Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analysed, and explained where relevant.

Country	Lesotho
Reporting period	*2015 -2016*
Fiscal period	*April 2015 –March 2016*
If the country reporting period deviates from the fiscal period, please provide a short explanation	*To be completed by the country*
Comprehensive Multi Year Plan (cMYP) duration	*2012 - 2017*
National Health Strategic Plan (NHSP) duration	

1. SUMMARY OF RENEWAL REQUESTS

Programme	Recommendation	Period	Indicative amount to paid by Gavi
NVS – Pentavalent in existing presentation	Renewal	2017	US$ 196,000
NVS – PCV in existing presentation	Renewal	2017	US$ 607,000
NVS – IPV in existing presentation	Renewal	2017	US$ 66,000

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	Human papillomavirus Vaccine	*2017*	*2018*

**Not applicable for countries in final year of Gavi support*

2. COUNTRY CONTEXT

N/A

3. GRANT PERFORMANCE AND CHALLENGES

3.1. New and underused vaccine (NVS) support

3.1.1. Grant performance, lessons and challenges

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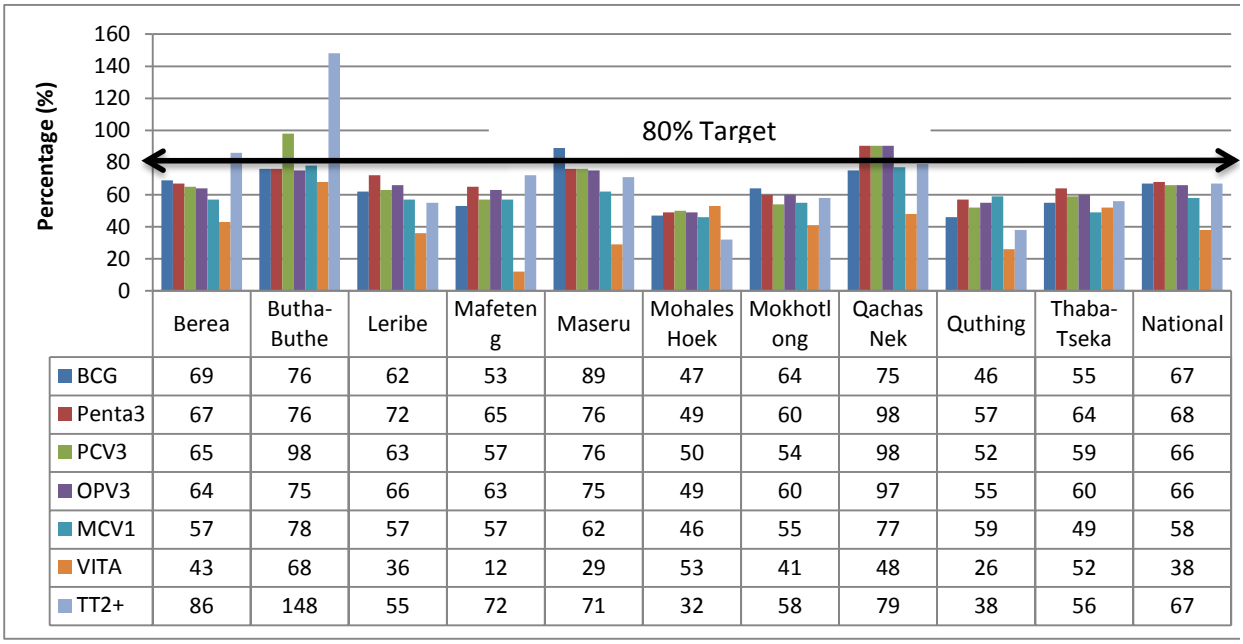
Programme Performance – Achievements and Challenges:

Lesotho's DPT3 coverage has consistently been below the targeted 80%. DPT3 coverage has consistently been in the 60-70% range[12]. For 2015, the national coverage is under 70% for all antigens. Additionally, admin data points to DPT drop-out rate being above the 10% expected range.

2015 EPI PERFORMANCE BY ANTIGEN



	Berea	Butha-Buthe	Leribe	Mafeteng	Maseru	Mohales Hoek	Mokhotlong	Qachas Nek	Quthing	Thaba-Tseka	National
BCG	69	76	62	53	89	47	64	75	46	55	67
Penta3	67	76	72	65	76	49	60	98	57	64	68
PCV3	65	98	63	57	76	50	54	98	52	59	66
OPV3	64	75	66	63	75	49	60	97	55	60	66
MCV1	57	78	57	57	62	46	55	77	59	49	58
VITA	43	68	36	12	29	53	41	48	26	52	38
TT2+	86	148	55	72	71	32	58	79	38	56	67

Improvements

- Completeness (which is measured in terms of number of reports submitted) and timeliness of reporting has been noted to be 100% and 80% respectively. The EPI has been encouraged to evaluate the quality and comprehensiveness of reporting while assessing completeness. This would entail ensuring that all antigens are reported, that correct forms are used inclusive of all new vaccines, and that values are within expected ranges for that facility.
- In the period under review, Pneumococcal Vaccine (PCV) was introduced in July 2015, IPV in April 2016 together with the switch from trivalent Oral Polio vaccine (tOPV) to bivalent Oral Polio Vaccine (bOPV).
- A cold chain inventory was conducted and a cold chain replacement and expansion plan developed. 57 fridges were procured with support from UNICEF and the process of installing them is underway.
- 5 EPI vehicles were procured with HSS funds to support improvement of immunization coverage in low performing districts.

[1]EPI Admin Data 2015
[2]UNICEF/WHO JRF 2003-2013

- Surveillance continued to perform well, all required indicators in surveillance were met in 2015: Annualized Non measles febrile rash illness detection rate cases/ 100 000 Pop was 6.3 while Non Polio AFP Rate/100 000 was 1.9
- Presence and commitment from local EPI partners including EPI technical working committee enhanced the few achievements that were realized during 2015.

Challenges:

The most significant challenge for the country over the last year has been programme management. The replacement of a new EPI Manager following the retirement of the previous Manager in 2015 took longer than expected. The EPI team has therefore been operating with a number of key vacancies and constrained bandwidth which has been challenging over the last year. The new EPI Manager has now been recruited which should alleviate some of the programme management constraints. Despite the fact that the EPI team has been short staffed, the country was still able to make advances in terms of vaccine introductions as outlined above and this speaks to the strong level of engagement and collaboration between the MoH and the key partners in the country.

Programmatic Enablers:

Data Quality: there are a number of data quality issues in Lesotho. There is a significant discrepancy between coverage estimates when looking at WEUNIC and admin data. The WEUNIC data for DTP3 coverage for 2015 is 93% while the admin data for the same period is 68%. The country utilises admin data for programme management, at the national level the EPI surveillance team has been capturing the timeliness of reporting from district level, however the team has not been capturing data completeness. The 2012 data quality self-assessment, revealed discordance between recorded and reported data and point of generation and management respectively. There may also be some data missing from private facilities. Data management continues to be centralized which is an added disadvantage because the districts have no mechanism to follow-up on late reporting from the health facilities. There is a need for further investigation to examine data being captured and produced at district and facility level to provide further insights into the coverage figures. In addition a feedback loop between national, district and facility level needs to be created – this will allow national level to share information with lower levels on where data is missing and in turn will provide lower levels with the opportunity to input into challenges with collecting and collating relevant data. A DHS was undertaken in Lesotho in 2014, and was subsequently disseminated in 2015 (Key Indicators Report) and 2016 (Full Report). The immunisation coverage rates in the DHS are 68% fully immunized, with 98% coverage of BCG, 85% coverage of Penta3, 76% coverage of OPV3, and 90% coverage of measles. The variance across the coverage rates in the country emphasise the data quality issues and the need for a deeper dive on data quality in 2017.

Coverage and Equity: 2013 EPI cluster survey showed results not different from the DHS 2014 report which highlighted small variations in the immunization coverage across urban and rural areas (70.1% and 67.6% for all basic vaccinations, respectively). The reasons for the variation were however not analysed. There are variations in routine immunization data coverage in terms of both the fully-immunised child and drop-out rates between vaccines across rural and urban areas. The proportion of children who received all basic vaccinations ranges from a low of 48% in Mokhotlong to a high of 80% in Mafeteng. There is a need in the country for some further analysis on equity related barriers to immunisation which would help the programme in developing strategies on how these can be addressed.

Supply Chain Management:

The Ministry of Health has a new unit called the Supply Chain Coordinating Unit which is responsible for forecasting, procurement and supply of all health commodities. The unit is also responsible for managing the EPI supply chain. In 2015, the program introduced electronic temperature monitoring devices in all vaccine supply chain levels. The program also conducted comprehensive cold chain inventory and developed replacement and expansion plan. Vaccine and dry stock distribution plan was also implemented. Absence of EPI focal persons at district level undermines implementation of EPI activities which includes quantification of vaccines and supplies. Vaccine and supply distribution is greatly affected by lack of adequate transport in the form of a truck for bundling of vaccines and supplies.

Poor logistics management and weaknesses in the cold chain were identified in the 2014 Effective Vaccine Management (EVM) assessment, the Comprehensive Review (2014), the Joint Appraisal (2015), and a lack of progress since the 2011 EVM assessment has been observed. EVM recommendations included:

- Strengthen stock management tools and usage; conduct refresher training if necessary.
- Ensure that every vaccine consignment that arrives at the port of entry is removed within 24 hours for safe storage.
- Introduce a system of calculating vaccine wastage and monitor its compliance.
- Adopt/ Develop Vaccine and Cold Chain Management manual/ handbook and distribute to all facilities.
- Introduce vaccine forecasting tool at district level.

In July and August of 2016, a UNICEF consultant conducted Immunization Supply Chain Management (ISCM) focused HR capacity need assessment, which provided more detailed recommendations related to EPI HR at all levels. EPI and WHO have also moved forward with reinvigorating MLM trainings in the country in order to strengthen skills of managers. UNICEF is providing a full time consultant to fill the position of the Logistics Officer.

Leadership and Governance:
The Lesotho ICC is chaired by the Minister of Health.. Key functions include:

- Advocacy for the programme at the higher admin and political level
- Resource mobilization; evidenced by endorsement of proposals to GAVI for support
- Coordination also evidenced by a multi membership from various stakeholders that share similar sentiments for EPI.

Over the course of the 2017 efforts will be undertaken to strengthen the functionality of the ICC. The ICC TORs will be revised to ensure that they adequately capture the oversight and strategic guidance role. The membership of the ICC will also be reviewed to ensure that the appropriate level of participants are engaged in the forum. In addition meetings will be set on a quarterly basis with fixed times proposed at the beginning of the year. A fixed agenda will be developed and action items from meetings will be reviewed at the next meeting.

3.1.2. NVS future plans and priorities

The country is in the preparation phase for the concurrent introduction of Measles Rubella (MR) and Rotavirus vaccines. Both introductions are planned for February 2017. MR will be introduced via campaign; it will subsequently replace Measles in the Routine Immunization system. Rotavirus will be introduced into the routine immunization system as a regular vaccine introduction.

MR will be administered to children aged, 9 months – 14 years during the campaign, a total target cohort of 849 035 children. The country has opted for Rotarix as the preferred Rotavirus presentation. The vaccine will be administered via a two-dose schedule, at 6 weeks and 10 weeks.

Lesotho is preparing to re-launch the HPV program. The EPI program is in the process of developing a request to Gavi to allow the country to apply through Gavi support for the national introduction.

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

The HSS work plan focusses on 4 objectives namely (1) to strengthen cold chain and associated logistics by making available requisite equipment and infrastructure, (2) to improve health sector capacity of providing vaccination and other MCH services by equipping health workers with requisite skills and knowledge, (3) to strengthen MCH interventions aimed at reaching hard to reach populations in Lesotho, and (4) to contribute to strengthening monitoring and evaluation of health sector performance.

All four objectives jointly contribute to improving coverage and equity access to immunization.

Objective 1- To strengthen cold chain and associated logistics by making available requisite equipment and infrastructure

The key activities under this objective are the rehabilitation of district vaccine stores and procurement of cold chain equipment. Rehabilitating of district vaccine stores (DVS) is targeted to be conducted in four districts. In 3 of these districts, the DVS, which is currently housed under the MCH clinic, will be relocated to the respective districts' district health management team (DHMT) offices. With DVS housed in the MCH clinic presents challenges on proper vaccine management and in general efficient and correct recording of vaccines inventory. Incorrect recording of vaccine inventory highly contributes to vaccine stock outs at health center level.

The Ministry through support from UNICEF conducted a cold chain inventory which informed the cold chain expansion and rehabilitation plan (CCERP). A cold chain procurement for 2015, 2016, and 2017 based on the identified gaps countrywide, is detailed in the CCERP. The identified gap is among other based on current liter capacity of the health facilities' respective fridges and envisaged future requirements. Procurement of the 2017 and 2018 cold chain equipment will be undertaken through the HSS grant. Having sufficient cold chain capacity at all health facilities will contribute towards vaccine availability for routine immunization and introduction of new vaccines and in turn improving the country's coverage rate.

Objective 2 – To improve health sector capacity of providing vaccination and other MCH services by equipping health workers with requisite skills and knowledge

Training of national EPI staff and district and health facility level staff is the key activity under this objective. Training constitutes ~25% of the overall revised budget for 2017. This signifies the realization that improvement of immunization coverage and to some extend equitable access, cannot be achieved without the key building block of health system strengthening, human resources for health, been adequately capacitated to carry out their activities. The main trainings outlined in this objective are district level Reach Every Child (REC) and surveillance trainings. As part of the main stakeholders in improving coverage, community structures will also be included in all district level trainings.

Objective 3 - To strengthen MCH interventions aimed at reaching hard to reach populations in Lesotho

Objective 3 aims at contributing to both improving coverage and equitable access. Activities under this objective include construction of health posts in hard to reach areas, procurement of 4 X 4s to be deployed in selected districts for the sole purpose of strengthening outreaches in the said districts, and catering for the provision of lunches when conducting outreaches.

Objective 4 - To contribute to strengthening monitoring and evaluation of health sector performance

Two key activities in objective 4 are to conduct a Data Quality Survey (DQS) and strengthening of supportive supervision. DQS is critical in determining the quality of the data and if available data does support decision that need to be made by EPI. The quality of the data will help EPI to determine the best interventions needed in improving the immunization coverage rate. Supportive supervision contributes immensely in building capacity at all levels to ensure a well-equipped human resource that will work towards achieving both objectives of improving immunization coverage and equitable access to immunization services.

3.2.2. Grant performance and challenges

The HSS grant was awarded in 2014, with the first tranche disbursed to the country in November of the same year. As of November 2016 only **~12%**of the total grant allocation has been spent thus far. Below is the implementation status;

	Budgeted	**Expenditure**	**Variance**
Objective 1	$322,582	$0	$322,582
Objective 2	$700,640	$75,942.84	$624,697.16
Objective 3	$1,354,449	$267,553.41	$1,086,895.59
Objective 4	$195,000	$0	$195,000

Implementation bottlenecks

A bottleneck analysis was undertaken in parallel to the revision of the HSS work plan. The analysis revealed the following;

Objective 1: There was non-availability of cold chain inventory to inform the procurement of fridges under the plan and their deployment. In addition, the cold chain inventory would have also revealed that required fridge tags and cold boxes and carriers to be distributed to the private sector, were available at the national vaccine store. For rehabilitation of DVS, key stakeholders such as MoH's estate management unit, were not aware of this activity as outlined in the plan.

Corrective measure(s);

- A cold chain inventory was undertaken and an expansion and rehabilitation plan developed to inform the procurement of fridges.
- Stakeholders within MoH has been engaged in the revision of the plan and are continuously updated and will be engaged moving forward.

Objective 2: Lack of oversight in implementing activities in this objective. The training activities involve a lot of coordination with district level personnel. Secondly, for those funds that needed to be claimed for conducting outreaches under objective 2, it was unclear how such funds can be claimed by nurses and nursing assistants.

Corrective measures: A training plan will be developed. District are also in been notified of available funding for them to conduct training which is to include community structures.

Objective 3:

Logistical challenges were experienced in the construction of health posts, the key activity in objective 3. The actual costs appeared to be higher than budgeted for in the work plan. In addition, there was no in-house capacity within MoH which may have been brought on by conflicting priorities. There were some activities within this objective whose implementation could only be undertaken once certain activities have been implemented.

Corrective measure(s);

- Costing of all foreseen necessities for construction of health posts were allocated for in the revised work plan.
- Assistance, in terms of surveying etc, for preparatory work to allow to construction herein will be engaged.

Objective 4:

One activity, mainly the training of village health workers (VHW), was in part implemented by other partners. The purchase of phones for VHW when visited for implementation purposes was deemed to be unsustainable while other activities, still included in the revised work plan, were scheduled to be implemented in 2017.

PEF 2016: Implementation of Technical assistance support.

A total of US$193,642 was disbursed through UNICEF in the report period to provide technical assistance support in the following areas:

- Leadership, management and coordination
- Supply chain and
- Demand promotion

The funds have supported implementation of the following activities:

- Assessment of training needs and implementation of MLM training for district level EPI leads: ongoing, to be concluded by first week of December, 2016 with support of an international consultant
- Programme management support at central level: 6 months national consultancy in place
- Training of national and district level Cold Chain Technicians on maintenance issues, installation of temperature monitoring systems at central level and solar direct drive refrigerators in hard to reach health facilities with support of an international consultant
- Ongoing recruitment process for institutional contract to conduct KAP study: final selection to be completed by end November for commencement of field work in January 2017.

Salary costs for existing staff supporting EPI activities (2 NO-B) were supported through other funding to maximize GAVI resources on the critical cold chain/logistics and capacity building efforts noted above. As of end November 2016, a total of US$148,188 (77%) has been utilized, with the balance earmarked for completion of the mid-level managers training and KAP survey by end March 2017

WHO PEF Update

WHO received financial support as part of PEF Funds were earmarked to support issues regarding adverse events following immunization (AEFI). By Dec 2016, AEFI guidelines were developed including training of AEFI expert committee and district EPI focal points on AEFI causality assessment. Further activities include printing of final AEFI guidelines and capacity building medical officers from the districts and CHAL hospital to ensure preparedness for the upcoming MR catch up campaign planned to be conducted in Feb 2017

3.2.3. Describe any changes to HSS funding and plans for future HSS applications

Technical Assistance (TA) has been engaged to support with the implementation of the HSS work plan. The departure point for the engaged TA was to support with the revision of the work plan. In revising the work plan the following needed to be determined; are the activities as conceptualized in 2014 relevant, and if so what is the scope of implementation feasible until December 2016, and what other activities are relevant today to include in the HSS work plan. The total cost of new activities, re-allocation request, is **$267,922**.

The revised work plan was informed by an activity based costing. Activity based costing has the advantage of transforming work plans in being more actionable. Furthermore, as mentioned above, TA has been engaged to support with the implementation of the work plan.

The activities included in the revised work plan are those deemed to be feasible to implement before expiration of the grant in December 2017. MoH is however aware that the final costing of the revised plan does not amount to the total grant allocation. The total amount disbursed to the country plus the cost estimates of the revised work plan amount to ~$2 million. This implies that there is ~$0.7million in residual of allocated funding. It is this regard that the country may request a no cost extension to implement the ~$0.7 on activities beyond December 2017.

3.3. Financial management of all cash grants*(e.g. HSS, VIG, campaign operational cost grant, transition grant)*

Cash utilization performance

PCV VIG: The total amount disbursed to the country was $100,000. $25,640 of the latter mentioned amount was spent for the PCV introduction, this would imply that $74,360 was unspent. The unspent amount still remains in-country.

IPV VIG: The total amount disbursed to the country in this regard was $100,000. Of this amount disbursed to the country $24,594 was spent for the introduction of IPV. This implies that $75,405.63 remains unspent and the funds are still in-country.

HSS grant: In November 2014 the first tranche amounting to $791,168 was disbursed to the country. As of November 2016 $78,152 has been spent. The latter mentioned amount excludes the cost of the recently procured 5 vehicles which is estimated at $265,344.66. MoH's Projects Accounting Office uses cash accounting and not accrual. This would imply that there is an estimated $351,430 available in-country.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

[Status of top 5 prioritised strategic actions from previous joint appraisal and any additional IRC or HLRP recommendations (if relevant)]

Prioritised strategic actions from previous joint appraisal/HLRP process	Current status
1. Depute/deploy a HSS coordinator to manage (planning, implementation and monitoring) of the HSS grant	Achieved, through Gavi support
2. Complete the inventory of CCE and deploy new CCE as per need	Partial. A comprehensive cold chain inventory was conducted in Q4 2015. 57 fridges were procured with UNICEF funding. More fridges will be procured with Gavi HSS funds as per the cold chain expansion and replacement plan.
3. Institutionalize monitoring and supervision mechanisms at all levels	Partial. Supportive supervision is happening but needs to be strengthened.
4. Build capacity of cold chain technicians and health facility staff	Partial. Cold chain technicians have been trained on equipment repair and installation in Q4 2016, Health facility staff scheduled to be trained on vaccine management in 2017 as per HSS work plan.
5. Conduct a KAP survey to establish evidence	Scheduled for Q1 2017

6. PRIORITISED COUNTRY NEEDS[3]

Prioritised needs and strategic actions	Associated timeline for completing the actions	Does this require technical assistance?**(yes/no)* If yes, indicate type of assistance needed
Procure cold chain equipment as per CCERP	Q1 2017	UNICEF has requested TA for application of CCEOP
Develop a proposal for HPV Introduction support	May 2017	Yes, technical assistance through WHO/IST
Data quality analysis to gain insights into the discrepancy between admin and WEUNIC data	Q3 2017	TA will be required to undertake the assessment and for the development of an Action Plan based on recommendations
Vaccine Supply Chain Assessment and implementation of recommendations	Q3 2017	TA will be required to undertake assessment and development of Action Plan
Programme and Financial Management Capacity Building	Q4 2017	Ta will be required to support development of Capacity Building Plan for EPI team

**Technical assistance not applicable for countries in final year of Gavi support*

[3]Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

7. ENDORSEMENT BY ICC, HSCC OR EQUIVALENTAND ADDITIONAL COMMENTS

This section does not need to be completed for joint appraisal update in interim years, instead the EPI manager is expected to endorse the joint appraisal report.

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	
Issues raised during debrief of joint appraisal findings to national coordination mechanism	
Any additional comments from: • **Ministry of Health** • **Gavi Alliance partners** • **Gavi Senior Country Manager**	

8. ANNEXES

This section does not need to be completed for joint appraisal update in interim years. Please include the following Annexes when submitting the report, and any others as necessary

Annex A. Description of joint appraisal process (e.g. team composition, how information was gathered, how discussions were held)

JA was conducted by EPI Technical Working Group which consisted of EPI Team and other relevant departments, WHO, UNICEF,CHAI and Red Cross. The Gavi SCM was in-country to support the JA workshop. The situational analysis included review of EPI routine and survey data sets. There was review of progress from 2015 objectives progress. Discussions issued way forward was determined which included review of the plan.