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INFORMATION MEMO FOR AMBASSADOR MARIA BREWER, LESOTHO

FROM: S/GAC – Acting U.S. Global AIDS Coordinator, Principal Deputy Assistant Secretary, Dr. Angeli Achrekar, DrPH, MPH

**THROUGH: Michael Ruffner, Chair
Matt Wollmers, PEPFAR Program Manager**

SUBJECT: Fiscal Year (FY) 2023 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Brewer,

First and foremost, I sincerely hope that you and your team are safe and healthy. I am pleased with your recent appointment as Ambassador to Lesotho and look forward to working with you at this important point in the program. I am also extremely grateful for the work of the PEPFAR program and additional COVID-19 response efforts during this difficult year.

While countries around the world continue to manage the effects of the COVID-19 pandemic, and the U.S. government acts on its commitment of support, it is encouraging to see vaccines making their way around the globe. The COVID response efforts – and continued use of the PEPFAR platform to support testing and vaccine delivery and uptake at point of care settings - are essential to our ability to provide ongoing care and lifesaving support for people living with HIV. PEPFAR has faced many challenges as a program during this period. Nevertheless, the PEPFAR family and our partners have carried the mission forward, even while enduring significant personal impacts from COVID-19. Despite these challenges, what remains true is the strength and resilience of PEPFAR in partnership with countries and communities – through our teams and our programs in the midst of dual pandemics.

Tremendous efforts have been made by PEPFAR over the past year to protect and accelerate gains against HIV while leveraging the platform to respond to COVID-19 as well.

PEPFAR Country/Regional Operational Plan (COP/ROP) 2022 (for implementation in FY2023) represents a pivotal year for PEPFAR, as several countries are reaching or approaching the agreed upon UNAIDS 95/95/95 benchmarks for attaining epidemic control. As countries approach these benchmarks, while pivoting from “scaling to close gaps” to “sustaining” epidemic control, we must ensure HIV program and population equity, address outstanding barriers that threaten to derail progress made in reducing new HIV infections and associated mortality, and tailor our programs to serve all populations.

This year it is particularly important to plan COP/ROP22 together with country governments, civil society, and multilateral partners. Across PEPFAR, the focus on equity requires vigilant attention to program data demonstrating results and gaps. A focus on equity also means a focus on population groups

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where our efforts to date have not closed gaps, and specific planning, resource allocation, and program tailoring are needed – depending on what the data reveal for each country – with a particular focus on children, adolescent girls and young women, and key populations.

While implementation continues, or in many cases, has started to scale up, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach COP/ROP 22 planning and implementation:

1. Achieve and sustain epidemic control using evidence-based, equitable, people-centered HIV prevention and treatment services.
2. Support resilient and capacitated country health systems, communities, enabling environments, and local partners to build enduring capabilities.
3. Strengthen cooperation and coordination for greater impact, burden sharing, and sustainability.
4. Employ an equity lens with a focus on reducing persistent inequalities experienced by children, key populations, and adolescent girls and young women.

I want to applaud the PEPFAR team for:

- Achieving 97% viral suppression of clients on treatment. This is a remarkable feat and testament to the work that the PEPFAR team and the Government of Lesotho have achieved together
- Rolling out multi month dispensing, including a large number of clients on 6-month ARV supplies.
- Impressive gains in serving adolescent girls and young women through the DREAMS program despite the ongoing COVID pandemic.

Together with the Government of Lesotho and civil society leadership we have made tremendous progress in the HIV response. Lesotho should be proud of the many gains made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing and deep coordination with the Global Fund and UNAIDS. Lesotho has been especially successful and is one of a number of countries to have achieved the UNAIDS 90-90-90 goals and effective control of the HIV epidemic, and I want to further congratulate the Government of Lesotho for its forthright leadership in developing sustainability plans despite the setbacks programmatically and economically that have come with COVID-19. We must continue to work to sustain the HIV impact and begin the long-term, gradual transformation of the program including the merging, management, and oversight of HIV services in more intentional alignment and integration with domestic systems. COP 22 will represent a critical step in this journey.

Despite the achievement of the UNAIDS high level goals, I want to emphasize that our work is not done. In COP 22 guidance, changes in program direction will vary depending on where countries are in reaching epidemic control and the continued COVID-19 mitigations efforts each program is facing.

Specifically, more focus and attention should be given to the following key challenges in Lesotho:

- Addressing the net loss in patients during the execution of the COP 20 program.
- Given the few positive HIV patients who are expected to be found, each new positive should be treated as a program-level event that triggers a review of sexual networks and contact tracing. Safe and ethical index testing must be performed at the appropriate scale and with fidelity.
- Recency testing must be fully rolled out with urgency.
- Reviewing existing programs for efficiencies and reinvesting savings into new challenges, including systems gaps and capability needs of the Government of Lesotho.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP 2022 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from years past, PEPFAR teams will once again be responsible for setting their own targets across PEPFAR program areas (with the treatment current target no less than the result that was to be achieved in COP 2021) in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's alone, but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals.

The PEPFAR COP 2022 notional budget for Lesotho is **\$75,000,000**, inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Lesotho and civil society of Lesotho, believes is critical for the country's progress towards controlling the epidemic and maintaining control.

Finally, in alignment with efforts by the U.S. government to support diversity, equity, inclusion, and accessibility as well as to advance equity for underserved communities and prevent and combat discrimination or exploitation on the basis of race, religion, gender identity or sexual orientation, PEPFAR will work to ensure that these principles are upheld, promoted, and advanced in all PEPFAR programs and in how we do business.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will review this planning letter and the details contained herein with your wider PEPFAR country team. Stakeholder engagement is essential for a productive and impactful planning process, and civil society engagement will continue to be an integral part of this planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society as we continue to finalize our approach to hosting a virtual COP/ROP 2022 planning and approval process.

Once again, thank you for your continued leadership and engagement during the COP/ROP 2022 process.

Sincerely,

Angeli Achrekar

Attachment: **COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction Summary**

CC: S/GAC – **Michael Ruffner, Matt Wollmers, Andy Pelletier**

Overview: COP 2022 PEPFAR Planned Allocation and Strategic Direction

With input from the field team through the quarterly monitoring POARTs, as well as Headquarters Country Accountability and Support Team (CAST) input, a thorough program review of your country program over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2020 and current COP 2021 implementation as we plan for COP 2022. We have noted the following key successes and challenges:

Successes:

1. Successful reinvigoration of the DREAMS program, including impressive increases in PrEP uptake.
2. Rapid scale up of HIV self-testing and strong linkage to care.
3. Full roll out of electronic registries, most with the pharmacy modules and linked to the Health Information Exchange (HIE).

Challenges:

1. The PEPFAR Lesotho program was one of the only PEPFAR OUs that experienced a net loss of patients during FY 2021. Best practices and innovative solutions across the clinical cascade should be closely adhered to. For the remainder of COP 2021 and in COP 2022, IPs must improve the use of HIEs to better track patients and the team should undertake a review of current practices to optimize the use of available data.
2. The identification of new positives has only kept pace with modeled new infections. Given the achievement of epidemic control, the team should develop a new case finding strategy that centers around the children, contacts, and sexual networks of new positives. Recency testing is an important tool that is missing in this effort.
3. Focusing prevention efforts in the COVID-19 pandemic era as needed has been understandably difficult, but the team should emphasize achieving saturation of VMMC in appropriate age groups, reinvigorating treatment as prevention in key population groups, tailoring basic prevention activities to KPs at highest risk of infection, and integrating FCI initiatives, where appropriate, into base programming.

Given Lesotho's status of having achieved epidemic control, the following priority strategic and integrated changes are recommended:

1. Rightsizing non-service delivery activities. Now that PEPFAR Lesotho's focus is shifting to sustaining impact, in partnership with the Government of Lesotho, the team must prioritize right-sizing non-service delivery. According to expenditure reporting data, for every dollar spent at a site, PEPFAR Lesotho spends up to a dollar and a half in non-service delivery activities. The team should review non-service delivery spending to identify duplicative activities that can be consolidated or centralized. Staff and material spending at site should be reviewed but generally maintained at current levels.
2. Working closely with the Government of Lesotho to identify and address their needs as we begin the gradual, long- term transformation of the PEPFAR program, which will be rooted in integration into domestic systems and funding.

3. Recognizing the programmatic and financial challenges that the Government of Lesotho will face in the next few years, develop a long-term sustainability strategy that is detailed, specific and flexible to account for unforeseen challenges.

SECTION 1: COP 2022 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year (EOFY) 2021 tool, and performance data, the total COP 2022 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

TABLE 1: All COP 2022 Funding by Appropriation Year

	Bilateral				Central				Total
	FY22	FY21	FY20	Unspecified	FY22	FY21	FY20	Unspecified	
Total New Funding	\$ 67,107,311	\$ -	\$ -	\$ -	\$ 1,601,000	\$ -	\$ -	\$ -	\$ 68,708,311
GHP-State	\$ 66,594,811	\$ -	\$ -	\$ -	\$ 1,401,000	\$ -	\$ -	\$ -	\$ 67,995,811
GHP-USAID	\$ -	\$ -	\$ -	\$ -	\$ 200,000	\$ -	\$ -	\$ -	\$ 200,000
GAP	\$ 512,500	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 512,500
Total Applied Pipeline	\$ -	\$ -	\$ -	\$ 6,291,689	\$ -	\$ -	\$ -	\$ -	\$ 6,291,689
DOD				\$ 284,763				\$ -	\$ 284,763
HHS/CDC				\$ 3,456,452				\$ -	\$ 3,456,452
PC				\$ 831,588				\$ -	\$ 831,588
USAID				\$ 1,452,347				\$ -	\$ 1,452,347
State/AF				\$ 266,539				\$ -	\$ 266,539
TOTAL FUNDING	\$ 67,107,311	\$ -	\$ -	\$ 6,291,689	\$ 1,601,000	\$ -	\$ -	\$ -	\$ 75,000,000

SECTION 2: COP 2022 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

PEPFAR Lesotho should plan for the full Care and Treatment (C&T) level of \$30,505,900 and the full Orphans and Vulnerable Children (OVC) level of \$14,045,400 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2022 Earmarks by Appropriation Year*

	Appropriation Year			
	FY22	FY21	FY20	TOTAL
C&T	\$ 30,505,900	\$ -	\$ -	\$ 30,505,900
OVC	\$ 14,045,400	\$ -	\$ -	\$ 14,045,400
GBV	\$ 215,600	\$ -	\$ -	\$ 215,600
Water	\$ 630,000	\$ -	\$ -	\$ 630,000

*Only GHP-State and GHP-USAID will count towards the earmarks (Care and Treatment, OVC, GBV, and Water).

**Only GHP-State will count towards the GBV and Water earmarks

TABLE 3: COP 2022 Initiative Controls: Each dollar planned in COP can belong to only one initiative. Most COP funding will be budgeted as Core Program. In general, initiatives other than Core Program are used to track activities/programs that cannot be tracked by the combination of program area and beneficiary alone. See Appendix 1 for more detailed information on initiatives.

	Bilateral	Central	TOTAL
Total Funding	\$ 73,399,000	\$ 1,601,000	\$ 75,000,000
Core Program	\$ 52,147,853	\$ -	\$ 52,147,853
Cervical Cancer	\$ 1,000,000	\$ -	\$ 1,000,000
Condoms (GHP-USAID Central Funding)	\$ -	\$ 200,000	\$ 200,000
DREAMS	\$ 14,000,000	\$ -	\$ 14,000,000
OVC (Non-DREAMS)	\$ 4,255,947	\$ -	\$ 4,255,947
USAID Southern Africa Regional Platform	\$ -	\$ 1,401,000	\$ 1,401,000
VMMC	\$ 1,995,200	\$ -	\$ 1,995,200

TABLE 4: Programmatic Controls: Programmatic controls are used to oversee directives that can be tracked by a combination of program area and/or beneficiary. Programmatic controls may overlap with Initiatives, for example PrEP for Adolescent Girls and Young Women may count towards both the DREAMS Initiative and the PrEP (AGYW) programmatic control. See Appendix 1 for more detailed information on programmatic controls.

	Bilateral	Central	TOTAL
Total Funding	\$ 918,800	\$ -	\$ 918,800
PrEP (AGYW)	\$ 856,300	\$ -	\$ 856,300
PrEP (KPs)	\$ 62,500	\$ -	\$ 62,500

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	\$ 171,143

See Appendix 1 for detailed budgetary requirements and other budgetary considerations.

SECTION 3: PAST PERFORMANCE – COP/ROP 2020 Review

TABLE 6. COP OU Level FY 21 Program Results (COP 20) against FY22 Targets (COP 21)

Indicator	FY 2021 result (COP 2020)	FY 2022 target (COP 2021)
TX Current <15	6,164	7,952
TX Current >15	226,018	247,652
VMMC >15	11,345	20,219
DREAMS (AGYW PREV)	114,981	58,178
Cervical Cancer Screening	33,080	50,888
TB Preventive Therapy	12,317	31,367

TABLE 7. COP 2020 | FY 2021 Agency-Level Outlays versus Approved Budget

Lesotho/Agency	Sum of Approved COP 2020 Planning Level	Sum of Total FY 2021 Outlays	Sum of Over/Under Outlays
DOD	\$945,000	\$555,888	\$389,112
HHS/CDC	\$36,750,832	\$33,911,247	\$2,839,585
PC	\$976,618	\$139,657	\$836,961
State	\$737,216	\$477,137	\$260,079
USAID	\$44,215,139	\$38,804,307	\$5,410,832
USAID/WCF	\$3,054,620	\$2,847,190	\$207,430
Grand Total	\$86,679,425	\$76,735,426	\$9,943,999

TABLE 8. COP 2020 | FY 2021 Results & Expenditures

Agency	Indicator	FY21 Target	FY21 Result	% Achievement	Program Classification	FY21 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	64,395	65,114	101%	HTS	\$4,528,939	93%
	HTS_TST_POS	6,273	4,359	70%			
	TX_NEW	6,084	5,248	86%	C&T	\$12,250,542	84%
	TX_CURR	115,342	84,819	74%			
DOD	HTS_TST	591	1,023	173%	HTS	\$100,887	100%
	HTS_TST_POS	83	112	135%			
	TX_NEW	81	82	101%	C&T	\$308,028	57%
	TX_CURR	1,565	1,530	98%			
	VMMC_CIRC	207	248	120%	PREV/VMMC	\$23,501	100%
USAID	HTS_TST	114,756	140,348	122%	HTS	\$3,230,244	54%
	HTS_TST_POS	10,773	9,288	86%			
	TX_NEW	10,332	10,023	97%	C&T	\$10,274,779	70%
	TX_CURR	196,121	145,833	74%			
	VMMC_CIRC	18,681	11,097	59%	PREV/VMMC	\$2,256,142	95%
	OVC_SERV	90,061	120,558	134%	OVC	\$4,853,477	98%
	Above Site Programs						\$5,938,379
Program Management						\$12,150,449	

SECTION 4: COP 2022 DIRECTIVES

The following section has specific directives for COP 2022 based on program performance noted above. Please review each section carefully including the minimum program requirements.

Minimum Program Requirements (MPR)

All PEPFAR programs – bilateral and regional– must ensure the following minimum program requirements are in place. Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g. facility, school, community). Evidence demonstrates that lack of any one of these policies/practices significantly undermines HIV impact and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all of the requirements below, and the COP 2022 planning meetings will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP 2022 planning meetings, the PEPFAR Lesotho team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY 2023. The list will be included in the Strategic Direction Summary (SDS) as well.

Failure to meet any of these requirements by the beginning of FY 2023 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table below.

TABLE 9. COP 2022 (FY 2023) Minimum Program Requirements

Care and Treatment	
1.	Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups. <u>Status:</u> Completed
2.	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥ 30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥ 4 weeks of age and weigh ≥ 3 kg, and removal of all NVP- and EFV-based ART regimens. <u>Status:</u> In-process (target date: first half of 2022) <u>Issues or Barriers:</u> TLD for those ≥ 30 kg is complete as is removal of NVP and EFV-based regimens. DTG for young children is pending procurement of commodities.
3.	Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups. <u>Status:</u> Completed
4.	All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. <u>Status:</u> Completed
5.	Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks. <u>Status:</u> In-process (target date: end of 2022) <u>Issues or Barriers:</u> POC and DBS VL testing are still being scaled up; some facilities still experience

<p>prolonged turnaround times due to factors such as vendor response time, commodity availability, and connectivity issues.</p>
<p>Case Finding</p>
<p>6. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV. <u>Status:</u> Completed</p>
<p>Prevention and OVC</p>
<p>7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) <u>Status:</u> In-process (target date: end of 2022) <u>Issues or Barriers:</u> Policies and programs are in place, but PrEP coverage of eligible population remains sub-optimal.</p>
<p>8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. <u>Status:</u> Completed</p>
<p>Policy & Public Health Systems Support</p>
<p>9. In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups. <u>Status:</u> In-process (TBD) <u>Issues or Barriers:</u> New legislation is needed to fully implement this requirement. Gender inequities and gender-based violence persist as structural barriers to improving HIV prevention and treatment outcomes.</p>
<p>10. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention. <u>Status:</u> Completed</p>
<p>11. OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy. <u>Status:</u> In-process (target date: end of 2022) <u>Issues or Barriers:</u> Infection prevention and control for respiratory diseases (both COVID and TB) remains</p>

<p>problematic. Capacity building is needed for facility staff on dual COVID/TB protocols. Compliance monitoring needs to be institutionalized at the DHMT level. There is a lack of IPC commodities and supplies.</p>
<p>12. Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other partner country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention. <u>Status:</u> In-process (target date: end of 2022) <u>Issues or Barriers:</u> U=U messaging efforts are ongoing, but have not been brought to scale. There is a need for capacity building of facility and community providers on the new national ART guidelines, provision of IEC materials and job aides, and monitoring of service provision.</p>
<p>13. Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses. <u>Status:</u> In-process (TBD) <u>Issues or Barriers:</u> The number of local partners able to manage USG agreements remains limited. Some progress has been made as funding levels to local partners continue increasing year by year; this is inclusive of funding to KP-led organizations. Alternative approaches are being explored (e.g., in-country leadership of international partners by Lesotho citizens and implementation of capacity development programs meant to strengthen local partners).</p>
<p>14. Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended. <u>Status:</u> In-process (TBD) <u>Issues or Barriers:</u> The Government of Lesotho remains highly dependent on donor support for the national HIV program, mainly from PEPFAR and The Global Fund.</p>
<p>15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. <u>Status:</u> In-process (target date: end of 2022) <u>Issues or Barriers:</u> Improvement is dependent on further roll-out of eRegisters in all sites.</p>
<p>16. Scale-up of case surveillance and unique identifiers for patients across all sites. <u>Status:</u> In-process (target date: end of 2022) <u>Issues or Barriers:</u> Case-based surveillance is dependent on the patient unique identifier. The roll out of the unique identifier in the eRegisters system continues and is likely to be completed by 2023.</p>

In addition to meeting the MPRs outlined above, it is expected that PEPFAR Lesotho will consider all of the following technical directives and priorities. A full list of COP/ROP 2022 Technical Priorities and Considerations are listed in COP guidance and can be referenced in Section 6.

Table 10. COP 2022 (FY 2023) Technical Directives

PEPFAR Lesotho-Specific Directives
HIV Clinical Services
<p>1. The team should work with IPs to better understand Lesotho’s cohort of PLHIV on treatment and what PLHIV are actually LTFU, how many are truly new positives, etc. While IPs may conduct routine root cause analyses to identify and address issues at the site level, the use of HIE in tracking clients should be reassessed by the team (i.e., how is it being used? What still needs to be improved? How are IPs using the system to track clients?) and improved as soon as possible—rather than waiting until unique identifiers are fully incorporated into the eRegisters system.</p>
<p>2. Case finding practices can still be further improved, especially around index testing with fidelity and at the appropriate scale. The expansion in self-testing during COP 20 is commended, but Lesotho should further integrate testing approaches like HIV self-testing and social network strategies (SNS) with index and other testing modalities to increase access and improve overall case-finding performance.</p>
<p>3. The team should work with IPs to improve retention in care among newly initiated CLHIV aged 1-9 years, which have very high IIT <3 months compared to other pediatric age groups and adults. This age group has consistently higher IIT compared to RTT, particularly among girls who had 32% IIT <3 months in the last quarter. Methods to reduce attrition could include rapid linkage to HCWs for psychosocial support and psychosocial support groups, universal follow-up after ART initiation, universal enhanced adherence counseling, peer buddy systems, and other methods to improve counseling with parents/caregivers including HIV-negative caregivers.</p>
<p>4. There is low TPT initiation among patients new on ART in seven of Lesotho’s districts. Therefore, the team should assess TPT activities in these districts and identify and rapidly address barriers, such as supply chain issues related to the COVID pandemic.</p> <p>Despite excellent TB screening coverage, there is a very low reported rate (1.1% positive for TB symptoms of screenings conducted) of TB symptoms among patients already on ART. In order to improve TB case finding among these patients, teams should work with IPs to ensure there are integrated CXR and/or molecular WHO-recommended rapid diagnostic (wRMD) tests to complement TB symptom screening; and review their screening processes and documentation of TB screening activities. Additional diagnostics such as TB LAM should also be more fully utilized.</p>
<p>5. The team should continue to build on its VL/EID successes by continuing POC VL implementation and roll-out for pediatric populations; improving use of the LIS system linking electronic data reporting between health care facilities and the lab with electronic reporting to MOH; and strengthening HR and infrastructure capacity for VL and EID. This is another programmatic area that will benefit from the full implementation of the e-register, after which data systems should be made fully interoperable.</p>
<p>6. Implementation of monthly monitoring of final PMTCT status, documented in the register by implementing partners, should be supported to identify infants eligible for a final status within the month, how many have a documented status, and track eligible infants without a documented status. Cases where eligible infants without documented status have been identified should be quickly reviewed and have a status documented by the end of the quarterly reporting period.</p>

HIV Prevention Services

1. In COP 2022, PrEP should continue to be scaled up with a focus on ensuring programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to the OU's epidemic context with a focus on Key Populations (including sex workers, men who have sex with men, transgender people, people in prisons and other closed settings, people who inject drugs), adolescent girls and young women including pregnant and breastfeeding AGYW, and other identified higher-incidence populations.

More specifically, PEPFAR Lesotho should continue PrEP scale-up by integrating PrEP at all facility and community access points (HTS and STI, primary care, ANC, FP, men's clinics, DICs) and linking PrEP initiation with HTS/HIVST for those testing negative at all entry points. The team and IPs should also focus on decentralized models of PrEP service delivery, including community models of initiation and monitoring, and improve PrEP access through MMD and DD service options.

2. The team should update their DREAMS saturation analysis with FY 21 results and finalize the maintenance plan for SNU's reaching either phased or full saturation. Based in part on this information, the team should also assess DREAMS funding needs for COP 22.

The team and partners should continue to prioritize the delivery of high-quality and innovative economic strengthening services to include creating pathways to meaningful wage employment and entrepreneurship opportunities as well as exploring opportunities to engage the private sector. There are demonstrated unmet needs among the AGYW being served, including the need for skills-based training. In order to support the pending government MHPSS strategy, the team and IP should review the MHPSS orientation previously provided.

3. Cervical cancer partners should work to increase the treatment rate of women who screened positive. Since one key challenge is clinical staff not being effectively or sufficiently trained in a mostly virtual environment to perform thermocoagulation, extra effort should be made to ensure that health care providers are well trained and confident in performing this procedure. There has also been a challenge with closing the communication loop for LEEP referrals where the referring facility is not aware if a woman received treatment. Therefore, the team should work with partners to improve bi-directional communication between referring and receiving facilities for LEEP to ensure treatment at the receiving facility is documented at the referring facility. Since cervical cancer screening target achievement for FY21 was still suboptimal at 55%, partners should introduce/scale up HPV DNA testing as recommended by the WHO 2021 guidelines for screening and treatment of cervical pre-cancer lesions.

Other Cross-Cutting Program Area, Government Policy, Systems, or Programming Changes Needed

1. OVC: Despite the increases in enrollment in FY 21, Lesotho must continue to prioritize offering C/ALHIV the opportunity to enroll in OVC programs, in order to reach the COP requirement to offer enrollment to >90% of TX_CURR <18 in high volume facilities in high burden SNU's. Particular emphasis should be placed on Maseru, where there is the greatest number of C/ALHIV that have not been offered enrollment into OVC.

2. HRH: In preparation for COP 22, the team and partners should use HRH Inventory data to review the existing staffing footprints of 2,078* FTEs reported; examine the alignment of current staffing investments with MER targets/achievements; analyze optimal staffing requirements and allocation to support program targets/goals; and inform adjustments of service delivery and non-service delivery staff.

* - Based on Q4 pre-clean HRH inventory

The team should also conduct staffing compensation analysis to assess alignment of clinical and ancillary staff with government pay scales for continued investment and to guide future transition. Additionally, as part of COP 22 planning, the team should work to advance local partner portfolios for building local system capacity for HRH (including for monitoring and reporting) to guide sustainability of investments, with more focus at the sub-national level aligned to host-country health system infrastructure.

3. Addressing Structural Barriers to KP service delivery: COP 22 plans should prioritize and take specific steps to address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as well as the lack of robust data to guide key populations programming. To strengthen strategic information to guide KP responses, plans may include efforts to strengthen individual level data systems and analyses and address gaps in subnational data. Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers. PEPFAR teams should ensure they are coordinating strategically with relevant State and U.S. government units (e.g. DRL), partner government, multilateral, and other donor funding streams and institutions. As part of the new COP 22 MPR, PEPFAR teams will be expected to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP 22 planning meetings.

4. Planning for sustainability: In addition to the development of a long-term sustainability plan that has been discussed above, including the merging, management, and oversight of HIV services in more intentional alignment and integration with domestic systems, the team should conduct an analysis to determine if the current portfolio and mixture of programmatic activities and funder responsibilities is optimal. The 2021 Sustainability Index and Dashboard (SID) and Responsibility Matrix (RM), which the team completed in partnership with the Government of Lesotho, UNAIDS and other major stakeholders, should help with this exercise. For example, the two lowest scoring elements in Lesotho's 2021 SID were *Epidemiologic and Health Data* and *Quality Management*. The biggest decreases in score over time have occurred in the *Civil Society Engagement* and *Private Sector Engagement* elements. Since each of these elements are critical components of sustainable programs, it will be important to ensure sufficient COP 22 investments in effort and funding, as needed, in these four elements.

COP 2022 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring, as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional, and international civil society and community stakeholders, multilateral partners, and the partner country government.

Civil society organizations are essential and are to be invited to participate in the virtual COP22 strategic retreats, planning meetings, as well as approval meetings. In particular, engagement with local CSOs at

the country level is required and should begin early and continue during the entirety of the COP planning, monitoring, and implementation process.

This engagement of civil society, including faith-based organizations/faith communities, specifically includes the sharing of FY 2021 Q4 and FY 2021 Annual Program Results (APR), analyses, and the convening of an in-country planning retreat with local stakeholders, no later than the week of February 7, 2022, in order to introduce and discuss all COP/ROP 2022 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2022. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund, with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic.

In March 2022, PEPFAR will convene virtual meetings where outstanding decisions will be discussed and finalized. In addition to partner country representatives, the meetings will also include representatives from local and international civil society and community organizations, faith-based organizations/faith communities, private sector, and multilateral partners. Specific guidance for the 2022 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2022 development, finalization, and implementation. As in COP/ROP 2021, the draft Strategic Direction Summary (SDS) is required to be shared with both CSO and FBO stakeholders for their input and comments at least 7 days prior to submission to S/GAC. Please refer to the COP/ROP 2022 Guidance for a full list of requirements and engagement timelines. In addition, a more detailed timeline for sharing key data visualizations and other information with stakeholders is forthcoming.

Community-Led Monitoring (CLM)

In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to develop, support, and fund community-led monitoring (CLM) in close collaboration with independent, local civil society organizations and host country governments. Community-led monitoring in COP 2022 should build on prior activities in COP 2021 and be designed to help PEPFAR programs and health institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM should continue to ensure indicators are defined by communities and health service users, and data should be additive and not a duplicate collection of routine data already available to PEPFAR through MER or SIMS. New in COP 2022, PEPFAR-supported community-led monitoring programs must include an explicit focus on key populations. CLM should be used to advance equity and to support improvement in programs, especially for populations who have not yet fully experienced the benefits of HIV epidemic control. For example, OUs with pediatric care and treatment programs should consider utilizing CLM to track and ensure accountability for child, adolescent, and family-centered care.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: PEPFAR Lesotho's COP 2021 minimum requirement for the Care and Treatment earmark is reflected in Table 2. If there is no adjustment to the COP 2022 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): PEPFAR Lesotho’s COP 2022 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries)
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. Generalized epidemic countries which do not meet the 50 percent threshold must provide a brief written justification in FACTS Info, explaining the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors.

AB/Y programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are AB/Y programming, and the denominator approximates all sexual prevention activities. The proportion of AB/Y programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

<p>Numerator</p> <p>Prevention: primary prevention of HIV and sexual violence (For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)</p> <p>+</p> <p>Prevention: community mobilization, behavior, and norms change (For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)</p> <hr/> <p>Denominator</p> <p>Prevention: primary prevention of HIV and sexual violence (all populations)</p> <p>+</p> <p>Prevention: community mobilization, behavior, and norms change (all populations)</p> <p>+</p> <p>50 % Prevention: Not disaggregated (all populations)</p>
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Gender Based Violence (GBV): PEPFAR Lesotho's COP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2022** funding programmed to the GBV cross-cutting code. Your COP 2022 earmark is derived by using the final COP 2021 GBV earmark allocation as a baseline. The COP 2022 planned level of new FY 2022 funds for GBV can be above this amount; however, it cannot fall below it.

Water: PEPFAR Lesotho's COP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2022 funding** programmed to the water cross-cutting code. Your COP 2021 earmark is derived by using the final COP 2021 water earmark allocation as a baseline. The COP 2022 planned level of new FY 2022 funds for water can be above this amount; however, it cannot fall below it.

Initiative Controls: Table 3 shows initiative controls where S/GAC has directed funding for a set of activities that cannot be accounted for through program areas and/or beneficiaries alone. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned.

The four initiative controls below (**Cervical Cancer, DREAMS, OVC (non-DREAMS),** and **VMMC**) have been assigned to the appropriate OUs. For OUs where these controls are designated in the PLL, the amounts reflect the minimum required. These initiative controls can be exceeded without a control change, but a control change request would be required before a lower level for these activities can be planned.

Cervical Cancer - This initiative provides funding for all activities related to cervical cancer screening and diagnosis and treatment of precancerous cervical lesions for women living with HIV as outlined in the COP Guidance.

DREAMS - The DREAMS initiative should capture all funding specifically allocated as DREAMS in the OU's planning level and must be used for the goal of HIV and sexual violence prevention among adolescent girls and young women (AGYW) ages 10-24 years (unless otherwise approved) in participating DREAMS SNUs in accordance with the DREAMS and COP Guidance. The DREAMS initiative can also include prevention interventions in DREAMS geographic areas for girls and boys aged 10-14 which may be cost shared with the OVC (non-DREAMS) initiative as noted in the COP guidance.

OVC (non-DREAMS) - OVC (non-DREAMS) is a new initiative in COP/ROP 2022. OUs should use the initiative to budget for OVC (non-DREAMS) programming, including all OVC comprehensive activities as outlined in the COP Guidance. The OVC (non-DREAMS) initiative should include ASP, SE, and PREV costs (except PrEP and VMMC) linked to any OVC beneficiary (including sub-beneficiaries such as OVC caregivers). As the initiative is new for COP/ROP 2022, OUs should pay particular attention to funds programmed under OVC (non-DREAMS) to ensure that the current cohort of children enrolled in the comprehensive program receive continuity of care for FY 2023. The OVC (non-DREAMS) initiative can also include prevention interventions for girls and boys aged 10-14 which may be cost-shared with the DREAMS initiative as noted in the COP guidance. The OVC (non-DREAMS) initiative cannot be met with any HTS, C&T, PM or commodities costs.

VMMC - All services and equipment related to providing surgical and ShangRing VMMC for boys/men ages 15 and above, and ShangRing circumcision only for boys age 13 and 14 years, should be budgeted using the VMMC initiative.

While the CLM initiative does not appear in PLL budget tables, as CLM remains a requirement in COP/ROP 2022 for all OUs, each OU is responsible for programming a portion of funds under the **Community-Led Monitoring** initiative.

Community-Led Monitoring - During COP/ROP 2020, PEPFAR invested in expansion of community-led monitoring, making it a requirement of all OUs, as a critical way to listen to community voices in assessment of program quality and design of client-centered services. Community-led monitoring remains a requirement in FY 2023.

In addition to the five initiatives above, S/GAC may also allocate funding to OUs under two additional initiative controls: **Condoms (GHP-USAID Central Funding)** and **One-Time Conditional Funding**. If the OU was designated to receive funding under either one or both these initiatives in COP/ROP 2022, Table 3 will reflect these amounts. Unless otherwise noted, country teams should meet these funding controls when programming in their FAST.

Condoms (GHP-USAID Central Funding) - This initiative control denotes the amount of GHP-USAID central funding the country team may use to procure male and female condoms, lubricants, and to ship these commodities to the OU. Any additional condoms and lubricants to be procured with PEPFAR funding should be budgeted in the FAST with bilateral funding.

USAID Southern Africa Regional Platform - This initiative is for the country's share of the costs to operate the USAID Southern Africa Regional Platform, which provides administrative and technical support for Angola, Botswana, Eswatini, Lesotho, and Namibia. These funds were previously planned as part of the bilateral COP funding, but are now budgeted and notified centrally, with country amounts included as central funding in the overall COP levels for Angola, Botswana, Eswatini, Lesotho, and Namibia. Only these 5 countries may use this initiative, and this initiative can only be used with central funding specifically provided as part of the PLL controls.

One-Time Conditional Funding - The release of any funding made available under this initiative is contingent upon the OU's ability to meet all requirements outlined in their final COP/ROP approval memo. OUs that fail to meet these minimum standards may be ineligible to receive these funds for programmatic implementation in FY 2023.

No control is set in the PLL for the **HBCU Tx** and **Surveillance and Public Health Response** initiatives, but OUs may include relevant funds under these initiatives instead of Core Program as appropriate.

All funding not attributed to one of the nine COP/ROP 2022 initiatives above should be attributed to the **Core Program** initiative.

For additional details on initiatives, see the [PEPFAR Financial Classifications Reference Guide](#).

Programmatic Controls: Table 4 shows programmatic controls where S/GAC has directed funding for certain programmatic activities. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned. Since every dollar programmed in COP must belong to one initiative, programmatic controls will be a subset of one or more initiative controls, even if the standard Core Program initiative.

PrEP (AGYW) - The PrEP (AGYW) programmatic control tracks all funding budgeted under the Prevention - PrEP program area and sub-program area for the Females - Adolescent Girls and Young Women sub-beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the

number of AGYW on PrEP wherever possible. Countries with a PrEP (AGYW) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

PrEP (KPs) – The PrEP (KPs) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for all sub-beneficiaries under the KP beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of KPs on PrEP wherever possible. Countries with a PrEP (KPs) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

State ICASS: Table 5 shows the amount that the OU must program under State for ICASS Costs.

Funds Programmed under State/SGAC (S/GAC TBDs)

No funding may be programmed under State/SGAC without prior approval from S/GAC M&B. In general State/SGAC TBDs are only used in extraordinary and or unusual circumstances. To the degree that funding is approved, the rationale and any conditions attached to the funding will be documented by M&B. Any S/GAC TBDs approved during COP/ROP 2022 planning will require supplemental language in the OU's COP/ROP 2022 approval memo, clearly outlining the process for how these funds can be accessed. Any funds that have not been distributed to agencies before the end of FY 2023 may be subject to reprogramming in future planning cycles towards the same OU or another OU.

COP/ROP 2022 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

Whenever possible, all agencies within an OU should hold several months of pipeline at the end of COP/ROP 2022 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain this buffer. With the exception of Dominican Republic, Ethiopia, Haiti, South Sudan, Zimbabwe, Asia Regional Program, and Western Hemisphere Regional Program, which should hold up to four months of pipeline, all other OUs are permitted to hold no more than three months of buffer pipeline.

Any agency that anticipates ending COP/ROP 2021 implementation (end of FY 2022) with a pipeline in excess of three or four months is required to apply this excessive pipeline to COP/ROP 2022, decreasing the new funding amount to stay within the planning level.

Transitioning HIV Services to Local Partners

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. In COP 19 Guidance, PEPFAR set a goal that 40% of partners must be local by the end of FY 19, and 70% by the end of FY 20. While considerable progress was made in this effort, the 70% mark was not achieved by all agencies in all

OUs, and thus in FY 22 and FY 23, teams must continue to prioritize this so that the 70% goal can be realized. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY 23 as appropriate through their COP/ROP 2022 submission.