAR Expenditure Analysis and the national expenditure of laboratory services were used to quantify and allocate funding for FY2015 COP. The log frame for required activities is shown below:

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s)  ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. Other Combination prevention	12. Viral suppression
<b>Support laboratory quality program</b>	Support QA/EQA programs for TB diagnosis, EID, VL, CD4 and Point of Care Testing (PIMA CD4, GeneXpert); support implementation of HIV Rapid Testing Quality Improvement Initiative (RTQII); Strengthening of Laboratory Management Towards Accreditations (SMLTA) and accreditation of national reference labs	Support QA/EQA programs for TB diagnosis, EID, VL, CD4 and Point of Care Testing (PIMA CD4, GeneXpert); support implementation of HIV Rapid Testing Quality Improvement Initiative (RTQII); Strengthening of Laboratory Management Towards Accreditations (SMLTA) and accreditation of national	\$417,364	\$400,000	HLAB	3. Performance data =9  7. Quality Management=5	X	X	X	X	X

		reference labs									
<b>Support equipment maintenance in five scale-up districts and national reference laboratories</b>	Work with MOH to develop guidelines and SOPs for maintenance services for major lab equipment, training staff for routine maintenance, development and enforcement of service contract with manufacturers or vendors for GeneXpert, MGIT, and CD4 machines (FacsCount/ FacsCaliber, VL machines, biosafety cabinets)	Work with MOH to develop guidelines and SOPs for maintenance services for major lab equipment, training staff for routine maintenance; development and enforcement of service contract with manufacturers or vendors for GeneXpert, MGIT, and CD4 machines (FacsCount/FacsCaliber, VL machines, biosafety cabinets)	\$125,000	\$125,000	HLAB	3. Performance data =9 7. Quality Management=5		X	X	X	X
<b>Laboratory Information (LIS) and M&amp;E System</b>	Support maintenance and update of electronic based LIS, Laboratory data collection, storage, analysis, M&E monitoring and reporting in PEPFAR scale-up district hospital laboratories and reference laboratories	Support maintenance and update of electronic based LIS, laboratory data collection, storage, analysis, M&E monitoring and reporting in PEPFAR scale-up district hospital laboratories and reference	\$115,000	\$115,000	HLAB	1. Epi data=12.8 3. Performance data =9 7. Quality Management =5	X	X	X	X	X
<b>Training and supervision of laboratory personnel to conduct TB testing, HIV rapid testing, CD4 testing, EID and VL testing</b>	Support procurement of minor equipment, refreshment of clinical laboratories to improve workflow and biosafety and waste managements; Support training of laboratory personnel to improve quality of diagnosis and patient monitoring	Support clinical laboratories to improve workflow and biosafety and waste management; support training of laboratory personnel to improve quality of diagnosis and patient monitoring	\$200,000	\$150,000	HVTB, HTXS, HBHC, PDTX, PDCS, MTCT	5. Human Resource for Health=12.7	X	X	X	X	X

<b>Sample transport network and referral testing services</b>	Transport of TB specimens for culture and DST; CD4, EID and VL tests and results returned to sites	Transport of TB specimens for culture and DST; CD4, EID and VL tests and results returned to sites	\$300,000	\$300,000	HVTB, HTXS, HBHC, PDTX, PDCS, MTCT	3. Performance data=9 4. Access and Demand=13.2		X	X	X	X
<b>Procurement of reagents and testing consumables for TB and HIV diagnosis and patient monitoring</b>	Lab testing performed for TB, OI, HIV diagnosis of patients, and monitoring of patients on care and on ART	Lab testing performed for TB, OI, HIV diagnosis of patients, and monitoring of patients on care and ART	\$2,317,401	\$2,500,000	HVTB, HTXS, HBHC, PDTX, PDCS, MTCT, VCT	6. Commodity Security and Supply Chain=7	X	X	X	X	X

## 6.2 Strategic information (SI)

Strengthening Strategic Information (SI) activities in Lesotho under PEPFAR is a key priority. There is focus on building national level capacity for routine monitoring, health information systems and surveillance to inform decision making towards epidemic control. In collaboration with MOH and SI stakeholders, PEPFAR Lesotho will build capacity to plan and coordinate for the national HIV response and gain consensus on mechanisms for strengthening the SI TWG by establishing an oversight steering committee and three task forces for each of the core SI functions: HMIS, M&E and surveillance. PEPFAR Lesotho will support the MOH to revise the SI TWG's Terms of Reference (TOR) to assume the role of an oversight committee to the three task forces. PEPFAR Lesotho will provide support to draft and submit the revised TORs for the SI TWG and the three task forces to the Lesotho MOH for review and finalization. PEPFAR Lesotho provided logistical support to two MOH Director General-led meetings where the revised TOR was discussed and endorsed. The primary objective of the newly formed TWG is to improve routine data monitoring and timeliness of reporting.

PEPFAR Lesotho will also provide support to develop a surveillance capacity-building strategic plan based on needs identified through the SI systems assessment and additional identification of MOH skills. A health impact assessment (HIA) will be included in the national surveillance plan to help close the data gaps in Lesotho related to incidence, viral load suppression, HIV drug resistance, and pediatric coverage. PEPFAR Lesotho will also support various assessments and evaluations specifically to obtain better baseline data and improve understanding of the data gaps for pediatric ART and priority populations, particularly for ACT and DREAMS.

DHIS2 was endorsed by MOH as a Health Management Information System (HMIS) and data warehouse to strengthen and streamline data flow and management in Lesotho. Following MOH endorsement of the system, PEPFAR Lesotho supported the development of a comprehensive

implementation plan for DHIS2 and has proceeded to engage a consultancy team that will lead the system development and customization process. In FY2015, PEPFAR Lesotho will customize, pilot and have the first version of DHIS2 operational in Lesotho. To support MOH in the nationwide roll-out of EMR, PEPFAR Lesotho will provide support to conduct fact finding visits to 2 EMR sites in scale-up to saturation districts Leribe and Maseru. PEPFAR Lesotho also plans to develop Health Information Systems (HIS) standard operating procedures and address DHIS, EMR and surveillance to align them with the national SI strategic plan and MER indicator requirements.

PEPFAR Lesotho will continue strong support for core SI activities to:

- 1) Enhance ability of national institutions to plan and coordinate M&E, HMIS and surveillance activities
- 2) Optimize Health Information System and promote an HMIS strategy to facilitate streamlined and efficient data flow, management and use across the health system
- 3) Build capacity and strengthen human resources to support country ownership of sustainable HMIS and surveillance activities

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
<b>Health Information Management Systems (HMIS)</b>											
Support the MOH to plan for the nationwide roll-out of Electronic Medical Record (EMR)	Costed EMR implementation plan developed  HMIS training manuals with EMR/DHIS2 interoperability components developed and disseminated	Feedback and adaptation meetings held on key EMR functionality (data verification, reports, etc.)  Effective and sustained use of EMR after the developer hands over system	HVSI	HVSI	17123	1.3 – Performance Data=9	X	X	X	X	X
Support the MOH to enhance the capacity of the current HMIS, LMIS, LMS, HRIS systems through nationwide roll-out of an interoperable open-source, web based DHIS2	SOPs for use of DHIS2 at national and district levels developed  Requirements and pilot in 5 scale-up districts finalized  District DHIS2 mentorship tool developed	DHIS2 rolled-out to all 10 districts  All districts use DHIS2 for data aggregation, analysis, use and reporting  Central level staff and program managers use DHIS2 output to monitor district performance, planning and CQI	HVSI	HVSI	17123	1.1 – Epidemiological and Health Data=12.8  1.2 – Financial/ Expenditure Data=14  1.3 – Performance Data=9	X	X	X	X	X
<b>Monitoring and Evaluation (M&amp;E)</b>											
Support the revitalization of the SI technical working group (TWG)	New or updated TWG terms of reference, member roster, meeting schedule, and actionable agendas  1 annual operational plan for HMIS strategic plan developed	SI TWG meetings provided with logistical support  National workshop on data to evaluate change in incidence of HIV hosted	HVSI	HVSI	17123	1.1 – Epidemiological and Health Data =12.8  1.3 – Performance Data=9	X	X	X	X	X
Support the MOH to build capacity and strengthen human resources to support country ownership of sustainable routine M&E activities	SI system assessment report summarizing gaps and challenges of SI (i.e. surveillance, M&E, and HRH) with strategic priorities and recommendations  Tools developed to identify HMIS human resource gaps  Guidance developed outlining minimum set of HMIS related	HMIS capacity building strategy will be developed  Costed SI capacity building annual work plan developed	HVSI	HVSI	17123	1.1 – Epidemiological and Health Data =12.8  1.3 – Performance Data=9	X	X	X	X	X

	positions needed at the national and district level (based on SI systems assessment findings and implementation strategy needs)  Staffing structures and job descriptions developed										
<b>Surveys and Surveillance</b>											
Population HIV Impact Assessment (PHIA)	Dissemination workshop hosted	Secondary data use/analysis workshops hosted	HVSI	HVSI	ICAP Global for SI	1.1 – Epidemiological and Health Data =12.8	X	X	X	X	X
Build MOH capacity to plan, design and implement surveys and related surveillance activities	Surveillance guideline documents produced and disseminated  5 year surveillance schedule with anticipated resources developed	TA provided to MOH to conduct major surveillances activities (ANC sentinel surveillance, HIV EWI, and ART cohort analysis)  2 surveillance trainings conducted based on findings of HMIS assessment.	HVSI	HVSI	17123	1.1 – Epidemiological and Health Data =12.8	X	X	X	X	X
Linkages and referrals within AIDS care and treatment national service delivery systems	Quality of referral system assessed and gaps identified  Barriers to care from communities to facilities and back to the community are identified	Documented	HVSI	HVSI	MEASURE Evaluation	1.1 – Epidemiological and Health Data =12.8	X	X	X	X	X

### **6.3. Health System Strengthening (HSS)**

#### **6.3.1 Human Resources for Health**

COP 2015 HRH investments will be directed towards building a sustainable nurse-led HIV response using the nurse initiated and managed anti-retroviral therapy (NIMART) program for PLHIV in Lesotho. More than 2,500 nurses have been trained in the last five years. PEPFAR Lesotho will work with the MOH to ensure that adequate nurses are recruited, deployed and retained in all service delivery sites in scale-up districts. The program will conduct periodic HRH site assessments in scale-up districts to assess facility- and community-based HRH capacity to deliver sustainable HIV services to PLHIV.

The nursing regulatory body needs to be strengthened to assure quality services and appropriate nursing competencies in service delivery sites. COP 2015 investments will support the Lesotho Nursing Council (LNC) to implement appropriate accreditation and credentialing systems in scale-up districts and service delivery sites. The LNC will be strengthened to build the institutional and human capacity to monitor and evaluate nursing practices based on the nursing code of practice and competency standards. These investments will also be leveraged by the current grant (\$10,000) given to LNC by the African Regulatory Collaborative (ARC) which supports the implementation of the continuous professional development (CPD) program for nurses.

#### **6.3.2. Supply Chain Management**

Commodity security for HIV drugs and laboratory commodities has remained a significant bottleneck adversely affecting identification and enrollment on treatment of PLHIV in Lesotho. Despite more than five years of PEPFAR investments in supply chain management systems, the country continues to have stock outs of laboratory reagents and a high wastage rate for ARVs. A lack of coordination between the programs in the Ministry of Health and the National Drug Supply Organization (NDSO) along with inefficiencies and ineffective decision-making processes throughout the supply chain cycle put at risk our ability to scale up PEPFAR programs.

In COP 2015, the PEPFAR team has proposed to bring in a new high impact supply chain management intervention. Lesotho requires a modernized supply chain management system that uses accurate and reliable Logistics Management and Information System (LMIS) data for forecasting, quantification, and procurement decisions. In addition, investments will be made in the last-mile distribution system that will ensure that commodities are delivered to the service delivery points in the scale-up districts.

In COP 2015 the PEPFAR Lesotho team is planning to implement a supply chain management intervention based on the Botswana central medical stores innovation. This program was highlighted by USAID as a supply chain management success story and received ISSO 9001 certification.

With front office support PEPFAR will seek an invitation from the GOL through an experienced partner to employ a team of experts at NDSO. The experts will directly and independently manage the supply chain management cycle. It will be emphasized that these SCM experts will be given delegated authority to manage the supply chain management system from the central level to the service delivery sites.

The GOL will also employ local staff as counterparts of the experts. This intervention will take 3 to 4 years to implement; with the initial 2 years spent on re-engineering the supply chain and procurement systems at NDSO, MOH and the service delivery points. In the third year the experts will work towards transitioning their roles to the local staff while still maintaining their advisory roles. In year 4 the partner will continue to provide TA to their former counterparts to complete transition to GOL.

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
<b>Human Resources for Health</b>											
<b>Build the capacity of the Lesotho Nursing Council (LNC) to support NIMART Quality Assurance programs in pre-service training institutions and service delivery sites in scale-up districts</b>	Support and develop the capacity of the Lesotho Nursing Council to accredit training institutions and credential nurses providing NIMART in service delivery sites.  2 nurse training schools accredited  584 nurses meet their CPD credentialing requirements to provide NIMART	Strengthen the capacity of the Lesotho Nursing Council to accredit training institutions and credential nurses providing NIMART in service delivery sites.  Accredit 4 nurse training schools  584 nurses meet the CPD credentialing requirements to provide NIMART	OHSS 200,000	OHSS 300,000	TSEPO	Human Resources for Health=12.7	X	X	X	X	X
<b>Support the Ministry of Health to assess staffing requirements for HIV and AIDS services in scale-up districts</b>	Using iHRIS data support the scale-up districts to build capacity to assess HIV staff requirements to meet service delivery demands for prevention, treatment and care services.  Staffing situation and gap analysis reports in service delivery sites completed.	Using iHRIS data support the scale-up districts to build capacity to assess HIV staff requirements to meet service delivery demands for prevention, treatment and care services.  Staffing situation and gap analysis reports in service delivery sites completed.	150,000	150,000	TSEPO	Human Resources for Health=12.7		X	X	X	X
<b>Support the Ministry of Health to recruit, deploy and retain critical staff for the delivery of HIV and AIDS services in scale-up districts</b>	Support the MOH implement the recruitment and retention policies to ensure adequate staff for the delivery of prevention, treatment and care programs in scale-up districts.  Support the MOH to recruit and retain 639 nurses to delivery HIV services	Support the MOH to implement the recruitment and retention policies to ensure adequate staff for the delivery of prevention, treatment and care programs in scale-up districts.  Support the MOH to recruit and retain 639 nurses, to delivery HIV services	300,000	300,000	TSEPO	Human Resources for Health=12.7	X	X	X	X	X
<b>Supply Chain Management</b>											

<b>Set-up a TBD supply chain mechanism that will independently manage the supply chain cycle for HIV, TB and laboratory commodities</b>	Employ experts with executive authority to manage supply chains from the central level to all service delivery sites	Employ experts with executive authority to manage supply chains from the central level to all service delivery sites	300,000	300,000	TBD	Commodity security and supply chain=7	X	X	X	X	X
<b>Build systems and capacities of local SCM staff in forecasting, quantification, procurement, inventory management, and LMIS for HIV commodities in preparation for transition in year 3</b>	Train 5 local staff to transition expert positions in year 3	Train 5 local staff to transition expert positions in year 3	100,000	100,000	TBD	Commodity security and supply chain=7		X	X	X	X
<b>Develop a modernized last-mile commodity distribution system at all priority service delivery points.</b>	Develop the last-mile re-engineering protocol	Implement the last-mile distribution in 286 service delivery points	1,500,000	1,500,000	TBD	Commodity security and supply chain=7	X	X	X	X	X
<b>Produce forecasting, quantification, procurement and inventory management stock status reports in scale-up districts</b>	2 forecasting and quantification reports 12 procurement reports 12 inventory management and stock status reports at NDSO 286 quarterly stock status reports (1,144 annually)	2 forecasting and quantification reports 12 procurement reports 12 inventory management and stock status reports at NDSO 286 quarterly stock status reports (1,144 annually)	100,000	100,000		Commodity security and supply chain=7	X	X	X	X	X

## 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 staff are aligned to the new PEPFAR business model and the programmatic pivot the team is undertaking in COP 2015.

At the February 2015 strategic framework development retreat convened by the Ambassador, there were six unmet staffing needs identified: two strategic information positions (Senior Strategic Information Technical Advisor and Monitoring and Evaluation Specialist) to provide ongoing program and epidemiologic data analysis that can be used to recalibrate programs as needed; two clinical positions (Care and Treatment Program Specialist and PMTCT/Pediatric Care Specialist) to strengthen the technical leadership and implementing partner management of the clinical care portfolio and oversee activities related to the new ACT and DREAMS initiatives; one coordination position (Deputy PEPFAR Coordinator) to facilitate interagency data coordination and much of the routine Global Fund coordination allowing the PEPFAR Coordinator to spend more time coordinating the PEPFAR program within the USG and externally with all stakeholders; and one communication/public affairs position (PEPFAR Communication Assistant) to support strategic communication and public affairs messaging on PEPFAR programs. Staffing aligns to our core, near-core, and non-core decisions, since our staff would focus on priority initiatives including SI, ACT, DREAMS, and care and treatment. The scope of existing, unfilled positions have been modified to better align with the new PEPFAR business model and program priorities by focusing on care and treatment, SI, adolescent girls and young women, and pregnant women/children. TA goals include increased capacity for SI and care and treatment.

The following factors were key in the staffing analysis undertaken by PEPFAR Lesotho: the notably small footprint in Maseru despite the complexity of the program; the administration and management burden of new PEPFAR business practices, such as SIMS, POART, and SID; and, most important, the programmatic pivot the PEPFAR Lesotho program is taking in order to meet the FY 2016 and FY 2017 ART scale-up targets in prioritized districts. This programmatic pivot cannot occur without additional clinical and strategic information advisors. COP 2015 requires much more active, hands-on management of PEPFAR partners as well as more frequent engagement with GOL and the Global Fund.

Factors that may change the cost of doing business in the next cycle include the costs associated with the increased number of staff. This increase in staff will enable us to meet our SIMS requirements, effectively manage the new DREAMS and ACT initiatives, improve the oversight of our SI activities, and manage our programs more efficiently. In addition, SIMS requirements will result in an increase in ICASS costs due to greater use of the motor pool.

# APPENDIX A

**Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15**

Activity	Core Activities	Near Core Activities	Non-Core Activities
Prevention: Community mobilization and advocacy	<p>Increase use of prevention services, such as PMTCT, care, treatment and VMMC</p> <p>Interventions to empower young women and adolescent girls and engage men and boys to promote positive norms and behaviors using a rigorously evaluated curriculum that have shown a significant impact on changing gender norms and related HIV risk behaviors</p> <p>Increase male and female condom distribution to public health facilities</p>	Adoption of safer sexual behaviors, such as partner reduction and use of PEP	<p>Radio spots</p> <p>Road shows</p>
Prevention: condoms and lubricant procurement, distribution, marketing and education	<p>Creation of condom distribution channels that are culturally acceptable and sustainable to ensure uninterrupted supplies to the end user.</p> <p>Increase correct and consistent condom use with all sexual partners</p>		
Prevention: Key populations		<p>Provision of risk reduction counseling</p> <p>Elimination of stigma and discrimination</p> <p>Increase distribution channels for condoms and lubricants for key populations</p>	Interpersonal communication activities targeting FSW and MSM aged 18 to 35 with HIV counseling and testing and condom and lubricants promotion toolkits
Prevention: Capacity building			<p>Support to MOH to strengthen their capacity in SBCC</p> <p>Support the MOH's Health Education Department through on-going coaching and mentorship to improve that entities capacity to better advice on, review, and coordinate health education and messaging activities implemented in Lesotho</p>
VMMC	<p><u>Site level</u></p> <p>Circumcise 80% of target population ~ 250,000 MCs over 5 years</p> <p>HIV testing and counselling for VMMC clients</p> <p>Counseling on GBV and post-procedure positive behavior</p> <p>In-service training with continued mentorship for VMMC providers</p> <p>Linking identified HIV positive individuals to care and treatment services</p> <p>Support scale up of EIMC services as sustainable component of VMMC program</p> <p>Waste management</p> <p><u>Sub-national level</u></p>	Operational research to guide program implementation and incorporation of innovative approaches	

	<p>Targeted demand generation communication – for increased use of VMMC and EIMC and post-procedure protective behaviors</p> <p>Advocacy and partnership with traditional leaders to ensure community ownership and partnership with village health workers</p> <p>Technical assistance to districts</p> <p><u>National level</u></p> <p>Support collection and use of data as part of one national M&amp;E system (data collection , reporting and feedback between facility, DHTM, and MOH)</p> <p>Technical assistance to the MOH (staff secondment and TA)</p> <p>Review of guidelines and tools as per developing national and global standards and recommendations</p> <p>Procurement processes</p> <p>Support partnerships with GF and other key stakeholders in VMMC</p> <p>Strengthen key technical areas for pre-service education and in-service training for nurses and midwives</p> <p>Advocacy for task shifting and decentralization of services</p> <p>Support for development of enabling regulatory environment for nursing education through strengthening Lesotho Nursing Council</p>		
PMTCT Prong 1: Prevent new infections among women of child bearing age	<p>Increasing uptake of HTC services for pregnant and lactating mothers to attain 90% coverage</p> <p>Conduct community initiatives to create demand for HTC services for pregnant and lactating mothers</p> <p>Couple HTC within MNCH/PMTCT settings</p>	<p>Community mobilization for pregnant and lactating mothers to attend ANC/PNC</p> <p>Conduct community initiatives to create demand for HTC services for pregnant and lactating mothers</p>	<p>Improve access to risk reduction package of interventions (to enable HIV negative pregnant and lactating women to remain HIV negative) i.e. risk reduction counseling, re-testing within MNCH</p>
PMTCT Prong 2: Eliminate unintended pregnancies among women living with HIV		<p>Scale up the number of sites that provide FP services within ART and MNCH settings</p> <p>FP compliance training for USG personnel, IPs and MOH</p> <p>Training and mentorship of health workers in long term and short term methods</p>	<p>Expand the range of FP services provided to WLHIV</p>
PMTCT Prong 3: Prevention of HIV transmission from pregnant women and lactating mothers living with HIV to their infants	<p>Provide ARVs to HIV-positive pregnant women and lactating mothers in ANC, labor and delivery and postnatal to attain 90% population coverage</p> <p>Provide ARV prophylaxis to HEI</p> <p>Support VL monitoring for HIV-positive mothers (pregnant and lactating) on ART</p> <p>Strengthen adherence support and counseling for pregnant and lactating</p>	<p>Mentorship and support supervision for health workers to improve competence for delivery of quality integrated eMTCT/MNCH/RH services</p>	<p>Support task sharing for nurse-led ART service delivery in MNCH/PMTCT</p>

	<p>mothers on ART.</p> <p>Strengthen community linkages and referral for ART for pregnant and lactating mothers</p> <p>Support the scale up of routine implementation of CQI activities at all eMTCT sites</p>		
PMTCT Prong 4: Provision of appropriate care, treatment and support to women living with HIV, their children and families	<p>Strengthen facility-community follow-up of mother-infant pairs</p> <p>Birth registration of HIV-positive women at community level and linkage to ART for mother and baby</p> <p>Support EID testing by 8 weeks of age and ensure receipt of results by care givers; and 2<sup>nd</sup> DNA PCR at cessation of breast feeding.</p> <p>Provide CTX to mothers and their HEI.</p> <p>Linkage to lifelong care and ART for HIV positive infants and mothers</p>	<p>Provide and scale-up integrated TB/HIV services in MNCH settings</p> <p>Strengthen PNC services to improve Mother baby pair follow-up</p> <p>Support the integration of NACS</p>	Cervical cancer and breast cancer screening in eMTCT settings
HTC: Community mobilization, advocacy and education	<p>Conduct social marketing to promote the know your status campaign and enhance community acceptance (KYS) in target locations</p> <p>Increase practice of safer sexual behaviors, including secondary abstinence, partner reduction and parallel to and following use of HTC services.</p> <p>Develop a communication strategy and HTC toolkits (creative development of communication activities, messaging and toolkits)</p> <p>Implement mid-media activities to support HTC outreaches in scale-up districts</p>	<p>Provide information regarding transmission, prevention, and PHDP.</p> <p>Promote condom use, VMMC, and gender equality through use of national media platforms</p>	<p>Development of legal frameworks that facilitate programming for key populations</p> <p>Address lack of knowledge and information that fuels stigma and discrimination against key populations</p> <p>Provide support in the national coordination of condom programming</p>
HTC	<p>Scale up targeted outreach HTC for key populations in selected locations</p> <p>Mobile counsellors provide HIV testing and counselling services in targeted community councils and districts</p>		
HTC: Pediatrics and adolescents	<p>Establish a know your status campaign and conduct community mobilization mass media campaign for pediatric care and treatment</p> <p>Design adolescent specific HTC outreaches in selected locations</p> <p>Refresher training for counselors on pediatric HTC counselling and procedures for infants, children, adolescents and caregivers/guardians</p>		
HTC: PICT	<p>Develop family tree using OVC child and pediatric patients for community index testing</p> <p>Implement routine opt-out HIV testing in priority settings (ART, MNCH/PMTCT, TB, nutritional corners, OVC settings, and pediatric inpatient wards)</p>		
HTC: Referral and linkages	<p>Link testing and counseling with clinical and community interventions, and improve referrals to TB and STI screening, and management, FP services, psychosocial support, VMMC, and ART</p>	<p>Development of SOPs describing the process by which individuals testing HIV-positive are linked to HIV care</p> <p>Roll our referral and linkages SOPs</p>	<p>Develop tool to effectively track linkages to prevention, treatment and care services</p>

HTC: Capacity building and quality improvement	<p>Refresher training of counsellors on PIMA usage with specific reference on quality assurance</p> <p>Site improvement monitoring and supervision</p> <p>Refresher training of counselors on pediatric HTC counseling</p> <p>In service training and mentorship</p> <p>Support all districts and sites to improve the quality of services through institutionalized QI approaches</p>	Provide TA for specialized counselling for different population groups (e.g. children, young people, couples and key populations)	
HTC: Policy guidance		Support the development and review of policies, guidelines and protocols	<p>Reducing HIV/AIDS-related stigma and discrimination at all levels</p> <p>Ensuring a supportive legal and policy framework within which the response is scaled up, including safeguarding the human rights of people seeking services</p>
HTC: HRH		Recruitment of counsellors, linkages facilitators/coordinators, IPC agents, HTC coordinators, condom coordinator	
HTC: PSM/commodities		Procurement of RTKs	Procurement of condoms and lubricants
Adult care and support: Prevention of opportunistic infections	Basic care package	<p>Screening to prevent cryptococcal meningitis for PLHIV with CD4 &lt;100</p> <p>HB screening and management</p>	Procurement of amphotericin B or fluconazole for prophylaxis and treatment cryptococcal meningitis
Adult care and support: Treatment of opportunistic infections	Treatment of opportunistic infections TB screening and management of all HIV-positive clients	Cervical cancer screening and management for women living with HIV/AIDS	Home-based care
Adult care and support: PHDP	<p>STI screening and management</p> <p>Voluntary FP services</p> <p>Condom access</p> <p>Adherence counseling and support</p>		Psychosocial support
Adult care and support: Assessment for ART eligibility	<p>Increasing CD4 coverage among pre-ART patients</p> <p>Point of care CD4+ testing at HTC outreaches</p> <p>WHO staging</p> <p>Active tracking of the “test and treat” cohort for early enrolment on treatment</p> <p>Procurement of CD4+ reagents and commodities</p> <p>Sample transportation</p>	Provide TA for specialized counseling for different population groups (e.g. children, young people, couples and key populations)	
Adult care and support: TB/HIV	<p>Improve early diagnosis and treatment of PLHIV to close gap between estimated TB incidence and current notification rates</p> <p>Increase access and utilization of GeneXpert to &gt;90% of all PLHIV.</p> <p>Support implementation of recently finalized GeneXpert national algorithm that prioritizes HIV-infected patients and other high-risk</p>	<p>Address TB in high-risk groups (i.e., children, contacts of index clients, prisoners, migrants, minors, and factory workers)</p> <p>Regional issues for TB and HIV treatment</p>	

groups. Provide additional GeneXpert cartridges in scale-up districts. Scale-up ART uptake among HIV-positive TB patients. Support timely initiation of treatment and improve retention on ART and TB treatment through mobile technologies, VHW, CAG, and basic care package provision.

Detect and treatment all MDR cases early

Implement 3Is nationwide

Intensify TB case finding among PLHIV in ART clinics, MNCH, correctional facilities, factories, mines, and health care facilities. Support tracking systems to ensure complete evaluation of TB suspects in register.

Scale-up IPT provision to cover all sites in prioritized districts not currently implementing IPT. Support trainings for IPT provision, M&E systems for IPT, support supervision, forecasting and distribution of IPT.

Support implementation of TB infection control (IC) measures and site-specific IC plans in prioritized health facilities, provision of N95 respirators, and coordination of IC committees.

Improve quality of TB cascade

HIV/TB program related evaluations e.g. TB intensive case finding cascade, monitoring of gene GeneXpert implementation, TB infection control in care settings in focus districts

Ensure engagement and retention of all PHLIV through mobile technology such as SMS reminders in scale-up districts

Support MOH to enhance and implement effective surveillance and M&E systems at central, district, facility, and community levels for TB/HIV activities. Implement revised TB/HIV MER indicators both in TB and HIV settings; TB/HIV cascade analysis; data quality assurance systems; and strengthening use and ownership of data for program planning, management and evaluation at district- and facility-level.

Support review of national guidelines, policies, tools, algorithms and M&E systems for TB/HIV activities

on cross-border management to maintain screening and cross-border referrals for TB and ART clients

Care and support: Nutrition Assessment Counseling and Support (NACS)

Identification of children living with HIV through PITC in nutrition and pediatric wards and children attending nutrition corners in OPD

Treatment initiation of newly diagnosed HIV-positive malnourished children

Growth monitoring of all children living with HIV

Counseling of care givers on optimal infant and young child feeding

Equipment procurement

Job aides for nutrition

Support supervision and mentorship of health workers to routinely screen for malnutrition among children attending MNCH, pediatric ART clinic, and pediatric in-patient wards

NACS for adults living with HIV

Policy and guideline development for nutrition in HIV

Procurement of therapeutic and supplementary foods

Procurement of nutrition-related drugs (e.g., iron, deworming tablets, vitamin A)

Distribution of therapeutic and supplementary foods at facility and community levels

	Referral of malnourished children to World Food Program therapeutic feeding programs	
Adult care and support: Linkages and Retention of Pre-ART clients	<p>Quality improvement of care services</p> <p>Roll out the national linkage and retention SOPs</p> <p>Strengthen linkages along the COR to ensure engagement in to care and retention between HTC into care; inter-facility referrals; facility-community referrals )</p> <p>Scale up activities that ensure engagement and retention of all PHLIV (Mobile technology, SMS reminders, Appointment registers, CHW, support groups, CAGS)</p> <p>Roll out the new ART Filing system to be able to count current in care and current in treatment</p>	
Adult care and treatment: Scale up treatment services	<p>Increase treatment coverage to attain to saturation levels in focus districts</p> <p>Scale up and sustain high quality B+ at all sites</p> <p>Integrate PITC in the clinical services portfolio</p> <p>Early ART initiation to eligible clients- “test and treat” cohort</p> <p>Supporting the decentralization of systems for the management of treatment failure</p> <p>Conduct surveys for drug resistance</p> <p>Quarterly program reviews with national stakeholders and implementers</p>	<p>Procure ARVS for the treatment program</p> <p>Collaboration with the MOH on improved availability and accessibility of data for HIV in all sites</p>
Adult care and treatment: Increase retention and Adherence to ART	<p>Develop and implement retention systems of clients to 90% at 12 months and 80% at 18 months (see care section)</p> <p>Cohort analyses for the care and treatment program</p>	
Adult care and treatment: Scale up quality improvement services for adult and adolescent treatment	<p>Develop a national QI strategy and implementation plan that is coordinated and integrated within the MOH</p> <p>Support MOH to identify reliable operating structures and clarify roles and responsibilities of different stakeholders in QI</p> <p>Support focus districts and sites to improve the quality of services through institutionalized QI approaches</p> <p>Integrate Quality improvement for ART services</p> <p>Use evidence built to scale up proven interventions</p> <p>Provide QI TA to the MO and sites and partners</p> <p>Collaborate with the SI/M&amp;E stakeholders to monitor QI initiatives</p>	<p>Support the national stakeholder consultation process to examine the individual, systemic, and structural barriers and key QI issues and disseminate a report on the national consultation process</p> <p>Support all HIV programs to prioritize the building of evidence base and share lessons learnt</p>
Adult care and treatment: Enhanced laboratory clinical monitoring	<p>Support training of clinicians in VL testing and result interpretation</p> <p>Mentorship to sites to ensure clinicians are requesting VL</p> <p>Support the national transport for EID and VL</p> <p>Support patient tracking and retention interventions to avoid LTFU and emerging HIVDR</p>	

Ensure CD4 access to 90% of all on pre-ART and those on ART who do not access VL

Adult care and treatment: Commodity management	HIV care and treatment drug delivery distribution to the facility level	
Pediatric care and treatment: Policy formulation and engagement		<ul style="list-style-type: none"> <li>Coordination of the national pediatric response</li> <li>Operationalization of policy and guidelines</li> <li>Updating training curricular and job aides</li> <li>Quarterly review meetings</li> <li>Expand performance based approach</li> </ul>
Pediatric care and treatment: Community engagement	<ul style="list-style-type: none"> <li>Community mapping</li> <li>Train CHW in pediatric prevention, treatment, adherence and support</li> <li>Community mobilization for the “know your status” campaign</li> <li>Strengthen bi-directional referrals, tracking and follow up</li> </ul>	<ul style="list-style-type: none"> <li>Define TOR for community pediatric care</li> <li>Involvement of men in pediatrics interventions</li> </ul>
Pediatric care and treatment: Early HIV Case finding	<ul style="list-style-type: none"> <li>Implement the Family Tree routine opt-out HTC in priority settings (ART, MNCH/PMTCT, TB, nutrition corners, OVC settings and pediatric in-patient wards)</li> <li>Scale up DNA/PCR testing in immunization outreaches</li> <li>Sample transportation and expedited results delivery at facility, district and central labs</li> <li>Refresher training of nursing assistants on DBS and HTC for PITC in the priority areas</li> <li>Refresher training of counselors on pediatric HTC counseling</li> <li>Enhance mentorships of health workers on pediatric care and treatment</li> <li>Introduction of POC DNA/PCR</li> </ul>	
Pediatric care and treatment: Linkage to care and treatment services	<ul style="list-style-type: none"> <li>Roll out the linkage SOPs</li> <li>Strengthen linkage and cross-referral strategies between and across clinical and social welfare programs</li> <li>Work with MOH and IPs to designate and formalize a patient escort/linkage facilitator in high case-load clinics</li> <li>Roll out QI initiatives to address linkage bottlenecks</li> <li>Review the effectiveness, coverage, and efficiency of the referral system</li> </ul>	

<p>Pediatric care and treatment: Scale up treatment and patient monitoring</p>	<p>Build capacity of health workers for comprehensive pediatric HIV care</p> <p>Recruit and assign resident pediatric HIV mentors to all districts</p> <p>Scale-up Baylor model especially for adolescents in focus districts</p> <p>Pediatric HIV/TB care quality improvement initiatives in scale-up districts</p> <p>Reorganize/renovate/partition to facilitate provision of adolescent HIV services</p> <p>Train private practitioners in providing pediatric HIV care and treatment based on new guidelines</p> <p>Provide mentorship for psychosocial support for HIV-infected children and adolescents</p> <p>Review and develop SOPs for pediatric and adolescents ART adherence counseling</p> <p>Establish support groups for pediatric HIV-positive caregivers and HIV-infected adolescents</p> <p>Increase VL monitoring to 90% coverage</p>	<p>Develop and maintain a pediatric HIV mentor pool contact list</p> <p>Conduct pre-service pediatric HIV Care and treatment training for graduating nurses</p>
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OVC: Programming is evidence-based	<p>Ensure effective integration with existing or planned child focused community and home based activities such as PMTCT, treatment and child survival</p> <p>Establishing linkages and referral systems between community and clinic based programs</p>	Support MOSD in ensuring a child-focused, family-centered approach to health and nutrition through ECD and school based programs	Improve access to health services through HES and social protection schemes such as health insurance policies
OVC: Capacity building and systems strengthening		<p>Strengthen leadership and governance within OVC organizations</p> <p>Ensure coordination and networking within the social service system</p>	Strong organizational systems
OVC: Strengthening the coordination of the national response	<p>Identification and registration of vulnerable children</p> <p>Data and information flow between the community councils, district and national headquarters</p> <p>Improving M&amp;E for interventions</p>	<p>Community mobilization</p> <p>Monitoring and evaluation</p> <p>Support to community councils</p> <p>Coordination of CSO interventions</p>	Resource mobilization
OVC: Education services		Support Government through relevant ministries to widely disseminate IECCD policy	Early childhood development programs building strong beginnings
OVC: Psychosocial support based on the principle of “do no harm”	<p>Parenting and family support interventions</p> <p>Community caregiver support</p>		<p>Peer and social group interventions</p> <p>Mentorship programs</p>
OVC: Household economic strengthening			<p>Improving money management interventions for savings</p> <p>Ensure access to consumer credit and fostering knowledge and behaviors for</p>

better family financial management to protect assets

OVC: Social protection	Create and enhance access and linkages to government supported cash grant programs Mobilizing child protection committees	Inform macro – level initiatives, through advocacy and policy dissemination.	
OVC: Referral and linkages	Ensure facilitation of referral to care and services like HTC, PMTCT and pediatric care and treatment Family tree using the OVC child		
SI: Surveillance and surveys		Linkage and retention survey Support for surveillance (HR, supplies, equipment, trainings) HIV Impact Assessment	
SI: HMIS	HMIS support for core cross-cutting activities from programs Develop, implement, interface with other information systems and hand over to national government District Health Information System Electronic Medical Record System Support for HMIS (salary support, supplies, equipment, trainings)		
SI: MER	Creation of linkage and retention indicator and system for collection Creation of VL monitoring indicator and system for collection Host a national workshop on data to evaluate change in prevalence /incidence of HIV	Key population surveillance and programmatic data collection, analysis and use Provide technical support to monitor implementation of revised national data Support for M&E (salary support, supplies, equipment, trainings) collection and reporting tools	
HRH: Governance – Policy and legal framework	HRH task sharing and shifting policy	HRH retention scheme	HRH strategic plan and policy Pre-service education strategic plans Continuous Professional Development strategy (CPD)
HRH: Management, recruitment and retention (PEPFAR 3 HRH strategy)	Recruitment and placement of nurses and district logistics staff in high burden HIV areas Recruitment and placement of CHW to support patient retention and follow-up, community-facility linkages and home-based HTC Recruitment and placement of adult and pediatric mentors; HTC coordinators; care and support coordinators in service delivery sites Support MOH to develop and implement an HRH salary support transition plan Support MOH develop sustainable HRH financing Support MOH develop and implement HRH performance management	Recruitment and placement of medical doctors, laboratory and pharmacy staff to support the delivery of HIV/AIDS services	Support to management and administrative staff Support to data clerks

	systems linked to Performance Based Financing (PBF)		
HRH: Information systems	Development of database to monitor nurse graduates credentialing, recruitment and placement	Technical assistance for the continuous monitoring of HRH movements between districts and outside Lesotho (iHRIS)	Support to the management and implementation of iHRIS
HRH: Pre- and in-service training	Competence based pre-service training of nurses Competence based in-service training of district logisticians and site level staff in inventory control	Pre-service training of pharmacy and laboratory cadres Pre-service training for medical doctors	Pre and in-service training for other paramedical and support staff
HRH: Regulation	Support to the Lesotho Nursing Council (NIMART)	Support for nurse CPD and credentialing program (Quality Assurance) Support to the Lesotho Medical Council	Support to the Council of Higher Education (accreditation of schools)
Health finance (SID)	Support the MOH develop and implement a health Financial Administration and Management System (FAMS) to aid budgeting and expenditure analysis in the sector.		
SCM: Governance – policy and legal framework			Medicines Bill STGs EML
SCM: Key functional areas (supply chain cycle)	Commodity Quantification, forecasting and procurement Commodity distribution (transportation and delivery : including Riders for Health)	Commodity selection Commodity use	
SCM: Support areas (critical enablers)	SCM stock status monitoring and evaluation	Organization of the system (SCM Unit) Financial management for commodities Management information systems HRH capacity (pre- and in-service competency based)	
Laboratory: Diagnosis and monitoring supplies	Procurement of reagents and supplies for HIV test, EID, VL, CD4, TB culture, and drug susceptibility tests Procurement of minor /PoC equipment for EID, VL, CD4 and TB tests	Procurement of ancillary equipment (e.g. centrifuges) 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)	Major renovations/ construction of a regional laboratory
Laboratory: Equipment maintenance system	Facility-based equipment maintenance services	Development of National strategic plan for Laboratory equipment maintenance program	
Laboratory: Sample transport and referral network	Sample transport to district/national reference laboratories for EID, VL, CD4, TB culture, and drug susceptibility tests		
Laboratory: Quality assurance/quality improvement Program	EQA/IPT program for HIV tests, EID, VL, TB, CD4 Rapid Testing Quality Improvement Initiative (RTQII)	Lab policy, guidelines and SOPs Implement GIS to map the test site locations and transport routes to monitor	

Laboratory: Human resource	In-service training	quality improvement
	Mentorship and supervision	Laboratory accreditation Pre-service training Hiring critical lab staff including lab data clerks and sample transporters

## APPENDIX B

### B.1 Planned Spending in 2016

**Table B.1.1 Total Funding Level**

Applied Pipeline	New Funding	Total Spend
\$275,000	\$38,925,000	\$39,200,000

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

PEPFAR Budget Code	Budget Code Description	PBAC 15-06-15	Recommended
HVOP	Other Sexual Prevention	\$ 997,784.73	\$ 797,785.00
IDUP	Injecting and Non-Injecting Drug Use	---	---
HMBL	Blood Safety	---	---
HMIN	Injection Safety	---	---
CIRC	Male Circumcision	\$ 1,747,210.00	\$ 1,747,210.00
HVCT	Counseling and Testing	\$ 4,504,468.87	\$ 1,099,363
HBHC	Adult Care and Support	\$ 3,905,817.87	\$ 2,163,284.50
PDCS	Pediatric Care and Support	\$ 441,124.88	\$ 2,146,878.00
HKID	Orphans and Vulnerable Children	\$ 2,582,256.55	\$ 2,582,264.00
HTXS	Adult Treatment	\$10,624,661.53	\$10,842,585.70
HTXD	ARV Drugs	---	---
PDTX	Pediatric Treatment	\$ 945,527.85	\$ 3,317,445.00
HVTB	TB/HIV Care	\$ 2,444,452.28	\$ 3,458,592.00
HLAB	Lab	\$ 757,363.70	\$ 657,363.70
HVSI	Strategic Information	\$ 681,627.33	\$ 786,640.48
OHSS	Health Systems Strengthening	\$ 1,741,936.51	\$ 609,872.62
HVMS	Management and Operations	\$ 7,005,000.00	\$ 7,005,000.00
<b>TOTAL</b>		\$39,402,124.07	\$38,925,000.00

## B.2 Resource Projections

### Process

The Lesotho PBAC Power Users were delegated authority to project the COP 2015 budget figures on behalf of the team. To carry out this assignment the PBAC Power Users were oriented to four tools:

1. PEPFAR Budget Allocation Calculator (PBAC) – used for deriving the COP 2015 budget code allocations
2. EA Data Navigation Tool – used for the outlier analysis and to examine pre-populated unit expenditures in the PBAC and through outlier analysis amended certain UEs as described below
3. EA-EPI Comparison Tool – used for comparison of historical UEs and geographic HIV disease burden analysis
4. Site Expenditure Allocation Tool (SEAT) – used for the efficiency analysis as a result of transitioning out of low yield sites

The budget team worked throughout the COP15 development process to analyze the historic investment profile as described by the FY2013 and FY2014 Expenditure Analyses. They also calculated efficiency savings and projected costs of the program. The budget team worked closely with the SI team on targeting and with program officers to analyze unit expenditures. The following budget profile and resource projection process was followed.

### Assess Alignment of Current PEPFAR Investments to Epidemic Profile:

The team used the EA-EPI comparison tool to analyze the current PEPFAR investments and their alignment to the epidemic profile.

### Efficiency Analysis

The budget team was advised by the SI team that 10 sites were to be centrally supported. These were the sites that yielded four or less HIV positives in the last 12 months. Table 1 provides the site names and results

**Table 1. Sites Yielding Four or Less HIV Positives in Last 12 months**

Site Name	District	# Positive	# Tested	Program Area
Tsaeng Health Post	Mafeteng	0	4	HTC
Leseli Medi Clinic (Private)	Butha Buthe	1	1	PMTCT
Thusanang HC	Butha Buthe	0	91	PMTCT
Lesotho College of Education	Maseru	4	25	PMTCT
Mafube HC	Maseru	4	18	PMTCT
National University of Lesotho	Maseru	4	26	PMTCT
LPPA HC	Mohale's Hoek	0	0	PMTCT
St Claire Clinic (Private)	Mohale's Hoek	0	0	PMTCT
Matebeng HC	Qacha's Nek	1	30	PMTCT
Mafa Health Post	Thaba Tseka	3	22	PMTCT

The 10 sites were uploaded into the SEAT tool and the following savings by program area were derived:

HTC: \$49,093  
FBCTS: \$10,785  
PMTCT: \$6,793

Classifying these 10 sites as centrally supported makes available savings in the amount of \$66, 671. These funds were then available for programming in the 5 scale-up districts.

### **Outlier Analysis**

This section documents the process and analysis that the budget team utilized to complete the outlier analysis of program areas by sub national units (SNU). Using the EA Data Navigation Tool and specifically the IM Unit Expenditure tab, the budget team reviewed all program areas UEs by comparing specific SNU UEs to the average UE and the outlier cutoff value. Any SNU UEs that were more than five times the average UE or over the outlier cutoff value by program area were considered as outliers. There was only one program with an outlier; this was VMMC. As a result the team attempted to use weighted averages excluding the outlier district (Mokhotlong) to calculate a new UE to be used for the COP 2015 budget projections. After further discussions the team opted to use \$95 from the new TSEPO program independent government estimate (IGE) for VMMC costing.

In addition, programs such adult and pediatric ART had some districts duplicated mainly due to the district rationalization process that occurred in early 2014. As a result two partners reported expenditure and UE in four districts though one of the partners was only active for a month or two. Therefore the budget team excluded their costs from the UE calculation as not representative of the program going forward.

### **UEs and Lump Sums Used to Populate PBAC**

With the significant changes to the program delivery approach in the scale-up districts moving to a more direct service delivery model in all sites, technical leads recommended adjustments to the historical UEs for PBAC planning. Specifically, the UE cost categories for personnel for Facility Based Care and Treatment Support (FBCTS) and PMTCT were adjusted to account for the increased number of human resources required in the scale-up districts. The UE for CBCTS and laboratory were also amended as outlined below.

**Personnel Cost Adjustment:** Technical colleagues calculated the projected additional human resources required to meet the saturation targets and projected the additional personnel costs. Personnel UE allocation was calculated using the TX\_CURR targets as this was felt to be the most universal count of all beneficiaries. This \$22.88 was added to the historic UE personnel costs.

**Table 2. Estimation of UEs for additional personnel for FBCT and PMTCT programs**

<b>Cadre</b>	<b>Number Required</b>	<b>Estimated Annual Salary</b>	<b>Total Estimated Cost</b>
Nurse	44	\$19,800.00	\$871,200.00
Nursing assistants	75	\$5,280.00	\$396,000.00
Doctor	12	\$38,500.00	\$462,000.00
M&E officers	10	\$10,560.00	\$105,600.00
Lay counselors/linkage facilitators	75	\$3,960.00	\$297,000.00
TB cough officer	75	\$3,960.00	\$297,000.00
District linkage coordinators	5	\$16,097.87	\$80,489.34
Data clerks	75	\$5,280.00	\$396,000.00
<b>Total</b>			<b>\$2,905,289.34</b>

FY2016 TX\_CURR (data pack 15-03-25: FY2015 current + net new FY 2016)

126,990

Personnel UE (total estimated cost / TC\_CURR)

\$22.88

Note: ESTIMATED ANNUAL SALARY was based upon listed MOH salary scales including 10%

**CBCTS:** There were no UEs calculated for CBCTS in FY2014 and the UE for FY2013 was felt to be significantly out of date and not in line with the projected programming of CBCTS. While the historical UE accounted for a program that was more focused on capacity building, the new approach for CBCTS will focus on psychosocial support, adherence counseling, retention and linkage to treatment. Due to the change in approach the technical team recommended a UE of \$12.00

**Site Level Laboratory Costs:** These UE calculations were based on the analysis of the FY2014 laboratory program area costs and international estimates of laboratory tests. The cross cutting FY2104 expenditure was allocated to laboratory tests based upon program data from the laboratory advisor. PEPFAR Lesotho contributed a total of \$1,949,105 in FY2014: \$1,056,133 was used for laboratory strengthening and \$892,972 was used for cross cutting activities. The crosscutting activities were primarily used to support procurement of laboratory reagents and supplies as a stop gap measure, support PT/EQA panels and sample transport for referral testing and related logistics.

Expenditure was allocated 6% for FBC/LFT/ALT tests, 16% for CD4 tests, 25% for EID, 27% for VL tests, and 26% for TB (GeneXpert) following calculated UEs. The budget team and laboratory advisor then calculated the relative PEPFAR expenditure to the test unit cost and produced realistic UEs for future laboratory programming in order to ensure that the program can sufficiently support the laboratory tests required to identify and retain people in quality care.

**Table 3. Estimation of UEs for Site Level Laboratory Activities**

Program	Type of test	Average Test per Year	Estimated Unit Cost	Estimated Cost per Year	Percent USG Contribution	USG UE		
<b>Pre-ART</b>	Adult Pre-ART	OI diagnosis (cryptococcal antigen)	1	\$2.50	\$ 2.50	0%	\$-	
		CD4: every 4 months	3	\$7.00	\$ 21.00	16%	\$3.36	
	<b>Pre-ART</b>	Pediatric Pre-ART	Blood glucose, cholesterol, triglycerides	1	\$ 2.50	\$ 2.50	0%	\$-
			<b>Total cost per patient</b>			<b>\$26.00</b>	<b>13%</b>	<b>\$3.36</b>
			CD4, baseline every 3 months/6 months	3	\$7.00	\$21.00	16%	\$3.36
<b>PMTCT-EID</b>	<b>PMTCT</b>	<b>Total cost per patient</b>			<b>\$21.00</b>	<b>16%</b>	<b>\$3.36</b>	
<b>EID</b>	Lab monitoring cost for HIV pregnant women was included in adult treatment (baseline and routine monitoring)							
		DNA PCR (screening and confirmatory)	2	\$15.00	\$30.00	25%	\$7.50	
		<b>Total cost per patient</b>			<b>\$30.00</b>	<b>25%</b>	<b>\$7.50</b>	
<b>ART</b>	Adult treatment (Baseline/routine monitoring)	FBC and/or Hemoglobin (baseline, 1 month, 2 month, every six months)	6	\$0.50	\$3.00	3%	\$ 0.09	
		LFT/ALT, creatinine (baseline, 1 month, 2 month, every six months for AZT based regimen)	6	\$1.20	\$7.20	3%	\$0.22	
		VDRL	1	\$1.00	\$1.00	0%	\$-	
		Pregnancy test	1	\$0.20	\$0.20	0%	\$-	
		HBsAg/Hepatitis C Serology	1	\$3.00	\$3.00	0%	\$ -	
	<b>ART</b>	Pediatric Treatment (Baseline and routine Monitoring)	CD4: Baseline and every 6 months	3	\$7.00	\$21.00	16%	\$3.36
			VL: Baseline and 6 months	2	\$15.00	\$30.00	27%	\$8.10
			<b>Total cost per patient</b>			<b>\$65.40</b>	<b>18%</b>	<b>\$11.77</b>
			FBC/hemoglobin, baseline, 8 weeks and 6 months	4	\$0.50	\$2.00	3%	\$0.06
			LFT/ALT	2	\$1.00	\$2.00	3%	\$0.06
		CD4: baseline and every 6 months	3	\$6.00	\$18.00	16%	\$2.88	
		VL: baseline and 6 months	2	\$15.00	\$30.00	27%	\$8.10	
		<b>Total cost per patient</b>			<b>\$52.00</b>	<b>21%</b>	<b>\$11.10</b>	
<b>TB Care</b>	TB lab diagnosis	TB smear microscopy (screening)	3	\$0.10	\$0.30	0%	\$ -	
		TB culture and DRS	1	\$2.00	\$2.00	0%	\$ -	
		GeneXpert	2	\$15.00	\$30.00	26%	\$ -	
		<b>Total cost per patient</b>			<b>\$32.30</b>	<b>24%</b>	<b>\$7.80</b>	

**Justifications for UEs and Lump Sums Applied in the Lesotho PBAC**

The technical leads of each program derived all lump sum figures in the PBAC. These figures are aligned to the amount of work that the program is expected to implement based on the implementing mechanism scope of work stated in the IM narratives. Brief descriptions below provide details how the lump sums were determined.

**Sustained Packages Costs:** The minimum package of HIV services that every PLHIV visiting PEPFAR-supported service sites should access so as to improve quality of life, prevent further HIV transmission, and delay HIV disease progression. For Lesotho sustained means passive enrollment adjusted to 25%, hub and spoke transition system for clinical service delivery: 5 high volume sites per district overseeing 3-4 low-medium volume sites, SIMS and IP site visits bi-annually to only the 5 high volume enforce quality improvement and quality assurance. The FY14 PEPFAR of \$5,631,562 was spent in the sustained districts (Butha Buthe, Mokhotlong, Thaba Tseka, Quthing and Qacha's Nek). This excluded national and above national costs. The team adjusted for historical expenditures by removing costs of construction, VMCC, adjusting cost HTC. In an attempt to secure funds for the scale-up districts, a lump sum of \$4 million was agreed upon by the team.

## **OHSS Lump Sums**

**Table 4. Health System Strengthening (HSS)**

Description of HSS Activities	COP 2015	EA 2014	Adjustments
Total	\$7,573,637	\$8,441,134	\$ (867,497)
Human Resources			
Pre-service Training	\$ 300,000	\$ 639,871	\$ (339,871)
Training of Trainers	\$ 105,000	\$ 204,653	\$ (99,653)
Curriculum Development		\$ 359,743	\$ (359,743)
HR Management and Retention	\$ 314,000	\$ 613,143	\$ (299,143)
Governance			
Technical-area Specific Guidelines, Tools and Policy	\$ 384,637	\$1,021,372	\$ (636,735)
General Policy and Other Governance	\$ 70,000	\$ 338,908	\$ (268,908)
Finance			
Financing Activities		\$ 19,382	\$ (19,382)
Systems Development			
Supply Chain Systems	\$2,000,000	\$ 223,865	\$1,776,135
Health Information Systems	\$ 700,000	\$ 368,516	\$ 331,484
Laboratory Strengthening	\$ 700,000	\$ 970,426	\$ (270,426)
Institutional and Organization Development			
Civil Society and Non-Governmental Organizations		\$ 255,174	\$ (255,174)
Government Institutions	\$ 150,000	\$1,007,649	\$ (857,649)
Other HSS Activities (not categorized above)			
Other Care and Treatment Maintenance costs	\$2,850,000	\$2,418,432	\$ 431,568

The OHSS budget was reduced in comparison with the EA 2014 expenditures except for Supply Chain Management and Health Information Systems. The reductions were mainly attributed to changes in the scope of HSS programs. In future, the focus will be on site-level HSS investments.

Supply Chain Management received more funds due to a deliberate effort to develop a solution for commodity insecurity issues in the health sector. The strategy is to employ five high level experts with

executive authority to manage the supply chain cycle from central medical stores to the service delivery points.

Health Information Systems investments will go towards the expansion of HR capacity to collect, reconcile and report health information into the DHIS2 system recently launched by the Ministry of Health. This is in an effort to improve timely availability and accuracy of HIV data for reporting purposes.

In sustained districts, PEPFAR will only provide technical assistance to the District Health Management Teams (DHMT).

### **Adjustments of Budget Codes to Meet Care and Treatment and OVC Earmarks**

Having completed in-putting both the recommended UEs and targets from the data pack, we had to complete some of the fund allocation processes outside the PBAC. Table B.1.2 shows a combination of the final budget code output from the PBAC and the shifts done in order to balance the budget to the resource envelope and also meet the prescribed earmarks.

### Lesotho COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
_Military Lesotho	8,333	600	2,318	830	2,120
Berea	127,353	14,551	27,663	10,913	20,896
Butha Buthe	-	-	-	-	-
Leribe	144,408	12,334	34,451	9,621	28,110
Mafeteng	62,440	9,315	21,815	4,617	16,044
Maseru	169,298	17,653	58,913	14,513	47,889
Mohale's Hoek	54,056	10,136	20,056	4,331	13,445
Mokhotlong	-	-	-	-	-
Qacha's Nek	-	-	-	-	-
Quthing	-	-	-	-	-
Thaba Tseka	-	-	-	-	-
<b>Total</b>	<b>565,888</b>	<b>64,589</b>	<b>165,216</b>	<b>44,825</b>	<b>128,504</b>

## Lesotho COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
_Military Lesotho	-	-	-
Berea	21,322	-	18,889
Butha Buthe	-	-	-
Leribe	-	2,112	7,962
Mafeteng	-	-	9,804
Maseru	50,861	3,347	36,077
Mohale's Hoek	-	-	7,923
Mokhotlong	-	-	-
Qacha's Nek	-	-	-
Quthing	-	-	-
Thaba Tseka	-	-	-
<b>Total</b>	<b>72,183</b>	<b>5,459</b>	<b>80,655</b>

## Lesotho COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
_Military Lesotho	-	-
Berea	6,178	1,507
Butha Buthe	-	-
Leribe	6,885	1,665
Mafeteng	4,267	1,250
Maseru	11,158	3,485
Mohale's Hoek	4,325	1,163
Mokhotlong	-	-
Qacha's Nek	-	-
Quthing	-	-
Thaba Tseka	-	-
<b>Total</b>	<b>32,813</b>	<b>9,070</b>

## Lesotho COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
_Military Lesotho	-	-
Berea	943	395
Butha Buthe	-	-
Leribe	1,689	709
Mafeteng	956	415
Maseru	3,810	1,603
Mohale's Hoek	1,069	447
Mokhotlong	-	-
Qacha's Nek	-	-
Quthing	-	-
Thaba Tseka	-	-
<b>Total</b>	<b>8,467</b>	<b>3,569</b>

## Lesotho COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
_Military Lesotho	5,134
Berea	3,255
Butha Buthe	-
Leribe	4,039
Mafeteng	2,977
Maseru	4,871
Mohale's Hoek	3,248
Mokhotlong	-
Qacha's Nek	-
Quthing	-
Thaba Tseka	-
<b>Total</b>	<b>23,524</b>



## HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural **Sustainability Index and Dashboard (SID)** during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

<b>Dark Green Score (17-20 pts)</b> <b>(sustainable and requires no additional investment at this time)</b>
<b>Light Green Score (13-16.9 pts)</b> <b>(approaching sustainability and requires little or no investment)</b>
<b>Yellow Score (7-12.9 pts)</b> <b>(emerging sustainability and needs some investment)</b>
<b>Red Score (0-6.9 pts)</b> <b>(unsustainable and requires significant investment)</b>

# Sustainability Analysis for Epidemic Control: LESOTHO

**Epidemic Type:** Generalized  
**Income Level:** Lower Middle Income  
**PEPFAR Categorization:** Long Term Strategy  
**COP 15 Planning Level:**

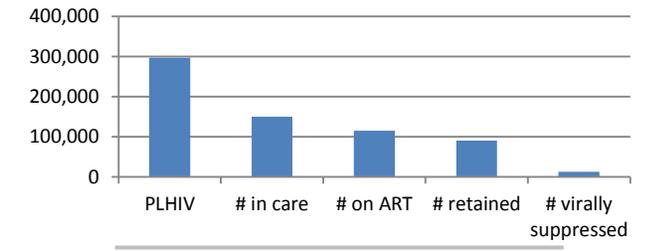


**SUSTAINABILITY DOMAINS AND ELEMENTS**

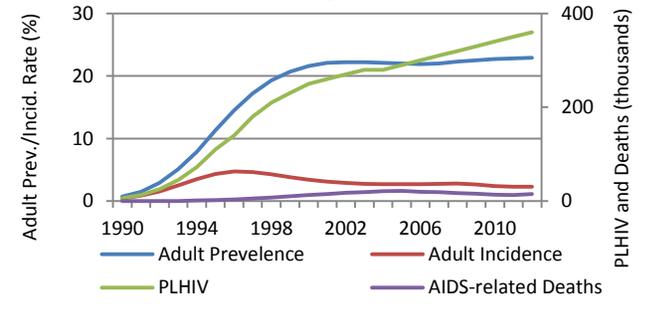
Institutionalized Data Availability		Score
1. Epidemiological and Health Data	Yellow	10.8
2. Financial/Expenditure Data	Green	14.0
3. Performance Data	Yellow	9.0
Domestic Program and Service Delivery		
4. Access and Demand	Green	13.2
5. Human Resources for Health	Yellow	12.7
6. Commodity Security and Supply Chain	Yellow	7.0
7. Quality Management	Red	5.0
Health Financing and Strategic Investments		
8. DRM: Resource Generation	Green	14.0
9. DRM: Resource Commitments	Red	5.0
10. Allocative Efficiency	Red	2.0
11. Technical Efficiency	Red	5.5
Accountability and Transparency		
12. Public Access to Information	Red	1.0
13. Oversight and Stewardship	Yellow	9.5
Enabling Environment		
14. Policies, Laws, and Regulations	Yellow	8.0
15. Planning and Coordination	Green	13.0

## CONTEXTUAL DATA

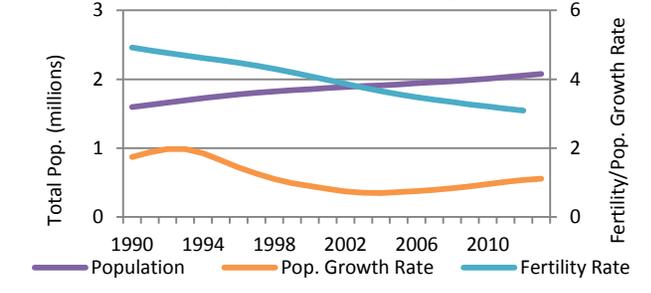
**Care and Treatment Cascade**



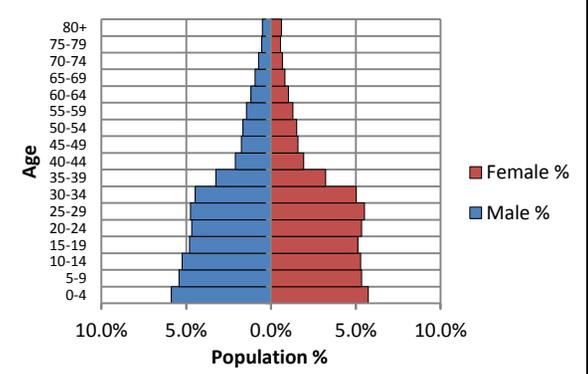
**Epidemiological Data**



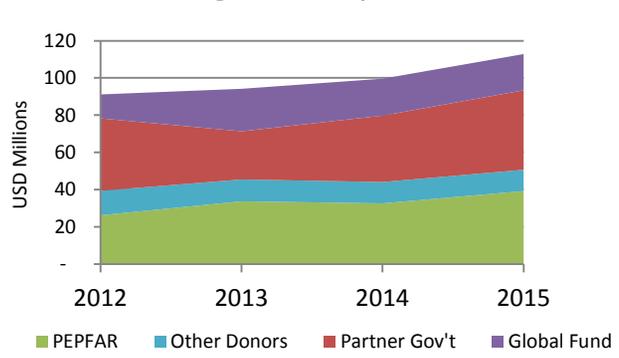
**Population and Fertility**



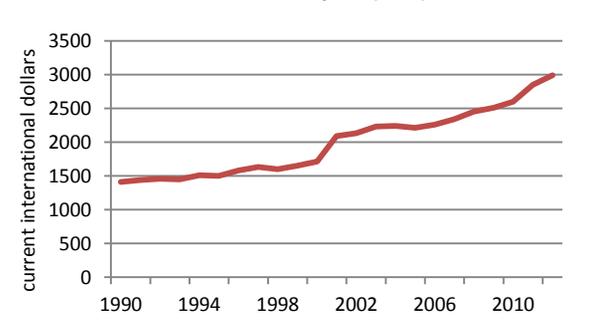
**Population Pyramid (2014)**



**Financing the HIV Response**



**GNI Per Capita (PPP)**



**CONTEXTUAL DATA**

## Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

		Source of data	Notes/Comments	
<p><b>1. Epidemiological and Health data:</b> Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.</p>				
<p><b>Q1. Who leads:</b> Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?</p>	<p><input checked="" type="radio"/> A. Host Country Government/other domestic institution</p> <p><input type="radio"/> B. External agency with host country government</p> <p><input type="radio"/> C. External agency, organization or institution</p> <p><input type="radio"/> D. Not conducted</p>	4.5	<p>Communication within the national Strategic Information TWG arranging the 2014 DHS.</p> <p>The Government of Lesotho/ Ministry of Health leads the planning and implementation of epidemiological surveys and surveillance through the Research ethics Committee. There is however extensive external agency support/ leadership/ management for some epi surveys and surveillance. E.g. USG taking lead on HIA, HIVDR EWI 2014, etc. It depends on the agency that has interest in certain surveillance or survey, but ministry has to have a buy in in the area of interest. Donors provides financial support and sometimes TA. Ideally the government has to take the lead.</p>	
<p><b>Q2. Who finances:</b> Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?</p>	<p><input type="radio"/> A. 80-100% of the total cost of latest survey was financed by Host Country Government</p> <p><input type="radio"/> B. 60-79% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> C. 40-59% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> D. 20-39% of the total cost of latest survey financed by Host Country Government</p> <p><input checked="" type="radio"/> E. 10-19% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> F. 0-9% of the total cost of latest survey financed by Host Country Government</p>	1	<p>DHS2014 budget December 3, 2013</p> <p>Calculation: GOL contribution of \$280,000 out of a total budget of \$2.7M.</p>	
<p><b>Q3. Comprehensiveness of Prevalence and Incidence Data:</b> Does Host Country Government collect HIV prevalence and or incidence data?</p>	<p><input type="radio"/> No, the government does not collect HIV prevalence or incidence data</p> <p><input checked="" type="radio"/> Yes, the government collects (check all that apply):</p> <p><input checked="" type="checkbox"/> A. HIV prevalence</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input type="checkbox"/> Sub-national data</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected every 3 years</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data analyzed for trends</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data made publicly available</p> <p><input type="checkbox"/> B. HIV incidence</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input type="checkbox"/> Sub-national data</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected every 3 years</p> <p style="margin-left: 20px;"><input type="checkbox"/> Data analyzed for trends</p> <p style="margin-left: 20px;"><input type="checkbox"/> Data made publicly available</p>	2.1	<p>DHS 2014, 2009 and 2004. Incidence assays will be conducted upon the DHS 2014 blood samples alongside HIV testing</p> <p>Age disaggregation - DHS</p> <p>Children Prevalance - NO</p> <p>Sex - DHS</p> <p>Key Pops - PSI study</p> <p>Subnational data - DHS</p> <p>Collect every 3 year - No</p> <p>Data analysed for trends - DHS</p> <p>Data made publicly available - No</p>	<p>Note: no prevalence data for &lt;15 years of age in DHS 2009 or DHS 2014; there has been no other population based survey between the two.</p> <p>HIV Prevalence data has been collected for KEY POPULATIONS: USG funded MSM and CSW BISS in 2014 though cell un-checked as unsure if 'Government collects' or question really relates to population surveys?</p> <p>HIV prevalence for children is not there but there is routine data that can give the idea (HTC routine data).</p> <p>EID will be collected in the new HIA study, currently the country does not collect incidence.</p>
	<p><input type="radio"/> No, the government does not collect viral load data</p>	2.4	<p>National Laboratory Information System (NLIS)</p> <p>Note: Viral Load (VL) has only been collected routinely in the last 6 months. VL to be included in the DHS 2014. As part</p>	

<p><b>Q4. Comprehensiveness of Viral Load Data:</b> Does Host Country Government collect viral load data?</p>	<p><input checked="" type="radio"/> Yes, the government collects viral load data (check all that apply):</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Collected by age</li> <li><input checked="" type="checkbox"/> Collected for children</li> <li><input checked="" type="checkbox"/> Collected by sex</li> <li><input type="checkbox"/> Collected by key population</li> <li><input checked="" type="checkbox"/> Sub-national data</li> <li><input type="checkbox"/> Collected every 3 years</li> <li><input type="checkbox"/> Data analyzed to understand trends</li> </ul>		System (LIS)	last 6 months; VL to be included in the UHS 2014. As not collected in 2009 there is no trend analysis, children are not included and not every 3 years. Lab reports Guidelines but not to say they are being done but to show they have to be done. Patient monitoring only for test and treat, for TB, Pregnant women and Children
<p><b>Q5. Key Populations:</b> Does the Host Country Government conduct size estimation studies for key populations?</p>	<p><input type="radio"/> No, the host country government does not conduct size estimation studies for key populations</p> <p><input checked="" type="radio"/> Yes, the government conducts key population size estimates (check all that apply):</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Men who have sex with men (MSM)</li> <li><input checked="" type="checkbox"/> Female sex workers</li> <li><input type="checkbox"/> Transgender</li> <li><input type="checkbox"/> People who inject drugs (PWID)</li> <li><input type="checkbox"/> Government finances at least 50% of the size estimation studies</li> <li><input type="checkbox"/> Government leads and manages the size estimation studies</li> </ul>	0.8	PSI/JHU, Examining factors associated with HIV-related risk behaviors, HIV prevalence, and population size estimates of two key populations—men who have sex with men (MSM) and female sex workers (FSW)—in Lesotho, 2014 Modes of transmission - UNAIDS PSI Study - PSI and PEPFAR Prisoners - GFCU Factory Workers - GFCU and PEPFAR ALAFIA	Note: awaiting publication

**Epidemiological and Health Data Score:** 10.8

		Source of data	Notes/Comments
<p><b>2. Financial/Expenditure data:</b> Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness.</p> <p><b>Q1. Expenditure Tracking:</b> Does the host country government have a nationally agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?</p>	<p><input type="radio"/> No, it does not have a national HIV/AIDS expenditure tracking system</p> <p><input checked="" type="radio"/> Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies):</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others</li> <li><input checked="" type="checkbox"/> B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening</li> <li><input checked="" type="checkbox"/> C. Collected sub-nationally</li> <li><input checked="" type="checkbox"/> D. Collected annually</li> <li><input type="checkbox"/> E. Data is made publicly available</li> </ul>	4	Annual MOH Resource Mapping Reports  Annex 69 Funding Landscape, Lesotho Concept Note Submission to the Global Fund, April 15, 2015
<p><b>Q2. Quality of Expenditure Tracking:</b> Is the Host Country Government tracking expenditures based on international standards? What type of expenditure data are available in the country, i.e. NHA, NASA, others:</p>	<p><input type="radio"/> No, they are not using any international standards for tracking expenditures</p> <p><input checked="" type="radio"/> Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model.</p>	5	As above and Lesotho Concept Note submission April 15, 2015  Note: The Global Fund has accepted the Resrouce mapping as part of the Concept Note submission.  NASA available from 2009 and there are discussions in the MOH to conduct a NHA in 2015

<p><b>Q3. Transparency of Expenditure Data:</b> Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?</p>	<p><input type="radio"/> No, they do not make expenditure data available to the public</p> <p>Yes, check the one that applies:</p> <p><input checked="" type="radio"/> A. Annually</p> <p><input type="radio"/> B. Bi-annually</p> <p><input type="radio"/> C. Every three or more years</p>	5	Annual Joint Review (AJR)	
<p><b>Q4. Economic Studies:</b> Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?</p>	<p><input checked="" type="radio"/> No, they are not conducting special health economic studies for HIV/AIDS</p> <p><input type="radio"/> Yes, check all that apply:</p> <p><input type="checkbox"/> A. Costing studies or analyses</p> <p><input type="checkbox"/> B. Cost-effectiveness studies or analyses</p> <p><input type="checkbox"/> C. Efficiency studies or analyses</p> <p><input type="checkbox"/> D. Cost-benefit studies or analyses</p>	0	Abt. Associates HSS20/20 project, HIV AIDS Program Sustainability Tool (HAPSAT), 2012	

**Financial/Expenditure Data Score: 14**

<p><b>3. Performance data:</b> Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.</p>		Source of data	Notes/Comments	
<p><b>Q1. Collection of service delivery data:</b> Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?</p>	<p><input type="radio"/> No, the government does not have an HIV/AIDS service delivery data collection system</p> <p><input checked="" type="radio"/> Yes, service delivery data are collected/reported for (check all that apply):</p> <p><input checked="" type="checkbox"/> A. For HIV Testing</p> <p><input checked="" type="checkbox"/> B. For PMTCT</p> <p><input checked="" type="checkbox"/> C. For Adult Care and Support</p> <p><input checked="" type="checkbox"/> D. For Adult Treatment</p> <p><input checked="" type="checkbox"/> E. For Pediatric Care and Support</p> <p><input checked="" type="checkbox"/> F. For Pediatric Treatment</p> <p><input checked="" type="checkbox"/> G. For AIDS-related mortality</p>	7	<p>MOH, HMIS HIV Site Report, December 2014</p> <p>Reporting annually: MOH, Annual Joint Review 2014, 2013, 2012 etc. DHIS2</p>	
<p><b>Q2. Analysis of service delivery data:</b> Does the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS-related mortality rates?</p>	<p><input checked="" type="radio"/> No, the government does not routinely analyze service delivery data to measure performance</p> <p><input type="radio"/> Yes, service delivery data are being analyzed to measure (check all that apply):</p> <p><input type="checkbox"/> A. Continuum of care cascade, including testing, care, treatment, retention and adherence</p> <p><input type="checkbox"/> B. Results against targets</p> <p><input type="checkbox"/> C. Coverage</p> <p><input type="checkbox"/> D. Site specific yield for HIV testing (HTC and or PMTCT)</p> <p><input type="checkbox"/> E. AIDS-related death rates</p>	0	<p>MOH, Annual Joint Review 2014, 2013, 2012 etc. MEST report HMIS assessment</p>	<p>Note: there is no format or section of the AJR that presents continuum of care cascade or site specific yield for HIV testing though the data is within the AJR separately</p>
<p><b>Q3. Comprehensiveness of service delivery data:</b> Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive?</p>	<p><input checked="" type="radio"/> No</p> <p><input type="radio"/> Yes, service delivery data are being: (check all that apply):</p> <p><input type="checkbox"/> A. Collected at least quarterly</p> <p><input type="checkbox"/> B. Collected by age</p> <p><input type="checkbox"/> C. Collected by sex</p> <p><input type="checkbox"/> D. Collected from all clinical sites</p> <p><input type="checkbox"/> E. Collected from all community sites</p> <p><input type="checkbox"/> F. Data quality checks are conducted at least once a year</p>	0	<p>MOH, HIV/AIDS HMIS Summary report, December 2014</p>	<p>Data is collected monthly from sites that includes age, sex and QA/QC - data verification exercises do occur. However not timely or accurate. Although data quality checks are being conducted however data quality still remains an issue.</p>

<p><b>Q4. Transparency of service delivery data:</b> Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely?</p>	<p><input type="radio"/> No, they do not make program performance data available to the public</p> <p>Yes, check the one that applies:</p> <p><input checked="" type="radio"/> A. At least annually</p> <p><input type="radio"/> B. Bi-annually</p> <p><input type="radio"/> C. Every three or more years</p>		<p>2 MOH, Annual Joint Review 2014, 2013, 2012 etc.</p>	<p>Although the AJR report exists, it is not made available on the MOH website.</p>
<p><b>Performance Data Score:</b></p>		<p><b>9</b></p>		

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

## Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIV/AIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

4. Access and Demand: There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.		Source of data	Notes/Comments
<p><b>Q1. Access to ART:</b> What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing ART.</p>	<p>Q1 Score: 4</p>	<p>MOH, Health Facility List, 2013 MOH, HMIS HIV Site Report, December 2014  MOH, National PMTCT and ART Guidelines, 2014</p> <p>95%. All public facilities are providing ART. The 5% that are not represent private facilities, which are not as consistent.</p>
<p><b>Q2. Access to PMTCT:</b> What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.</p>	<p>Q2 Score: 3</p>	<p>As above.</p> <p>All public facilities are providing PMTCT services. However there are challenges with some private facilities providing PMTCT services.</p>
<p><b>Q3. Who is delivering HIV/AIDS services:</b> What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p>	<p>Q3 Score: 3</p>	<p>MOH, HMIS HIV Site Report, December 2014</p> <p>220 public and CHAL (faith based component of the public health system) health facilities, 47 private accredited.</p>
<p><b>Q4. Services to key populations:</b> What percent of key population HIV/AIDS prevention program clients receive services at public service delivery</p>	<p><input checked="" type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p>	<p>Q4 Score: 0</p>	<p>Note: Key Pop. BBIS, 2013 survey does not quantify. Data is being collected through SIMS (CEE).</p>

<p>sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p>			
<p><b>Q5. Uptake of services:</b> What percent of PLHIV are currently receiving ART? 29%</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. 80% or more of PLHIV are currently receiving ART</p> <p><input type="radio"/> B. 50-79% of PLHIV are currently receiving ART</p> <p><input checked="" type="radio"/> C. 20-49% of PLHIV are currently receiving ART</p> <p><input type="radio"/> D. Less than 20% of PLHIV are currently receiving ART</p>	<p>Q5 Score</p> <p>2</p>	<p>UNAIDS Gap Report, 2014</p>	<p>Awaiting final denominator number from UNAIDS</p>
<p><b>Q6. Rights to Access Services:</b> Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations.</p> <p><input checked="" type="radio"/> Yes, there are efforts by the government (check all that apply):</p> <p><input type="checkbox"/> educates PLHIV about their legal rights in terms of access to HIV services</p> <p><input type="checkbox"/> educates key populations about their legal rights in terms of access to</p> <p><input checked="" type="checkbox"/> National policy exists for de-stigmatization in the context of HIV/AIDS</p> <p><input checked="" type="checkbox"/> national law exists regarding health care privacy and confidentiality protections</p> <p><input type="checkbox"/> government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found</p>	<p>Q6 Score</p> <p>1.2</p>	<p>MOH, National Strategic Plan for HIV and AIDS 2012/13 - 2015/16</p>	<p>Though the HIV/AIDS NSP talks of legal and PLHIV support AND TGF grant supports both activities, do these qualify? Education is supported through civil society.</p>
<b>Access and Demand Score</b>			<b>13.2</b>	

<p><b>5. Human Resources for Health:</b> HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.</p>	<p><b>Source of data</b></p>	<p><b>Notes/Comments</b></p>
<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not available</p> <p><input checked="" type="radio"/> A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand</p>	<p>Q1 Score:</p> <p>0</p>	<p>Average National Score on SIMS Facility Tool Staffing CEE</p> <p>3 data sources: MOH Burden calculation; SIMS; IHRS tool. Question is limited to clinical staff, not whole service delivery staff</p>

<p><b>Q1. HRH Sufficiency:</b> Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?</p>	<p><input type="radio"/> B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply)</p> <p><input type="checkbox"/> HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand</p> <p><input type="checkbox"/> HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites</p>			
<p><b>Q2. HRH Transition:</b> What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers</p> <p><input type="radio"/> B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date</p> <p><input checked="" type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date.</p> <p><input type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan</p> <p><input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated</p>	<p>Q2 Score: 2</p>	<p>PEPFAR official communication with the MOH;</p> <p>Global Fund: Plan of Action for Global Fund supported Human Resources, 15 November 2013 to March 2014</p>	<p>USG and Global Fund have inventory and optioned HR transition plans by Implementing Partners. The HRH support from the Global Fund Rd 8 HIV was only partially achieved by the GOL. No staff transitioned from USG funding.</p>
<p><b>Q3. HRH Financial reform:</b> Has financial reform been undertaken in the last 5 years to address government financing of health workers?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. No financial reform has been undertaken in the last 5 years to address government financing of health workers</p> <p><input checked="" type="radio"/> B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply):</p> <p><input checked="" type="checkbox"/> Wage reform to increase salaries and or benefits of health workers</p> <p><input checked="" type="checkbox"/> Increase in budget allocation for salaries for health workers</p>	<p>Q3 Score: 2</p>	<p>MOH Salary memo 2013.</p>	<p>Note: there has been wage reform to increase salaries and benefits of HCWs; Increase in budget for salaries for HCWs; rural hard to reach incentives/ allowances for the nurses' retention scheme.</p>
<p><b>Q4. Pre-Service:</b> Does current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p> <p><input type="checkbox"/> content updated for all HIV/AIDS services</p> <p><input checked="" type="checkbox"/> updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input checked="" type="checkbox"/> updated curriculum is problem based/competency based</p> <p><input checked="" type="checkbox"/> updated curriculum includes practicums at high volume clinical/ social services sites</p>	<p>Q4 Score: 2.2</p>		<p>NEPI- curriculum (HIV/AIDS); lab- curriculum reviewed (National Univ of Lesotho); IMI trainings being conducted for graduate nurses (last year of program)</p> <p>Group believes that content for ALL HIV/AIDS services has not been updated (ie. content for VMMC / EIMC). Unticked first and last box. NHTC for pharm technicians</p>

	<input type="checkbox"/> institutions that track students after graduation			
Q5. <b>In-Service:</b> To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training.</p> <p><input type="radio"/> B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented.</p> <p><input checked="" type="radio"/> C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date.</p> <p><input type="radio"/> D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.</p>	Q5 Score: 1	National In-service Training coordination Strategy, MCC (2012)	Partners IP were providing in service training; MOH has mandated the use of nationally approved curricula.
Q6. <b>HRIS:</b> Does the government have a functional Human Resource Information System (HRIS) for the health sector?	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. No, there is no HRIS</p> <p><input checked="" type="radio"/> B. Yes, the government does have a HRIS (check all that apply)</p> <p><input checked="" type="checkbox"/> The HRIS is primarily funded by host country institutions</p> <p><input checked="" type="checkbox"/> There is a national interoperability strategy for the HRIS</p> <p><input checked="" type="checkbox"/> The government produces HR data from the HRIS at least annually</p> <p><input type="checkbox"/> The government uses data from the HRIS for HR planning and management</p>	Q6 Score: 1.5		Group suggests that more information is provided for the last box. Conflicting views on the last box. It seems like the HRH unit may have this information, but it is not well communicated to other units of MOH or IPs.
Q7. <b>Domestic funding for HRH:</b> What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources?	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input type="radio"/> A. Less than 20%</p> <p><input type="radio"/> B. 20-49%</p> <p><input type="radio"/> C. 50-79%</p> <p><input checked="" type="radio"/> D. 80% or more</p>	Q7 Score: 4	MOH, Annual Joint Review 2014, 2013, 2012 etc.	The remaining 20% posts in the health sector are supported by development partners mainly because the MoH has not fully completed the procedures to request the filling-up of all vacant or new posts to the public service commission.

**Human Resources for Health Score** **12.7**

6. <b>Commodity Security and Supply Chain:</b> The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.		Source of data	Notes/Comments
Q1. <b>ARV domestic financing:</b> What is the estimated obligated funding for ARV procurement from domestic public revenue (not donor) sources?	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input type="radio"/> A. 0-9% obligated from domestic public sources</p> <p><input type="radio"/> B. 10-29% obligated from domestic public sources</p> <p><input checked="" type="radio"/> C. 30-79% obligated from domestic public sources</p>	Q1 Score: 2	MOH, HIV Resource Mapping, 2014
			As earlier noted; no report or data set publically available though again captured in the Global Fund, 'Willingness to Pay' documentation accompanying the 2015 Concept Note submission. Government needs to share their plan for coverage of ARVs for sustainability

	<input type="radio"/> D. 80% or more obligated from domestic public sources			
<b>Q2. Test Kit domestic financing:</b> What is the estimated obligated funding for Rapid Test Kits from domestic public revenue (not donor) sources?	<p>Check the one answer that best describes the current situation:</p> <input type="radio"/> This information is not known <input checked="" type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources <input type="radio"/> C. 30-79% obligated from domestic public sources <input type="radio"/> D. 80% or more obligated from domestic public sources	Q2 Score: 0	MOH, HIV Resource Mapping, 2014; From SSF grant, gap analysis	As above
<b>Q3. Condom domestic financing:</b> What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?	<p>Check the one answer that best describes the current situation:</p> <input type="radio"/> This information is not known <input checked="" type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources <input type="radio"/> C. 30-79% obligated from domestic public sources <input type="radio"/> D. 80% or more obligated from domestic public sources	Q3 Score: 0	MOH, HIV Resource Mapping, 2014	As above
<b>Q4. Supply Chain Plan:</b> Does the country have an agreed-upon national supply chain plan with an implementation plan or a thorough annually-reviewed supply chain SOP?	<input type="radio"/> A. No, there is no plan or thoroughly annually reviewed supply chain SOP <input checked="" type="radio"/> B. Yes, there is a Plan/SOP. It includes these components: (check all that apply) <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Human resources</li> <li><input checked="" type="checkbox"/> Training</li> <li><input checked="" type="checkbox"/> Warehousing</li> <li><input checked="" type="checkbox"/> Distribution</li> <li><input checked="" type="checkbox"/> Reverse Logistics</li> <li><input checked="" type="checkbox"/> Waste management</li> <li><input checked="" type="checkbox"/> Information system</li> <li><input checked="" type="checkbox"/> Procurement</li> <li><input checked="" type="checkbox"/> Forecasting</li> <li><input checked="" type="checkbox"/> Supply planning and supervision</li> </ul>	Q4 Score: 4	MOH, Strategic Plan for Supply Chain Management Strengthening, 2014. Procurement and Supply Chain Strategic Plan for Medicines and Health Products 2013/14 - 2016/17.	Supply chain strategic plan exists
<b>Q5. Stock:</b> Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?	<input checked="" type="radio"/> A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time <input type="radio"/> B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time <ul style="list-style-type: none"> <li><input type="checkbox"/> Both public and (if they exist in the country) private storage facilities at central level</li> <li><input type="checkbox"/> Both public and (if they exist in the country) private storage facilities at intermediate level</li> </ul>	Q5 Score: 0	MOH, AJR 2014 NDSO monthly stock status report, December 2014 etc.	Test kits, ARVs stock outs. Need to strengthen procurement
	<input type="radio"/> A. No assessment has been conducted nor do they have a system to oversee the supply chain <input checked="" type="radio"/> B. Yes, an assessment was conducted but they received below 80%	Q6 Score: 1	SCMS/Global Fund, National Supply Chain Assessment Technical Report, 2013	Partners note major challenges with supply chain / stock outs and issues with coordination of procurement, delivery schedules, community consumption. SAPR results continue to note stock outs of test kits as a major barrier. Need

<p><b>Q6. Assessment:</b> Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment?</p> <p>(If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)</p>	<p><input type="radio"/> C. No assessment was conducted, but they have a system to oversee the supply chain that reviews:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Commodity requirements</li> <li><input type="checkbox"/> Commodity consumption</li> <li><input type="checkbox"/> Coordinates procurements</li> <li><input type="checkbox"/> Delivery schedules</li> </ul> <p><input type="radio"/> D. Yes, an assessment was conducted and they received a score that was 80% or higher</p>		<p>to strengthen contracts from gov't side (transparency, more vendors). Waivers are needed to procure from other vendors. This delays the processing of procurements for urgent HIV and AIDS commodities.</p>
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**Commodity Security and Supply Chain Score** **7**

7. Quality Management: Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.			
		Source of data	Notes/Comments
<p><b>Q1. Existence of System:</b> Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?</p>	<p><input type="radio"/> A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH</p> <p><input checked="" type="radio"/> Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Routinely reviews national HIV/AIDS performance and clinical outcome data</li> <li><input type="checkbox"/> Routinely reviews district/regional HIV/AIDS performance and clinical outcome data</li> <li><input type="checkbox"/> Prioritizes areas for improvement</li> </ul>	<p>Q1 Score: 1</p>	<p>QA Unit within MOH; assist w QI/QA project; USG has never seen a report on QI/QA; no QI QA report within MOH. QA/QI is largely partner driven. Limited leadership from QA unit at MOH for QI. There are standards in place for accreditation. However, none of those boxes can be ticked.</p>
<p><b>Q2. Strategy:</b> Is there a current (updated within the last 2 years) national QM/QI strategy that is either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?</p>	<p><input checked="" type="radio"/> No, there is no HIV/AIDS-related QM/Q strategy</p> <p><input type="radio"/> B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years)</p> <p><input type="radio"/> C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements</p> <p><input type="radio"/> D. Yes, there is a current HIV/AIDS program specific QM/QI strategy</p>	<p>Q2 Score: 0</p>	
<p><b>Q3. Guidelines:</b> Does national HIV/AIDS technical practice follow current WHO guidelines for PMTCT and ART?</p>	<p><input type="radio"/> A. No, the national practice does not follow current WHO guidelines for PMTCT or ART</p> <p><input checked="" type="radio"/> B. Yes, the national practice does follow current WHO guidelines for:</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> PMTCT (option B+)</li> <li><input checked="" type="checkbox"/> Adult ART</li> <li><input checked="" type="checkbox"/> Pediatric ART</li> <li><input checked="" type="checkbox"/> Adolescent ART</li> <li><input checked="" type="checkbox"/> Test and treat for specific populations</li> </ul>	<p>Q3 Score: 4</p>	<p>MOH, National PMTCT and ART Guidelines, 2014</p>

<p><b>Q4. QI Data use:</b> Does the host country government monitor and use data for HIV/AIDS quality improvement?</p>	<p><input checked="" type="radio"/> A. No, there is no monitoring for HIV/AIDS quality improvement</p> <p><input type="radio"/> B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> All sites</li> <li><input type="checkbox"/> Use of data to determine quality of program or services</li> <li><input type="checkbox"/> Making recommendations and action plan for mid-course corrections</li> </ul>	<p>Q4 Score: 0</p>		<p>QI systems led by Implementing Partners, No national system</p>
<p><b>Q5. Post-transition:</b> Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned from a direct implementation role?</p>	<p><input checked="" type="radio"/> A. No, there is no quality monitoring at sites post-transition</p> <p><input type="radio"/> B. Yes, there is quality monitoring at transition sites. Monitoring includes:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> All transition sites</li> <li><input type="checkbox"/> Review of service outcomes</li> <li><input type="checkbox"/> Client feedback on changes in quality</li> <li><input type="checkbox"/> Quality improvement action plan</li> </ul> <p><input type="radio"/> C. PEPFAR/other donors have never supported direct service delivery in the country</p>	<p>Q5 Score: 0</p>		<p>Not applicable. No transition has occurred. Other donors are still providing DSD and have not transitioned back to the gov't yet.</p>
<p><b>Quality Management Score</b></p>			<p><b>5</b></p>	

THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN

## Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and/or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

<b>8. Domestic Resource Mobilization: Resource Generation:</b> The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS.		<b>Source of data</b>	<b>Notes/Comments</b>
<b>Q1. Domestic budget:</b> Is there a budget line item for HIV/AIDS in the national budget?	<input type="radio"/> A. No, there is no budget line item for HIV/AIDS in the national budget <input checked="" type="radio"/> B. Yes, there is an HIV/AIDS budget line item under the Health budget <input type="radio"/> C. Yes, there is an HIV/AIDS program-based budget across ministries <input type="radio"/> D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators	Q1 Score: 3	MOF, Budget Statement 2014/2015
<b>Q2. Budgetary Framework:</b> Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program <input type="radio"/> C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program	Q2 Score: 3	As above
<b>Q3. Fiscal Policy:</b> Does the country pass the MCC scorecard indicator for fiscal policy? (Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)	<input checked="" type="radio"/> Yes <input type="radio"/> No	Q3 Score: 4	OGAC-provided data sheet (follows tab E)  derived from: <a href="http://www.mcc.gov/pages/election/scorecards">http://www.mcc.gov/pages/election/scorecards</a>
<b>Q4. Domestic public revenue:</b> What was annual domestic government revenue as a percent of GDP in the most recent year available? (domestic	Check the appropriate box for your country's income category: <u>FOR LOW INCOME</u> <input type="radio"/> A. More than 16.4% (i.e. surpasses category mean) <input type="radio"/> B. 14.8%-16.4%, (i.e. 90-100% of category mean) <input type="radio"/> C. Less than 14.8%, (less than 90% of category mean) <u>FOR LOW MIDDLE INCOME</u> <input checked="" type="radio"/> D. More than 22.3% (i.e. surpasses category mean)	Q4 Score: 4	OGAC-provided data sheet (follows tab E)  Original Source: IMF Government Finance Statistics

revenue excludes external grants)	<input type="radio"/> E. 20.1-22.3% (i.e. 90-100% of category mean) <input type="radio"/> F. Less than 20.1% (less than 90% of category mean) <b>FOR UPPER MIDDLE INCOME</b> <input type="radio"/> G. More than 27.8% (i.e. surpasses category mean) <input type="radio"/> H. 25.0%-27.8% (i.e. 90-100% of category mean) <input type="radio"/> I. Less than 25.0% (less than 90% of category mean)		
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<b>Score for Domestic Resource Mobilization: Resource Generation:</b>	<b>14</b>
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9. Domestic Resource Mobilization: Resource Commitments: Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.		Source of data	Notes/Comments
<b>Q1. Benchmarks for health spending:</b>  <b>African countries:</b> Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)?  <b>Non-African countries:</b> Is government health expenditure at least 3 percent of GDP?	<input type="radio"/> A. Yes  <input checked="" type="radio"/> B. No	Q1 Score: 0  OGAC-provided data sheet (follows tab E)  Original sources: WHO and World Bank	Lesotho = 14.5% Higher than Middle Lower Income country; \$194 per capita
<b>Q2. Domestic spending:</b> What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? _____ 28.5 _____%	<input type="radio"/> A. Less than 10% <input type="radio"/> B. 10-24% <input checked="" type="radio"/> C. 25-49% <input type="radio"/> D. 50-74% <input type="radio"/> E. 75% or Greater	Q2 Score: 5  MOH, Resource Mapping 2014	Calculation based upon actual GOL expenditure 2013/2014
<b>Q3. Key population spending:</b> What percent of key population-specific interventions are financed	<input checked="" type="radio"/> A. None or information is not available <input type="radio"/> B. 1-9% <input type="radio"/> C. 10-24%	Q3 Score: 0  MOH, Resource Mapping 2014	No budget line item for Key populations

with domestic public and domestic private sector funding (excluding out of pocket expenditure)?	<input type="radio"/> 25-49% <input type="radio"/> 50-74% <input type="radio"/> 75% or Greater			
<b>Score for Domestic Resource Mobilization: Resource Commitments:</b>			5	



10. <b>Allocative Efficiency:</b> The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).	Source of data	Notes/Comments		
<b>Q1. Data-driven allocation:</b> Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?	<input checked="" type="radio"/> A. No, data are not used annually  <input type="radio"/> B. Yes, data are used annually. Check all that apply: <input type="checkbox"/> Epidemiological data are used <input type="checkbox"/> Health/service delivery data are used <input type="checkbox"/> Financial data are used <input type="checkbox"/> There is integrated analysis across data streams <input type="checkbox"/> Multiple data streams are used to model scenarios	Q1 Score: 0  MOH, National Strategic Plan for HIV and AIDS 2012/13 to 2015/16, 2013  MOH, National Operational Plan for HIV and AIDS 2013/2014, 2014	MOH, National Strategic Plan for HIV and AIDS 2012/13 to 2015/16, 2013  MOH, National Operational Plan for HIV and AIDS 2013/2014, 2014	Although the MOH has the NSP and an Operational Plan; they don't routinely use financial and Epi data for decision making. Unable to identify a source to demonstrate use of financial data. Though Epi and health service delivery data exists it is not used to produce sub-national targets or district level PMTCT analysis.
<b>Q2. Geographic allocation:</b> Does the host country government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?	<input checked="" type="radio"/> A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites  <input type="radio"/> B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients  <input type="radio"/> C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients  <input type="radio"/> D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients  <input type="radio"/> E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients	Q2 Score: 0	In country government source, i.e., presentation, GIS data, planning document:	No government analysis of site level yield.

<p><b>Q3.Data driven reprogramming:</b> Do host country government policies/systems allow for reprogramming investments based on new or updated program data during the government funding cycle?</p>	<p><input type="radio"/> A. No, there is no system for funding cycle reprogramming</p> <p><input type="radio"/> B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used</p> <p><input checked="" type="radio"/> C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data</p> <p><input type="radio"/> D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data</p>	<p>Q3 Score: 2</p>	<p>MOH, National Strategic Plan for HIV and AIDS 2012/13 to 2015/16, 2013</p> <p>MOH, National Operational Plan for HIV and AIDS 2013/2014, 2014</p>	<p>The Government does have a national annual planning cycle but it's not transparent and the programming with partners doesn't show evidence of how financial data being used. The Government has a recurrent budget but they have a limited development budget.</p>
<p><b>Allocative Efficiency Score:</b></p>		<p>2</p>		

<p><b>11. Technical Efficiency:</b> Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.</p>		<p>Source of data</p>	<p>Notes/Comments</p>
<p><b>Q1. Unit costs:</b> Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services?</p> <p>(note: full score of five points can be achieved without checking all disaggregate boxes).</p>	<p><input checked="" type="radio"/> A. No</p> <p><input type="radio"/> B. Yes (check all that apply):</p> <p><input type="checkbox"/> Annually</p> <p><input type="checkbox"/> For HIV Testing</p> <p><input type="checkbox"/> For Care and Support</p> <p><input type="checkbox"/> For ART</p> <p><input type="checkbox"/> For PMTCT</p> <p><input type="checkbox"/> For VMMC</p> <p><input type="checkbox"/> For OVC Service Package</p> <p><input type="checkbox"/> For Key population Interventions</p>	<p>Q1 Score: 0</p>	<p>MOH, Resource Mapping, 2014</p> <p>MOH, Funding Gap Analysis for Global Fund Interim Application, 2013</p> <p>MOH, Funding Gap Analysis for Global Fund Concept Note, 2015</p> <p>Though the country is collecting resource mapping data; this provides expenditure by populations, geographic and program areas. The NSP and the Global Fund proposal used Unit costs but these were developed by external partners</p>
	<p>Check all that apply:</p> <p><input type="checkbox"/> Using findings from cost-effectiveness or efficiency studies to modify operations or interventions</p>	<p>Q2 Score: 0.5</p>	<p>MOH, NSP for HIV and AIDS 2012/13 to 2015/2016 mid-term review and revision, 2013</p> <p>Mainly because it has been stated in the Global Fund proposal narrative.</p>

<p><b>Q2. Improving efficiency:</b> Which of the following actions is the Host Country Government taking to improve technical efficiencies?</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Streamlining management to reduce overhead costs</li> <li><input type="checkbox"/> Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling</li> <li><input type="checkbox"/> Improving procurement competition</li> <li><input type="checkbox"/> Integration of HIV/AIDS into national or subnational insurance schemes (private or public)</li> <li><input type="checkbox"/> Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact</li> <li><input checked="" type="checkbox"/> Geographic targeting in high burden/high yield sites to increase impact</li> <li><input type="checkbox"/> Analysis of expenditure data to establish appropriate range of unit costs</li> </ul>			
<p><b>Q3. Loss ratio:</b> Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)?</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes</p>	<p>Q3 Score: 3</p>	<p>MOH, Resource Mapping, 2014</p>	
<p><b>Q4. Benchmark prices:</b> Are prices paid by the government for first-line ARVs and Test Kits within 5% variance of international benchmark prices (UNAIDS Investment Case)?</p>	<p>Check boxes that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> They are not paying for any ARVs</li> <li><input checked="" type="checkbox"/> They are not paying for any test kits</li> <li><input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for first line ARVs</li> <li><input type="checkbox"/> They are paying no more than 5% above the international benchmark price for test kits</li> </ul>	<p>Q4 Score: 2</p>	<p><a href="http://apps.who.int/hiv/amds/price/hdd/Default.aspx">http://apps.who.int/hiv/amds/price/hdd/Default.aspx</a></p>	<p>No data available at the moment</p>
<p><b>Q5. ART unit costs:</b> Have average unit costs for providing ART in the country reduced within the last two years?</p> <p>Unit cost 2 years ago: \$ _____</p> <p>Current unit cost: \$ _____</p>	<p><input checked="" type="radio"/> A. No</p> <p><input type="radio"/> B. Yes</p>		<p><a href="#">WHO, Global Price Reporting Mechanism - http://apps.who.int/hiv/amds/price/hdd/</a></p>	<p>The answer is 'No' because the Government doesn't produce ART unit cost data.</p>
<p><b>Technical Efficiency Score:</b></p>			<p>5.5</p>	

**THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN**

## Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

**12. Public Access to Information:** Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.

			Source of data	Notes/Comments
<p><b>Q1. OBI:</b> What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)</p>	<p><input type="radio"/> A. Extensive Information (OBI Score 81-100; or PEFA score of A- or better on element PI-10)</p> <p><input type="radio"/> B. Significant Information (OBI Scores 61-80; or PEFA score of B or B+ on element PI-10)</p> <p><input type="radio"/> C. Some Information (OBI Score 41-60; or PEFA score of B-, C or C+ on element PI-10)</p> <p><input type="radio"/> D. Minimal Information (OBI Score 21-40; or PEFA score of C- or D+ on element PI-10)</p> <p><input checked="" type="radio"/> E. Scant or No Information (OBI Score 0-20; or PEFA score of D or below on element PI-10)</p> <p><input type="radio"/> F. There is neither Open Budget Index score nor a PEFA assessment to assess the transparency of government budget</p>	<p>Q1 Score: 1.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Open Budget Index (<a href="http://survey.internationalbudget.org/">http://survey.internationalbudget.org/</a>) and PEFA data (<a href="http://www.pefa.org">www.pefa.org</a>)</p>	
<p><b>Q2. National program report transparency:</b> Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?</p>	<p><input checked="" type="radio"/> A. No, the national HIV/AIDS program progress report or presentation of results is not made public</p> <p><input type="radio"/> B. Yes, the national HIV/AIDS program progress report and/or results are made publically available (Check all that apply):</p> <p><input type="checkbox"/> On Website</p> <p><input type="checkbox"/> Through any type of media</p> <p><input type="checkbox"/> Disseminate print report or presentation of results</p>	<p>Q2 Score: 0.0</p>	<p>In country source, i.e., last annual national HIV/AIDS progress report or presentation:</p>	<p>Last report was a long time ago. Reportedly currently working on 2013 report. MOH REPORTS ON HIV/AIDS PROGRAM ANNUALLY BUT IT IS INTEGRATED WITHIN THE LARGER HEALTH SECTOR REPORT</p>
<p><b>Q3. Audit transparency:</b> Does the host country government make an annual national HIV/AIDS program audit report publically available?</p>	<p><input checked="" type="radio"/> A. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically</p> <p><input type="radio"/> B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply:</p> <p><input type="checkbox"/> On website</p> <p><input type="checkbox"/> Through any type of media</p> <p><input type="checkbox"/> Disseminate print report</p>	<p>Q3 Score: 0.0</p>	<p>In country source, i.e., last HIV/AIDS audit report:</p>	<p>NO OFFICIAL AUDIT HAS BEEN DONE SO FAR</p>

**Public Access to Information Score: 1**

13. Oversight and Stewardship: Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.				Source of data	Notes/Comments
<p><b>Q1. Availability of Information on Resources Received by Service Delivery Units.</b> PEFA score on PI-23 was C or higher in most recent assessment.</p>	<p><input type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input checked="" type="radio"/> B. PEFA was conducted and score was below C</p> <p><input type="radio"/> C. PEFA was conducted and score was C</p> <p><input type="radio"/> D. PEFA was conducted and score was B</p> <p><input type="radio"/> E. PEFA was conducted and score was A</p>	<p>Q1 Score: 0.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p>	<p>NO NACS RESPONSIBLE FOR STEWARDSHIP AND ACCOUNTABILITY. MOH ALLOCATES ONLY 2% BUT NOT DISAGGREGATED BY DELIVERY UNITS. Score was a D.</p>	
<p><b>Q2. Quality and timeliness of annual financial statements.</b> PEFA score for element PI-25 was C or higher in most recent assessment.</p> <p>Actual scores are ____</p>	<p>Check A or B; if B checked, select appropriate disaggregates:</p> <p><input checked="" type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input type="radio"/> B. PEFA was conducted and score was C or higher for:</p> <p><input type="checkbox"/> (i) Completeness of the financial statements</p> <p><input type="checkbox"/> (ii) Timeliness of submission of the financial statements</p> <p><input type="checkbox"/> (iii) Accounting standards used</p>	<p>Q2 Score: 0.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p>	<p>Scores were D for each disaggregate in the 2012 assessment.</p>	
<p><b>Q3. Government Channels and Opportunities for Civil Society Engagement:</b> Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?</p>	<p>Check A, B, or C; if C checked, select appropriate disaggregates:</p> <p><input type="radio"/> A. No, there are no formal channels or opportunities</p> <p><input type="radio"/> B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback</p> <p><input checked="" type="radio"/> C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply:</p> <p><input checked="" type="checkbox"/> During strategic and annual planning</p> <p><input checked="" type="checkbox"/> In joint annual program reviews</p> <p><input checked="" type="checkbox"/> For policy development</p> <p><input checked="" type="checkbox"/> As members of technical working groups</p>	<p>Q3 Score: 5.5</p>	<p>As above and Lesotho Concept Note submission April 15, 2015</p>	<p>Mid term review-- CSO was heavily involved. There is report from the mid term review and a participant list</p>	

	<input checked="" type="checkbox"/> Involvement on evaluation teams <input type="checkbox"/> Giving feedback through social media <input checked="" type="checkbox"/> Involvement in surveys/studies <input checked="" type="checkbox"/> Collecting and reporting on client feedback			
<p><b>Q4. Civil society Enabling Environment:</b> What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society?</p> <p>If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?</p>	<input type="radio"/> A. EEI score of 0-0.38; or if no EEI score, there are laws or policies that restrict civil society playing an oversight role <input type="radio"/> B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government <input checked="" type="radio"/> C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight	<p>Q4 Score: 4.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Civicus Enabling Environment Index (<a href="http://civicus.org/eei/">civicus.org/eei/</a>)</p> <p><a href="#">UNDP, Legal and Environmental Assessment, (draft) 2015</a></p>	<p>There are no CSO laws preventing them from playing their oversight role, they are accepted by government but their active involvement is limited due to capacity issues. Capacity building of the umbrella CSO bodies (the NGOs) to be able to engage actively with government.</p>
<b>Oversight and Stewardship Score:</b>		<b>9.5</b>		

THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN

## Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

**14. Policies, Laws, and Regulations:** Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.

**Source of data**

**Notes/Comments**

**Q1. Structural obstacles:** Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?

- A. No, there are no such laws or policies
- B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score):
- Criminalization of HIV transmission
  - HIV testing disclosure policies or age requirements
  - Non-disclosure of HIV status laws
  - Anti-homosexuality laws
  - Anti-prostitution legislation
  - Laws that criminalize drug use, methadone use or needle exchange

Q1 Score: 1.0

HTC policy;

This Information is found in the HTC policy and guidelines. Lack of SOPs for standardised care, no regulatory mechanisms. Anti-homosexuality laws exist, but are not enforced). Laws that criminalize drug use exist.

**Q2. Access protection:** Is there a National HIV/AIDS Policy or set of policies and laws that creates a legal and policy environment that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated?

(note: full score of six points possible without checking all boxes)

- A. No, there are no such policies or laws
- B. Yes, there are such policies and laws. Check all that apply:
- For people living with HIV
  - For men who have sex with men
  - For transgendered persons
  - For sex workers
  - For people who inject drugs
  - For children orphaned or affected by HIV/AIDS

Q2 Score: 3.0

GOL, National HIV Policy, (2006)

The National HIV/AIDS Policy is dated 2006. Not specific on injection of drugs - generalised. Lack of legislation on Domestic Violence.

	<input checked="" type="checkbox"/> For young girls and women vulnerable to HIV <input type="checkbox"/> For survivors of gender-based violence			
<b>Q3. Civil society sustainability:</b> Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages?	<input type="radio"/> A. No, there are no special provisions or advantages for CSOs <input checked="" type="radio"/> B. Yes, there are special provisions and advantages for CSOs. Check all that apply: <input type="checkbox"/> Significant tax deductions for business or individual contributions to not-for-profit CSOs <input checked="" type="checkbox"/> Significant tax exemptions for not-for-profit CSOs <input checked="" type="checkbox"/> Open competition among CSOs to provide government-funded services <input type="checkbox"/> Freedom for CSOs to advocate for policy, legal and programmatic change	Q3 Score: 2.0	Government of Lesotho Value Added Tax (VAT) Act of 2001	Tax exemption exists for CSOs registered as trusts and not as Private Voluntary Organizations (PVOs). Tax exemptions for CSOs are on a case by case basis to reclaim tax paid rather than having an exemption upfront.
<b>Q4. Enabling legislation:</b> Are there policies or legislation that govern HIV/AIDS service delivery?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, there are. Check all below that are included: <input type="checkbox"/> A national public health services act that includes the control of HIV <input type="checkbox"/> A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services	Q4 Score: 2.0	Public Health Act	The Public Health act should be referenced here. Its neither enabling or disabling, rather neutral.
<b>Policies, Laws, and Regulations Score:</b>		<b>8</b>		
<b>15. Planning and Coordination:</b> Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated.			<b>Source of data</b>	<b>Notes/Comments</b>
<b>Q1. National Strategy:</b> Does the country have a	<input type="radio"/> A. No, there is no national strategy for HIV/AIDS <input checked="" type="radio"/> B. Yes, there is a national strategy. Check all that apply: <input checked="" type="checkbox"/> It is multiyear	Q1 Score: 4.0	MOH, NSP for HIV and AIDS 2012/13 to 2015/16	

<p>multi-year, costed national strategy to respond to HIV?</p>	<p><input checked="" type="checkbox"/> It is costed</p> <p><input checked="" type="checkbox"/> Its development was led by the host country government</p> <p><input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy</p>			
<p><b>Q2. Data driven prioritization:</b> Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?</p>	<p><input type="radio"/> A. No data-driven prioritization approach was used</p> <p><input type="radio"/> B. Yes, a data-driven prioritization approach was used but it did not</p> <p><input checked="" type="radio"/> C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources</p>	<p>Q2 Score: 4</p>	<p>L. Lawson, Ending AIDS in Lesotho: The Investment Case, UNAIDS, 2014</p>	
<p><b>Q3. CCM criteria:</b> Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?</p>	<p><input type="radio"/> A. No or there is no CCM</p> <p><input type="radio"/> B. Yes, with conditions</p> <p><input checked="" type="radio"/> C. Yes</p>	<p>Q3 Score: 2</p>	<p>Global Fund Eligibility List 2014</p>	
<p><b>Q4. Coordination of national response:</b> Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?</p>	<p><input checked="" type="radio"/> A. No, it does not track or map all HIV/AIDS activities</p> <p><input type="radio"/> B. the host country government coordinates all HIV/AIDS activities. Check all that apply:</p> <p><input type="checkbox"/> Of Civil Society Organizations</p> <p><input type="checkbox"/> Of private sector</p> <p><input type="checkbox"/> Of donor implementing partners</p> <p><input type="checkbox"/> Activities are tracked or mapped</p> <p><input type="checkbox"/> Duplications and gaps are addressed</p> <p><input type="checkbox"/> Joint operational plans are developed that include key activities of all implementing agencies</p>	<p>Q4 Score: 0.0</p>		<p>No National AIDS Commission to do multisectorial coordination. Cabinet has commenced the set up of the Lesotho HIV and AIDS Authority (LeHA) to replace the defunct NAC but not operational yet</p>
	<p><input type="radio"/> A. No</p>	<p>Q5 Score: 3.0</p>	<p>Lesotho Concept Note submission April</p>	<p>Some advocacy exists, but not strong. Service delivery exists</p>

<p><b>Q5. Civil society engagement:</b> Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response?</p>	<p>B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders and/or networks representing affected populations) are actively engaged. Check all that apply:</p> <p><input type="checkbox"/> In advocacy</p> <p><input checked="" type="checkbox"/> In programmatic decision-making</p> <p><input checked="" type="checkbox"/> In technical decision-making</p> <p><input checked="" type="checkbox"/> In service delivery</p>		15, 2015	
<p><b>Planning and Coordination Score:</b></p>			13	

**THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN**