

Approved



Lesotho

Country Operational Plan

FY 2014

Note: *Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.*



Operating Unit Overview

OU Executive Summary

Country Context

The Kingdom of Lesotho, a mountainous country surrounded by South Africa, has a population of approximately 1,880,000. The 80% of the population living in rural areas depend heavily on small-scale agriculture for livelihoods; 43% of Basotho live on less than \$1.25 per day. With limited employment prospects in Lesotho, many Basotho migrate to South Africa for work. The impact of the HIV epidemic is linked to broader health and development challenges in Lesotho. For example, among worsening health indicators maternal mortality has risen to 1,155 deaths per 100,000 live births.

Lesotho's HIV prevalence is among the highest in the world, persisting at just over 23% since 2001. In 2013 new infections dropped from 27,000 to 23,000 and pediatric infections from 6,100 to 3,700. However, the number of people living with HIV (PLWHA) continues to increase; currently, an estimated 360,000 Basotho live with HIV. UNAIDS modeling shows that HIV incidence has not decreased significantly over the last 10 years, as it has in some other southern African countries, and Lesotho has not reached a 'tipping point' in turning the tide of the epidemic. Of those people infected with HIV, over half are women, and more than ten percent are children. Thirty-one percent of people who need treatment are not accessing it, pediatric coverage remains low at 25%, and PMTCT coverage has plateaued at approximately 50% since 2008. With the adoption of the 2013 WHO antiretroviral guidelines in 2014, an additional 130,000 Basotho are eligible for ART. With a prevalence of tuberculosis that is also among the highest in the world, 80% of patients identified with TB in Lesotho are co-infected with HIV.

To address these epidemiological and programmatic findings, in 2013 the Government of Lesotho (GOL) reviewed and revised its National Strategic Plan for HIV and AIDS 2011/12–2015/16 (NSP). Using the UNAIDS Investment Framework approach, the revision included resource mapping, costing and gap analysis of the prioritized activities. With aggressive multi-sectoral scale-up targets, the NSP is responsive to Lesotho's commitment to the Millennium Development Goal for AIDS and will halve new infections by 2020 if executed fully. However, with an estimated annual resource envelope of \$116 million, 70% funded by donors, there remains a \$237 million funding gap through 2016.

COP14 will support Lesotho to make progress on its NSP priorities to reduce new infections, reduce AIDS-related deaths, and eliminate mother-to-child transmission of HIV while keeping mothers alive. The USG will execute its program in coordination with all other stakeholders including the GOL, The



Global Fund To Fight AIDS, Tuberculosis and Malaria (GF), UNAIDS, and civil society.

PEPFAR focus in FY 2014

With its revised NSP, the GOL has made significant steps towards ownership of the response and making a greater impact on the epidemic. To support this plan and respond to the continuing urgency of the HIV/AIDS situation in Lesotho, the USG team initiated significant changes in approach. The USG team undertook an exhaustive re-alignment process during FY2013, towards support of district-based comprehensive clinical care, with the aim of improving both efficiency and effectiveness.

For COP14, the USG team undertook an evidence-based priority-setting exercise, incorporating the 59 separate recommendations from seven technical working groups (TWG) and a robust portfolio review of all mechanisms. Using a continuum of response/care model to quantify targets, client flows, and inputs, as well as an expenditure analysis of actual spending and unit expenditures to validate the feasibility of targets and projected efficiencies, the USG team shifted resources to meet priority unmet needs. With a static \$34.2 million annual budget, every increase was necessarily accompanied by a decrease in other budget codes. Subsequently, further programmatic and budget amendments were made in order to meet the revised Care and Treatment earmark. The majority of activities were recoded as they provided direct clinical service support to patients but the prevention and health system strengthening programs were adversely affected by a budget reduction.

Overall, the care and treatment category received an increase in funding over COP13, to empower the Ministry of Health (MOH) to achieve a net national increase of 26,000 Basotho on ART in FY2014 and 44,000 in FY2015, while increasing national ART coverage to 66% by FY2015 and 80% by FY2016. This will push the country towards achieving the 'tipping point' ratio and maximize the impact of treatment as prevention as the country adjusts to the newly adopted Option B+ plan. This ambitious goal must be accomplished while promoting earlier initiation of HIV-positive clients and TB/HIV co-infection and prioritizing identification and treatment for the sickest. Given the prominent role the USG has in the national response and because Lesotho is a 'long-term strategic support' country, PEPFAR Lesotho maintained level funding from the previous year in the broad category of health systems support. In light of increases in other program areas, funding for prevention will decrease, specifically in the areas of MTCT, HIV testing and counseling (HTC), and behavioral prevention. The impact of these decreases will be offset by increased efficiencies in PEPFAR operations, by the benefits of 'treatment as prevention,' and by careful alignment and active management of the in-country resources and activities of partners such as the GF.



As achievements in other southern African countries make clear, a dramatic reduction of incidence has correlates directly with increased clinical program coverage, e.g. PMTCT, HTC, and care and treatment services. PEPFAR's top priority is support for the rapid scale-up of programs as detailed in the NSP, through:

- 1) strengthening the national continuum of response to reach a 'tipping point' by FY2015 and sustain it over the next three years, while increasing national ART coverage to at least 80%;
- 2) focusing on the linkages, retention and quality assurance of services to strengthen the continuum of response (COR);
- 3) focusing the prevention portfolio on clinical service demand creation;
- 4) improving the quality of Antenatal Care (ANC) and delivery services to increase and expand the pool of women and infants accessing PMTCT and pediatric services; and
- 5) fostering increased sustainability within the 'long-term strategy' approach of PEPFAR, through increasing the capacity of Lesotho's health systems to manage the growing workload.

PEPFAR's re-organization of clinical partners to a district-based comprehensive clinical care model underlies our support for the COR. For COP14 each district has one USG implementing partner at the facility level to support PMTCT, provider initiated counseling and testing (PITC), care and treatment services, and health systems. In line with the MOH Revitalization of Primary Health Care (PHC) and civil society's community empowerment initiatives, these partners will provide more integrated support, improving linkages and retention throughout the COR. A strengthened COR, underpinned by national and USG district and facility targets, will result in programmatic scale-up and improved patient outcomes for those already accessing services. The new USG programmatic structure also addresses the increased Monitoring, Evaluation and Reporting (MER) requirements. The USG will provide M&E TA, adapted to the capacities of each site and backed up by Health Management Information Systems (HMIS) support from USG partners.

Building on the COP13 review and prevention TWG visit, the COP14 prevention portfolio has reinforced PLWHA as a priority population to be linked to clinical services. Programming approaches will be redefined though greater profiling of condoms within a standard prevention message to HIV-positive and -negative Basotho. Core communication activities will also be segmented to higher-risk populations and tailored to the recipients, while financial support for mass media investments will be curtailed. HTC remains the key entry point to clinical services; COP14 re-balances community and PITC to leverage better yields while maintaining early identification of HIV-positive Basotho. In COP14, funding for voluntary male medical circumcision (VMMC) has been supplemented with \$2.1 million of central plus-up funding that will fund an additional 18,000 safe male circumcisions over the base funding targets. The prevention budget has decreased as biomedical prevention strategies are leveraging the new clinical



services model. The USG will prioritize at-risk populations and increase synergies with non-USG funding, and Lesotho will benefit from incidence reduction through earlier treatment.

Though the PMTCT budget for COP14 has reduced by 50%, maternal and pediatric HIV remains a focus of the USG program. All ART costs associated with HIV positive pregnant women as well as mother-baby-pairs (Option B+) will be covered under the respective care and treatment budget codes. There is also significant investment from the Global Fund as well as national resources. MCC investments and PMTCT funding that improve the quality of ANC and delivery services will increase demand during pregnancy and from mother-baby pairs up to five years and will expand the pool of women and infants accessing PMTCT and pediatric services.

PMTCT uptake will increase along with adult treatment scale-up, as more HIV-positive women receive ART earlier. Retention within the clinical cascade is already very good at over 95%. USG support to programs to improve the quality of ANC and delivery services at health centers nearer the rural populations will also increase PMTCT demand and coverage when linked to PHC community systems. A consortium led by the Vodafone designed to provide universal access to pediatric HIV treatment for children and complement current USG investments will commence in FY2015. In addition to pediatric treatment, the scope has expanded to include PMTCT via the MNCH platform, in order to increase access to pediatric HIV positive patients through ANC, delivery, and mother-baby pairs. By integrating services, targeting women and infants <18 months, the project will support EID, identify more pediatric HIV cases, and improve infant health as well as have the intentional residual effects on maternal mortality and under 5 mortality.

The GOL has a bold vision for its health sector that is articulated in the PHC revitalization initiative, the NSP, and other program strategies. However, the underlying essential health system building blocks require comparable support to upgrade their capacity to meet the increasing demands of program scale-up. COP14 therefore maintains stable budgets for laboratory, human resources for health (HRH), supply chain management (SCM), and SI.

Progress and Future

During 2014, the USG will engage national stakeholders in the development of a Sustainability Plan. The Lesotho Partnership Framework (PF) will conclude in September 2014 without meeting its most ambitious goal of a 35% reduction in HIV incidence, largely because of delays in initiating rapid VMMC expansion. However, there has been a reduction in morbidity and mortality of HIV-infected Basotho, and the human resource capacity and health systems for HIV service delivery have all improved, in line with



PF goals.

The COP14 priorities and programmatic shifts reflect the current status of the epidemic, global PEPFAR trends and new GOL priorities. The USG seeks to contribute to the reduction of HIV incidence in Lesotho with evidence-based interventions that align to national priorities, while retaining USG commitment to the principles and purpose of the PF to 'address the HIV/AIDS epidemic in Lesotho in a collaborative manner'.

The magnitude of the NSP funding gap leaves Lesotho vulnerable to stakeholders taking an inefficient 'cherry-picking' approach to NSP activities, as well as loss of accountability by programs with insufficient funding levels. The USG will continue to support Lesotho to further prioritize the NSP; however, the USG's ability to fully support the NSP remains constrained by a static budget and the growing resource needs of clinical service delivery.

In addition to programmatic assistance to the national HIV and AIDS program in FY2014, the USG will conduct a joint assessment of capacity and risks to inform the development of the sustainability plan. This exercise will draw heavily from ongoing USG work in HRH, HMIS, and governance projects. Under PHC revitalization, the MOH has indicated a desire to re-organize its structure and funding. This process may be completed in FY2014 and would be fundamental to the development of a sustainability plan.

Unfunded priorities

There are several activities that would have a great impact on the HIV/AIDS epidemic in Lesotho but are outside of the resources currently available to the PEPFAR Lesotho team. These activities are all related to systems strengthening. 1) There is a need to carry out an AIDS Indicator Survey (AIS) in Lesotho to provide data for decision-making; however, there is insufficient identified funding. 2) There is a need to increase the availability of regular, timely, and high quality data to inform programmatic decisions. A major part of the inability to get such data is the lack of a functional nationwide electronic medical record system. We will address this lack with our new HMIS partner, but there are likely to be resource needs above what we have currently budgeted for this activity. 3) Plans and blueprints were made for the construction of a regional laboratory in Leribe district, but construction has been postponed until funds can be secured. 4) To generate a 'Health Rights' awareness in the population, reduce stigma, and advocate for health seeking behavior, a civil society strengthening program with a strong focus on advocacy is needed.

Program Overview



Continuum of Response

The 'Continuum of Response' (COR) describes the planning matrix as it follows a clinical cascade from HIV diagnosis to care and treatment. Through modeling and analysis of the COR, Lesotho will be better able to plan and execute the required program scale-up and mitigate risks. Therefore, partners have provided support for the MOH to develop a National Operational Plan (NOP) for HIV with district-based targets for the entire clinical cascade, as well as some primary prevention interventions that begin to link the components of the national COR.

The USG has built upon this work to further examine the COR at a national level and for key populations. Such information will assist the MOH to maintain the appropriate mix and number of clients in the different levels of the COR. COR modeling has shown that a judicious mix of HTC channels targeting key populations will improve linkage of PMTCT, Early Infant Diagnosis (EID), and pre-ART to ART client flow, and will yield sufficient numbers of ART-eligible clients for Lesotho to achieve the 'tipping point.' The models also demonstrate that the USG can support the program within budget and maintain the balance between upstream HTC services such as PMTCT, TB/HIV screening, primary HTC, and patient flow between the clinical cascade steps. Modeling work on the COR strongly influenced national and USG programming, bringing ownership and accountability for program scale-up to the service providers. The USG team will undertake further analysis of the impacts and cost efficiencies achieved through re-balancing the clinical cascades and priority populations. This analysis will provide decision-makers greater clarity and understanding of the trade-offs when managing the divergence between NSP goals and available resources.

National challenges to maintaining a COR have been exemplified by weak data systems and vertical programming. Part of this challenge is the chronic lack of data to quantify the retention of clients within the clinical care continuum. The lack of a unique patient identifier, weak referral systems, and vertical service provision make it difficult for overburdened clinicians to monitor or track inter-program referral. There is also a lack of adequate data on key populations; a Behavioral Surveillance Survey on key populations will be completed in 2014, as will an ongoing multi-partner qualitative study to understand real and perceived barriers for PLWHA to transition into care and treatment. This latter study will allow us to develop evidence-based interventions to overcome these barriers at all levels of the clinical cascade.

Care & Linkages

In COP14, the USG will replicate program successes as well as benefit from the PHC revitalization initiative and empowerment of village health workers (VHW) and other community systems to track patients, facilitate linkages, and find lost clients. Implementing partners will provide support for 1) policy



development, 2) job aids for all staff along the COR to reinforce responsibility and accountability for promoting and maintaining linkages, 3) improved patient flow within clinics, and 4) the development of guidelines with central MOH and district health management teams (DHMTs) to articulate and formalize relationships between programs.

The USG will support a situational analysis of linkage, engagement, and retention as part of efforts to improve clinical care services. New tools for patient tracking in health facilities have been nationally adopted and rolled out. The USG will support the development of a national 'basic care' package (including NACS) and support effective M&E systems for clinical care services. We will prioritize strategies to enhance or complement linkages along the COR to ensure retention in care and improve the quality of care available to PLWHA. The USG will support the MOH to develop a national Positive Health, Dignity, and Prevention (PHDP) strategy to establish national standards. The basic care package and PHDP strategy will assist with retention in care of pre-ART patients, who will have access to an expanded package of care and prevention services.

Additional care and treatment funds will support the improvement of systems for active patient monitoring, linkages and retention through health system navigators/linkage facilitators between community and facilities and inter-facility using lay counselors and expert patients. As well as develop the USG programs for community support group meetings, community adherence groups' and support for essential prevention activities for PLHIV.

For orphans and vulnerable children (OVC), the USG will focus on the capacity of local civil society organizations to provide community-based care and support services and referrals to clinical settings for OVC and their families. As a target country for the OVC Special Initiative on early childhood development (ECD), Lesotho is conducting a randomized controlled trial to generate evidence on the impact of ECD training interventions on the health outcomes of children. Evidence from this activity will inform strategies for ECD scale-up and effective linking of OVC interventions to the COR. For TB/HIV, the USG will strengthen implementation of the directly observed therapy strategy (DOTS) and Lesotho's national tuberculosis program (NTP) strategic plan and will provide technical and financial resources to support the expansion, integration, and decentralization of HIV and TB services. Along with PMTCT, TB/HIV has been a model example of improving linkages and retention of Basotho who access the services. Primarily through the improved integration of services, including joint TB/ART clinics and retention in MNCH of mother-baby pairs through provision of quality ART, our programs have shown that easing access to services has a demonstrable effect on linkages and retention. See prevention, care, and treatment TANs for more information.

Retention of infants via the VHW structure will be a fundamental plank of COP14. Vodafone Foundation



is expected to commence a program specifically focusing upon capacitating the community structures around health facilities to improve identification, referral and entry of pediatric clients to ART.

The USG is working with the GOL on data use. In FY 2015 and FY 2016, SI partners will continue to provide extensive technical assistance (TA) at national and district levels, while our service delivery partners will work directly with communities, health facilities and district health teams to build their capacity for service provision, data collection, use, inventory, and analysis through trainings and clinical mentorship.

ART scale-up

ART scale-up is central to reaching the tipping point of the epidemic in Lesotho, as reflected in the primacy of ART in the NSP, with scale-up targets of over 80% coverage by 2015/16 and early initiation of HIV+ individuals in sero-discordant relationships. COP14 priorities reflect prioritization of ART scale-up built on the upstream prevention, HTC, and care programs as well as health system building blocks.

The USG supports direct service delivery for a third of ART recipients, but much of the scale-up is targeted in smaller, more community-focused health centers, for which PEPFAR supports technical assistance only. USG partners will focus programs on assisting with policy development, continuing in-service medical education on the revised ART guidelines, best practice and mentoring to build skills, especially of nurses, to initiate and manage ART programs.

USG funding per direct ART client supported will rise from less than \$10 to \$40 during FY2014 and FY2015. This increase will add to rather than displace GOL and GF support. As capacities improve, implementing partners will move onto new facilities in a stepwise approach. With about 200 registered ART sites, this capacity building stage will take at least until 2015/16. The MOH will conduct a baseline service provision assessment of all health facilities in 2014 and a mid-term review in 2015/16.

To support aggressive scale-up, COP14 focuses on limited key components of health systems: supply chain management (SCM), laboratory, and human resources for health (HRH). The USG will continue to support systems strengthening in these fields and will monitor essential commodity stocks so that health care providers can provide quality treatment.

The USG will address persistent challenges with commodity stock-outs and shortages of skilled clinical staff (including laboratory personnel, data managers, clerks, and physicians). The MOH will initiated restructuring of its SCM division and has begun to absorb critical HRH positions currently supported through GF grants. See the governance and systems TAN for more details.



VMMC

Since early 2012, the GOL has rapidly expanded VMMC services, now provided in hospitals in all ten districts. Further scaling up VMMC to reach 80% of males aged 15 to 49 years by 2016 would avert more than 106,000 new adult infections by 2027. The USG will continue to ensure high quality VMMC provision through quality assurance (QA) and supportive supervision visits, training of providers, and development of QA tools. The USG will scale up an innovative campaign to encourage service uptake, particularly among men and boys aged 10-29, in collaboration with an extensive range of partners. Despite the excellent progress in VMMC service expansion, human resources challenges pose serious constraints; the USG team is working to make task-shifting a possibility in Lesotho.

Sustainability of response

MOH implementation capacity is very limited, largely because of limited managerial and programmatic capabilities. The MOH struggles to deploy and adequately train sufficiently experienced health professionals, provide adequate commodities, and effectively monitor and supervise to ensure high quality service delivery. The GOL commits a significant portion of its annual budget to health care, approximately \$100 per capita, but donor resources have been essential in support of all national programs: prevention, care, treatment, and health systems strengthening. Lesotho has received much less funding per capita than countries in the region with similar HIV burdens, such as Swaziland, Namibia, and Botswana, all of which have achieved much steeper reductions in incidence.

Through COP14, the USG will provide support for Lesotho to develop the workforce, organizations and systems needed to effectively perform program activities and carry out responsibilities to achieve NSP goals. With increasing capabilities to respond, Lesotho will increasingly attain political, institutional, and community ownership. Progress on the health system building blocks has contributed to the small but significant steps towards sustainability seen in FY2013.

Overall performance of the USG HRH portfolio has been outstanding. The program reached a cumulative output of 1400 new graduates from 2010 to 2013. In spite of this achievement, Lesotho still has 0.54 doctors, nurses and midwives working in the public sector per 1000 population compared to the WHO standard of 2.28. In FY2014, the USG will support the MOH to re-organize DHMT structures, develop a task-shifting policy to support VMMC and ART service delivery, and revise the Village Health Worker policy to incorporate community health workers developed with other donor funding and standardize recruitment, retention, and compensation packages.



Within the laboratory sector, major priorities are to strengthen the laboratory infrastructure, provide quality-assured and integrated laboratory services, and support scale-up HIV care and treatment services. This requires the strengthening of referral testing and networking of laboratories, as well as scale-up of point-of-care testing to leverage efficiencies and reduce results turnaround time.

Stock-outs of rapid test kits (RTKs) and other essential commodities were a substantial hindrance to HIV/AIDS service delivery in recent years. Building on recent successes such as the establishment of a four month buffer stock for RTKs and direct commodity delivery between the National Drug Supply Organization and implementing partners, the USG will engage the MOH to develop and monitor risk mitigation plans to ensure commodity security. In partnership with the GF, the USG will support implementation of the SCM strengthening plan though the fiscal space will only allow support to the central level. The Global Fund will support other components of the strengthening plan, including some district support.

Strengthening SI systems is an important focus of the GOL. The USG will support NSP implementation by establishing baseline and biological measures to monitor the impact of the response, harmonize monitoring and evaluation systems, and build adequate and appropriate HR capacity. Despite GOL and donor commitment to a single, unified M&E system, M&E systems in Lesotho remain stove-piped, with data flowing through different channels at different times of the year to different national authorities. The MOH does not currently have an operational HMIS strategy with established enterprise architecture and standards to guide the adaptation of electronic medical record (EMR) systems. The USG will build on long-standing partnership and collaboration with the MOH to ensure that all activities have full government ownership and buy-in and that the MOH is able to sustain and expand high quality surveillance of HIV-related epidemiologic trends for design and implementation of population surveys, to contribute to an evidence-based HIV/AIDS response.

GHI, Central Initiatives, and other considerations

Although USG development funding in Lesotho is largely focused on HIV/AIDS, applying Global Health Initiative (GHI) principles to investments will produce a greater impact on Lesotho's broader health and development outcomes. In partnership with the GOL, the USG in Lesotho remains committed to support and strengthen national governance and systems. The USG will implement integrated and efficient programs that benefit both the formal and informal health sectors in ways that have a significant and sustainable impact. The USG will make a concentrated effort to improve cross-cutting areas of health systems strengthening that improve access to integrated services.



As an example of such integration and leveraging funding from the broader health presence in Lesotho, the PEPFAR program will build upon the accomplishments of the MCC Compact, which built or renovated 138 health centers and the outpatient departments in Lesotho's district hospitals. The PEPFAR program supports HIV clinic set up and operation as well as material support for the renovated clinics. The program has also maintained the human resources for health work in partnership with Irish AID through drafting and enacting the incentives for hard-to-reach areas as well as HR management. The identified spill-over of PMTCT programming on MNCH services is another example. The USG strives to integrate services in other ways by supporting activities such as Public-Private Partnerships, policy reform such as VMMC task shifting, and support to the central MOH to expand its institutional knowledge base through an internal Service Provision Assessment (SPA).

Coordination is principally managed through the Health Development Partners Group. The GOL lacks a central coordinating structure for the HIV/AIDS response; the MOH, as the biggest national stakeholder, has assumed much of the coordination responsibility. Protracted negotiations are ongoing to initiate a Sector Wide Approach to health programming. Lesotho does not have a robust harmonized approach to planning the HIV/AIDS response or have accountable sector-specific targets, and must rely on the MOH-centric Annual Joint Review to evaluate progress. The USG will focus on expanding joint planning to other multilateral partners as well as UNAIDS. Further detail is provided in the multilateral engagement tab of the overview.

Central Funding

The PEPFAR Lesotho program will execute several activities additional to base funding. \$3.75 million (COP12 plus-up funding received in FY2014) of OVC programming, focusing on early childhood development and linking OVC programs to PMTCT and pediatric care, will be implemented in FY2014/15. VMMC programming has been supplemented with \$3.75 million plus-up funding that became available for programming at the start of FY2014. These funds have been further supplemented with \$2.1 million of central funding in FY2014 that will support FY2015 programming. Additional central NACS and GeneXprt support already in country will also augment FY2014 programming.

Pipeline

The PEPFAR team engaged in a rigorous exercise to identify pipeline that can be used for unfunded programmatic priorities and vulnerabilities in the overall portfolio. In addition to the \$750,000



programmed to cover unfunded need for HTC in March, the Lesotho program has reduced the COP14 new funding request by \$1,790,746 so is only requesting \$32,409,254 of new COP14 funding in order not to create a pipeline.

The PEPFAR Lesotho team recommends to OGAC that the \$1,790,746 reduction of new funding request due to applied pipeline of prior year funds be allocated to support the funding of an AIDS Indicator Survey in Lesotho.

Pipeline Analysis: USAID: The OGAC analysis at 30 June 2014 showed a USAID Pipeline of \$19.3m. The actual USAID pipeline analysis, after adjusting for expenditures in phoenix by 31 August and annualizing it to 30 September 2014 is \$7.2m - almost \$12.1m lower than OGAC's projection. It is for this reason that USAID opted not to apply any pipeline because all USAID mechanisms except for TBDs have pipeline lower than 18 months. USAID may therefore have to request for a reclama in FY2015.

Pipeline Analysis: CDC: There are several factors that tended to increase CDC's apparent pipeline. First, disbursements of funding such as Reclama give the portfolio a large bolus of funding during a time when pipeline is being scrutinized. Second, partial and unpredictable disbursements of funding to implementing partners have created a tendency to exercise fiscal caution by slowing down activities to prevent running out of money until the next tranche of money arrives. This results in a decrease in burn rate and an increase in pipeline. Third, a 'perceived' pipeline is created by the inability of CDC's Payment Management System to capture actual expenditures by in-country partners in a timely manner. Fourth, there are pipeline funds that are currently tied up in "expiring" cooperative agreements (final year of the agreement) that cannot be deobligated for use in the next fiscal year.

We are now in a position to address all of these issues. The accumulated supplemental funding will be used by partners to accelerate the completion of programmatic activities while increasing burn rate and decreasing pipeline. CDC Lesotho is continuing to work with its implementing partners to develop a real-time system to reconcile differences in pipeline as detected by PMS and as estimated by implementing partners. This combination of interventions will allow us to appropriately implement activities while at the same time increasing burn rate and decreasing pipeline. The funds that are currently in final year "expiring" cooperative agreements will be obligated and spent down, and will no longer be available for use next fiscal year.