

Joint Appraisal Report

Country	LESOTHO
Reporting period	<i>Month/Year of the last appraisal report – July 2014 Month/Year of the current appraisal- Aug 2015 (for Jan-Dec 14)</i>
cMYP period	2012-17
Fiscal period	April 2014-March 2015
Graduation date	NA

1. EXECUTIVE SUMMARY

(MAXIMUM 2 PAGES)

1.1. Gavi grant portfolio overview

The government of Lesotho (GoL) through the Ministry of Health (MoH) is committed to providing all its citizens health care through the adoption of PHC of which EPI is a key component.

Lesotho has been receiving Gavi support since 2002 and has introduced Penta in 2008 and PCV in 2015 with Gavi support. The country has also introduced HPV through other donor support and it is now funding the vaccine fully through government budget. Gavi has provided US\$ 4.8 million till date against a commitment of US\$ 7.55 million. 70% of the support is for vaccines and 30% for non-vaccine support.

The country has received vaccine introduction grants \$100,000 each for PCV and IPV introduction in 2014 & 2015 respectively.

The country was approved for a HSS grant from 2014-17. The first tranche of US\$ 791,168 was disbursed in Nov 2014. GAVI's HSS support is meant to support and resolve the health systems challenges to increase immunization coverage and sustainability in the country. The major areas covered by the HSS grant are: to support and strengthen cold chain and associated logistics by making available requisite equipment and infrastructure; improve health sector capacity of providing vaccination and other MCH services by equipping health workers with requisite skills and knowledge; strengthen MCH interventions aimed at reaching hard to reach populations in Lesotho; and contribute to strengthening monitoring and evaluation of EPI performance.

The introduction of new vaccine provides an opportunity to strengthen the routine immunization systems through strengthening supply chain, promoting routine immunization and building capacity of health workers in micro-planning, monitoring and supervision as well as in improving their interpersonal communication skills.

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)
<p>Achievements</p> <ul style="list-style-type: none"> • Lesotho with support from Gavi, introduced pentavalent vaccine in December 2008 and PCV in July 2015. The country also got approved for HSS grant for 2014-2017 to resolve the health systems challenges and increase immunization coverage and sustainability. The approved budget is \$2,707,134 for a period of 4 years (2014 - 2017) • Using the opportunity of introduction of new vaccines (in 2015 for PCV), New Vaccine Support (NVS) and Vaccine Introduction Grant (VIG) from GAVI, the country was able to strengthen the existing structure of routine immunization program. This was done through capacity building of the health workers on cold chain management, new and underused vaccines and conducting social mobilization activities to increase community awareness and participation on strengthening the routine vaccination services. • Comprehensive EPI and Surveillance survey was conducted in 2014: implementation of recommendations are on-going • Effective Vaccine Management Assessment has been conducted in Dec 2014 • AFP performance significantly improved (3.8/100,000) • Slight improvement noticed on routine immunization coverage: Penta 3 (2013=66% 2014=69%) • New cold room at central level has been installed. • Distribution and installation of 90 EPI fridges (in 2014) at health facilities as per 2012 cold chain replacement Plan <p>Challenges</p> <ul style="list-style-type: none"> • Weak program management, coordination, supervision and oversight at all levels leading to poor performance and delays in program implementation • Low capacity for data management and use for action • Low capacity for vaccine and logistics management at all levels • PCV launch was significantly delayed due to many systemic challenges and procurement issues • Though the first tranche of funds for HSS had been received by the country in 2014 November, there has been no expenditure till date due to lack of procurement and detail program implementation plan • No micro-plans in majority of health facilities
Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)
<ol style="list-style-type: none"> 1. HSS: <ul style="list-style-type: none"> ○ Depute/deploy a HSS coordinator to manage planning, implementation and monitoring of the HSS grant ○ Annual work plan and procurement plans need to be prepared and endorsed by ICC ○ ICC chaired by Minister of Health should monitor implementation on quarterly basis 2. Capacity building: training of staff on program planning, implementation and monitoring and use of data for action in all areas of EPI 3. Governance and oversight mechanism: <ul style="list-style-type: none"> • Strengthen ICC • Strengthen monitoring and supervision mechanisms at all levels using the current

<p>institutional mechanism</p> <ul style="list-style-type: none"> • Create indicator dashboard to monitor implementation of EPI and HSS at the office of the Minister <p>4. Vaccine logistics management:</p> <ul style="list-style-type: none"> • Build capacity of cold chain technicians and health facility staff • Complete the inventory of CCE and deploy new CCE as per need <p>5. Service Delivery: Develop health facility and district micro plans before start of each FY and implement and monitor the plans</p> <p>6. Demand Creation and Social Mobilization: Strengthen engagement of communities in planning, implementation and monitoring of the program</p>
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5.1. Requests to Gavi's High Level Review Panel

<p>Grant Renewals</p> <p>New and underused vaccine support</p> <ul style="list-style-type: none"> • <i>Extension of Pentavalent vaccine in the existing presentation</i> • <i>Renewal of PCV vaccine in the existing presentation</i> • <i>Renewal of IPV vaccine in the existing presentation</i> <p>Health systems strengthening support</p> <ul style="list-style-type: none"> • <i>No request</i>
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5.2. Brief description of joint appraisal process

<p>A joint appraisal was conducted in Lesotho from 10-14 August 2015. Preparations were started for the mission from June 2015, starting with country's agreement to have the joint appraisal and dates for the appraisal. A desk review was conducted of various documents such as APR, cMYP, EPI comprehensive review etc. The in-country joint mission was held from 10-14 Aug 15 by a team comprising of Dr Karan Singh Sagar from Gavi Secretariat, Dr Amos Petu from WHO IST and Deepa R Pokharel from UNICEF ESARO. The team was supported by EPI/MoH and by WHO and UNICEF in-country offices. The team met stakeholders from ICC, EPI, MoH, Planning and Statistics, Project Account Unit, Ministry of Finance, CHAL, Red cross and procurement unit and discussed about the program performance, challenges and way forward. The team also visited 2 health facilities to observe program implementation. The report was prepared jointly with inputs from WHO, UNICEF regional & country offices. The findings of the joint appraisal were presented to the MoH/ICC on 14th Aug 2015.</p>

2. COUNTRY CONTEXT

(MAXIMUM 1-2 PAGES)

2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants.

<p>Background</p> <p>Lesotho is a small, land-locked country completely surrounded by South Africa. Its population is estimated at 2.2 million out of which 51% are females. Twenty three percent (23%) of the population lives in urban areas and the rest live in rural and remote mountainous areas. The country is divided into 10 districts. The four largest districts of Maseru, Leribe, Berea and</p>
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Mafeteng which have 62.2% of Lesotho's population. The annual birth cohort was estimated to be 53,801 in 2014 (surviving infants 52,157).

There are 372 health facilities in Lesotho: 1 referral hospital, 2 specialty hospitals, 18 district hospitals, 3 filter clinics, 188 health centers, 48 private surgeries, 66 nurse clinics and 46 pharmacies. All filter clinics are public facilities, while all nurse clinics and pharmacies are private. In total there are 216 health facilities in the country out of which, 79 of health facilities are owned and managed by CHAL and 4 by Lesotho Red Cross Society and rest by MoH.

Leadership & Governance

The ICC was established in Lesotho in 1996. It is a standalone committee chaired by the Minister of Health. Membership of this committee is drawn from the Ministry of Health, Maseru City Council, Rotary Club International, WHO, UNICEF, Lesotho Red Cross, Ministry of finance, National Polio Expert Committee (NPEC) chairperson and Bureau of statistics and CHAL. Most of the Departments from MoH are represented in this committee including PHC and Family Health Division which houses EPI program. The committee met 5 times in 2014 but the meetings were mostly to endorse Gavi related business (APR, proposals etc.), EPI program performance was also discussed in the meetings but no action emerged on how to remove the weakness in the program implementation. The meeting is usually chaired by the Director Primary Health Care; partners are represented by the technical officers and the decisions of the meetings don't seem to carry weight, as evidenced by weak follow up of decisions and delays in program implementation (vaccine launches or implementation of HSS project).

A NITAG has not yet been established in the country. The country needs to assess the requirements of the NITAG and decide if they have the right expertise to form the NITAG. The National Strategic Development Plan (2011/12-2015/16) is an overarching document that guides the implementation of development interventions. In 2012, the MoH also developed the Lesotho Health Policy. The Comprehensive Multiyear Plan for immunization (cMYP) is for the period of 2012-2017.

Actions needed

- Revive ICC: ToR, expand membership- include other Development partners like USAID
- Minister of Health has to lead in ICC
- Continue to hold regular meetings on quarterly basis
- Guide & monitor program and not just for specific activities like new applications/APR to GAVI
- Budget issues should be a regular agenda item

Programme Management

The MoH coordinates the provision of health services in Lesotho. It has structures at central, district and community levels. There are altogether 216 health center/hospitals. The central MoH is largely responsible for the development of policies, strategic planning, resource mobilization, supervision, monitoring and evaluation (M&E) and providing a legal framework. The District Medical Officer (DMO) heads the district hospital and reports to MoH Headquarters. The delivery of health services is in the process of being decentralized and decision making authority will be at district level with the District Health Management Team (DHMT) focal person managing health services delivery at health centers and community level.

The national EPI unit is housed within the department of family health led by the Head of Family Health who reports to the Director Primary Health Care. EPI team has staff of 10 including the EPI manager, Surveillance Officer, 2 Logisticians, 2 Data Managers, 2 Cold Chain Technicians, 2 Cold Chain Assistants. Health Education Unit supports the EPI team in social mobilization and communication. It has a focal point dedicated to EPI Programme. The

EPI manager is managing the day to day operations of routine immunization as well as the HSS. This appears to be an overwhelming task and there is an urgent need of additional HR to assist with programme management (1), HSS (1). There is also a need for more delegation of tasks to other members of the team (after building their capacity). There is weak capacity in data management and use at all levels and in vaccine management including regular monitoring of vaccine forecasting, vaccine utilization and stock-outs

The techno-managerial (program management, data, LSCM) capacity of the team needs to be enhanced, through additional TA (HR on long term basis to work on day to day basis to build the capacity of the team)

There are a number of departments that provide support functions to EPI (PAU, Procurement, Planning and Statistics Division, Finance, Monitoring and Evaluation and Health Education Unit. However there is no regular coordination and communication mechanism between the departments and EPI. This has caused prolonged delays in new vaccine introduction and HSS implementation, e.g. PCV was to be introduced in 2013 and was finally introduced in July 2015; HSS first tranche was sent in Nov 14, but no implementation has started till date because the procurement plan is not ready. Training, which constitutes almost 25% of the HSS budget has not been started as there is no detail training plan. The MoH needs to establish a mechanism whereby the EPI and other departments meet on regular basis to review plans, implementation and monitor progress.

EPI team has to acknowledge the need for additional support from the partners.

WHO & UNICEF have been providing the technical assistance in their respective areas, however they can play a more proactive role in supporting EPI unit in planning, implementation and monitoring implementation of the EPI activities and HSS.

Actions needed:

- Put Institutional mechanisms in place for all elements of EPI program i.e. skilled human resource, mentoring mechanism, resources, clear deliverable and accountability mechanism
- Create a platform for coordination with other stakeholders- PAU, Statistics, M&E, HR, HE, Finance, Procurement and partners
- Partners have to be proactive in support to the team

At district level

- Assign EPI focal points at district and HF level
- Prepare detailed annual operational plans
- Resources to be made available and DHMT and held accountable for results
- Prepare & implement micro plans with community engagement (reach every community)- transport and resources needed
- Strengthen supervision: resources, training, tools and accountability

Costing and Financing

The new government is committed to the EPI program and has considered it as one of the priority programs in addition to TB, HIV, Nutrition, Training and Community Engagement. The country has been buying the traditional vaccines through UNICEF and has been meeting the co-financing obligation. In 2014, the country went into default but cleared the payments. The default was due to delay in administrative processes to seek and release the funds. There is a specific line item in the national budget for EPI which covers the procurement of traditional vaccines, co-financing and the operational costs are budgeted under recurrent expenditure.

The country has voluntarily co-financed higher amounts for Penta vaccine. It has introduced HPV vaccine and is now funding it through government resources.

In 2014, the total expenditure on immunization was US\$1,752,404, the Government funded 23.7% (Traditional Vaccines, New and underused Vaccines, Injection supplies and Personnel); Gavi provided 65.4% funds for New and underused Vaccines, Injection supplies; UNICEF about 9.7% and WHO about 1.1%.

Ministry of Finance (MoF) is fully aware and supportive of the needs of EPI program. MoF had allocated 9 million Maloti (US\$ 700,000) for EPI for 2014 and 10 million Maloti (US\$ 779,500) for 2015. There is a projection of 14 million Maloti (US\$ 1.09 million) for 2016-17 and 5 million Maloti for 2017/18, MoH and MoF will review and increase budget to fulfil EPI activities in due course.

With economic growth at 4.9% in 2015 over 4.3% at 2014 and revenue projection of the government, there is fiscal space to accommodate additional requirements for EPI. The MoF is willing to support the needs of the EPI program, provided realistic projections are made and submitted on time

The main challenges faced by MoF while working with MoH include the following:

- MoH doesn't inform and get MoF concurrence to spend donor money- not done for Gavi funds
- Delays in requesting for funds
- Documentation is incomplete and sent at last moment- proper review of the plans doesn't happen.
- Lack of regular communication between the program and MoF
- Budget issues are not discussed at the ICC

Actions needed

- Appropriate budgeting for immunization programme and timely initiation of fund request by MoH to MoF needs to be improved
- Similarly, the MoH would benefit from regular interaction and coordination with MoF to reduce bottlenecks in release of funds for program
- The country is requesting technical assistance for developing financial sustainability strategies, mobilizing funding for immunization and capacity building for engagement with policy makers regarding co-financing issues in particular and immunization financing in general

Immunization Service Delivery

The country introduced Penta vaccine in 2008 and had planned to introduce PCV in 2014. The introduction of the PCV vaccine was delayed due to weak management capacity and other administrative reasons. The vaccine was introduced on 10th July 2015.

The country is in the process of finalizing their resubmission of an application for rota vaccine in Sep 2015.

The IPV introduction was planned for Sep 2015, but due to supply constraints, it may be pushed to 2016.

The administrative coverage remains low and service delivery in many remote areas is erratic. Even within Maseru, the EPI coverage is seen to be low and there is lack of capacity of the health centres staff to analyse challenges and barriers and derive solutions. Micro-plans are not available for majority of health facilities. Outreach services are compromised due to lack of transportation. Supervision and monitoring is seen to be weak at both national as well as district and facility level.

The key constraints that the health sector including EPI faces in Lesotho include difficult terrain and hard to reach areas; shortage of human resource especially in hard to reach areas; lack of managerial and supervisory skills at many levels; shortage of equipment and infrastructure; shortage of transport, poor data management and use; as well as weak social mobilization and demand creation interventions. Donor partners like Global fund, MCA, PEPFAR, Ireland aid are supporting the country to overcome some of these challenges. GAVI will be supporting EPI related challenges through the HSS funding.

Actions needed:

- The country needs to develop coverage improvement plans to reach the unreached/missed and decrease the drop outs, strengthen program management at all levels, improve the capacities of managers and health workers to manage & use data for action. Community engagement and involvement in EPI programme planning, implementation and monitoring also needs to be strengthened.

Cold Chain and Logistics management

There is adequate cold chain capacity at national and district level (until 2020) and vaccines are well stored following the FEFO/FIFO standard. While Stock Management Tool is used, there is inadequate capacity to analyze and use the data for planning and monitoring. Given the number and cost of vaccines the country is planning to introduce, there is urgent need to strengthen the capacity at central level in the analysis and vaccine stock management. WHO has engaged and deployed a logistician at central unit as a temporary support. This support needs to be continued until the time the position can be absorbed by government.

Preventive maintenance is not functioning well- there are no plans/resources (spare parts/tool kits), transport is not available on time, break down and down time are not monitored etc. The last cold chain inventory was done in 2012, following which the government has procured 113 cold chain equipment all of which have been deployed in the health facilities by Aug 2015.

Vaccine delivery is done using the push mechanism. The national level makes annual forecasts for vaccines and logistics but there is no such mechanism at the districts and health facilities. The stock registers are used but the data is not analysed and used. As per the decision letters of 2014, the country was supposed to receive 202300 doses of Penta and 117300 doses of PCV. The actual receipt was 148050 doses of Penta and 117000 doses of PCV. In 2014 a total of 13,660 doses of Penta cannot be accounted for, the MoH took initiative and requested technical support from UNICEF and WHO hence engagement of logistics assistant to address identified gaps.

During the monitoring visit by Gavi in May 2015, it was observed that in the facilities visited there were stock outs of vaccines, and yet facilities were not proactive enough to collect vaccines from the district store, where vaccine was available (Pentavalent), on the other hand districts were not monitoring vaccine distribution. The vaccine wastage is not monitored at district or health facility level.

In general there are serious capacity gaps in cold chain maintenance, vaccine and logistics management at all levels.

The country conducted the EVM in Dec 2014 and the main findings were:

- Management of vaccines at the National Vaccines Store has improved across categories between 2011 and 2014, and many criteria are now satisfactory. However there remain areas for operational improvements.

- District Vaccine Stores have also improved in the time frame, but there are no criteria or categories where they have reached a satisfactory level of performance on average.
- Health facilities sampled achieved worse results in most areas. There was no evidence of significant improvement at this level, and this level must focus in improving EVM.

The EVM improvement plan has been developed but will need to be costed, implemented and monitored closely with support from the partners.

Actions needed:

- Comprehensive and systematic approach to CCM and LSCM is needed
- Implementation of the recommendations from the EVM in a timely manner
- Expansion of cold chain capacity in health facilities for smooth introduction of the upcoming new vaccines in the country.
- Strengthening of vaccine information systems at all levels.
- Capacity building of staff on CC maintenance and vaccine/logistics management at all levels
- Update of inventory at all levels and installation of procured equipment
- Plans for Preventive maintenance should be drawn and implemented
- Procurement of tool kit and fast moving spare parts
- Liaison with WHO to send CCTechnicians for training

Data management

The annual birth cohort of the country was 53,801 in 2014 (surviving infants 52,157). The country uses the denominators given by the bureau of statistics (based on the projections made last census of 2006). However the districts and health facility insist that the targets given are higher than the head counts available through the village health workers. This creates a discrepancy in coverage data. The administrative coverage is lower than that reported through coverage surveys such as EPI coverage survey (2013) and Demographic Health Survey (2014)

The last EPI coverage survey conducted in 2013 pegged the national Penta 3 coverage at 95% while the admin coverage for 2014 was 69%

		BCG	OPV3	Penta 3	MCV 1
JRF 2012	Target (%)	75	75	75	70
	Achievement (%)	68	66	67	60
JRF 2013	Target (%)	75	75	77	75
	Achievement (%)	65	66	66	61
JRF 2014	Target (%) 2014	80	80	86	80
	Achievement 2014 (%)	51	67	69	59
CES 2013	Coverage based on card and recall %	87	93.5	95	92

The health facilities submit paper based reports to the national level on monthly basis. In 2014, 100% of the facilities submitted the report (97% in 2013) and 93% reports were received on time (61% in 2013). The national level is supposed to analyse the data and share feedback with the districts. But due to lack of capacity in data triangulation and analysis, the use of data for planning, and monitoring is lacking.

The data analysis tools like EPI Info and SMT are available and the data manager and logistician have been trained in the use, but due to lack of confidence not using the tools appropriately to do data analysis and provide good feedback to the districts or health facilities.

There is no structured mechanism for the EPI unit and the department of planning and statistics to have regular coordination meetings. Lack of human resource in the Department is a hindering factor for the more integrated approach to data management. DHMT hold quarterly meetings where they review district performance using administrative data. Performance is also assessed annually at national level during joint reviews. There is limited use of data at health facility level. There is an urgent need to strengthen the data management capacity at national as well as sub-national level. Use of data to improve the programme needs to be prioritized.

The country has started the roll out of DHIS2, DHIS2 is being updated to capture all the required information on EPI and with the use of DHIS2 there will be no duplication of information. Financial data, stock information, vaccine receipt information submitted in the APR in May was incorrect and country submitted revised information in Sep 2015. It is important that the top management (government and partners) validates the information in APR before signing off on it.

Actions needed:

- Prepare and implement data quality improvement plan
- Promote use of data for action at local levels (feedback and feed forward)
- Urgently work to enhance capacity of data clerks/PHN/ DHMT for use of data for action
- M&E team needs to work with EPI to overcome general systemic weakness
- Monitoring visits by data managers after their capacity building
- Validate reports (APR) before signing off
- NEED TO INCULCATE A CULTURE FOR USE OF DATA FOR ACTION

Supervision and Monitoring

It has also been observed that facilities operational plans exist, however supervision is not regular due to other priorities and unavailability of transport. In 2014 the EPI manager did not visit any district for supportive supervision. The Data manager and Surveillance officer visited 5 out of 10 districts and the logistician visited 4 districts. However, they didn't use the supervision checklist and no follow up on the recommendations was done. There is an urgent need to use the existing institutional mechanisms for supportive supervision for EPI. Follow up & accountability mechanisms need to be established at all levels.

The national program conducted 2 reviews with district public health nurses at Maseru in 2014 (no such review has been done in 2015).

Actions needed:

- There is an urgent need to use the institutional mechanism for supportive supervision for EPI and strengthen it.
- Follow up & accountability mechanisms need to be established at all levels.
- The oversight and monitoring of EPI from senior management of the ministry needs to be strengthened

VPD and AEFI surveillance

There is an integrated disease surveillance and reporting system in place, which captures information on vaccine preventable diseases (AFP, Measles, NNT, Rota and PBM). However, the EPI receives parallel reports from the districts. The data in the 2 systems is usually not matching and there is no mechanism for data harmonization. For e.g. the number of suspected measles cases reported by IDSR was 669 in 2014 and EPI reported 527 cases in the same period.

There were 527 suspected cases of measles in 2014, none tested positive for IgM (296 were positive for rubella).

The AFP surveillance system is supported by WHO and has been able to maintain good surveillance indicators (Non Polio AFP rate of 3.8 in 2014 and stool adequacy rate of 100%) The country also has sentinel surveillance for rotavirus and PBM. In 2014, 43% of diarrhea cases tested positive for rotavirus and 13% of suspected meningitis proved to be due to Pneumonia.

There is no AEFI surveillance system in the country. There is no national regulatory authority in the country

Actions Needed

- Build the capacity of national and health facility staff on VPD and AEFI surveillance.
- Monitor Performance of staff
- Harmonize data in the 2 systems (IDRS and EPI)
- Establish AEFI surveillance system (SOPs, trainings, AEFI committee etc.)
- Partners to provide TA.

Demand generation and communication

The Health Education division within the MoH is responsible for social mobilization and communication activities for health related programmes. There is a communication focal point for EPI within the Health Education division. There are no district health promotion officers in place and health assistants are requested to assist in health promotion issues. They have other priorities related to their jobs and have inadequate knowledge and skills to conduct social mobilization and communication activities. Health Education Unit is usually not involved in the EPI planning phase such as in development of cMYP or in EPI annual plans. Support is provided on ad-hoc basis, mainly during campaigns or for new vaccine introduction-largely when IEC material is needed. Community engagement and involvement needs to be strengthened to improve demand for and utilization of existing EPI services. The health education activities are dependent on the existing health staff in the facilities and are often not conducted due to other priorities. Till date no social data is available to inform the social mobilization and communication plans and strategies. There is an urgent need to conduct a KAP survey to establish evidence on social mobilization and communication as well as to measure the effectiveness of the interventions.

The country developed a national social mobilization and communication plan with assistance from UNICEF in July 2015. It needs to be finalized and endorsed by the MoH.

Actions needed:

- Community engagement and involvement needs to be strengthened to improve demand for and utilization of existing EPI services.
- There is an urgent need to conduct a KAP survey to establish evidence on social mobilization and communication as well as to measure the effectiveness of the interventions.

CSO engagement in EPI

CHAL and Lesotho Red Cross Society are working with the support from government and other partners and running health centres in the country. CHAL runs 71 health centres, 8 hospital and 4 nursing schools. LRCS runs 4 health centres. They also conduct Social mobilization & Health Education to promote routine immunization&during campaigns. They are members of the ICC and part of the HSS project as implementers.

2013 CES& DHS 2014 findings

- According to 2013 EPI coverage survey national DTP3 (by card) was 81.46%, DHS 85.5%, measles EPI coverage: (by card) 80.2% and 90% from DHS.
- As reported in the 2014 JRF (Routine admin data) national DTP3 is 69% and measles 58%
- Based on DHS 2014 report, 2 out of 10 districts have DTP3 coverage below 80% while administrative coverage indicates 8 out of 10 of districts attaining below 80% DTP3 coverage
- No gender barriers to access of immunizations services
- Using the indicator, children who have received all basic vaccinations (DHS 2014) there are geographic and socio economic barriers for access to immunizations within districts.

Strengths of Immunization Programme in Lesotho Based on Survey Results

- High immunization coverage rates in districts for all individual antigens evidenced by card+history source: 87 -97% nationally.
- According to the survey results all the districts in Lesotho are managing to reach the WHO African Regional Office target of 90% coverage for DPT3 based on card+history criteria.
- The survey registered a very high level of overall child immunization card retention rate (92%) nationally which constitutes a reliable source to determine immunization status of the child for many years to come.

Challenges of Immunization Programme in Lesotho Based on Survey Results

- In some districts very low coverage rates measured by “By card” for all EPI vaccines are of great concern (Maseru and Berea). Especially Maseru coverage rate of less 50% for all the antigens.
- Substantial discrepancy exists between immunization coverage rates measured by “Card+history” and “By card” in Maseru and Berea districts.
- The survey demonstrated some inconsistencies between administrative and survey coverage rates (by card plus history) regarding DPT3, OPV3 and measles vaccine- which indicates a likely evidence of a not so efficient reporting system.
- One of the prominent gaps was found to be the low immunization coverage for measles in some districts measured by “Card” (three districts had <80% coverage; among them Maseru had <50%, Berea 74.1% and Butha Buthe with 78.8%. It is to be mentioned that the low coverage of measles immunization leaves huge pools of target children unprotected to this vicious infection.
- As for children missing immunization, 24% was due to lack of information, 13% was due to lack of motivation and 63% due to other obstacles. Some of the reasons mentioned were: Unaware of the need to vaccinate (9%), vaccine not available (9.4%), postponed until another time (10.1%) and mother too busy (24.7%) etc. (EPI coverage survey 2013). There are also other identified obstacles for immunization failure were related to health service provision and management at immunization sites (lack of vaccines, absence of the vaccinator, inconvenient time for immunization sessions, etc.).
- Use of outreach services and private sector as a source for immunization is very small creating a lot of missed opportunities for immunization.

Political Changes

The country experienced political instability since Aug 2014 till April 2015. After fresh elections

in Feb 2015, a new government was formed in Apr/May 2015. This has also caused delays in program implementation across the Ministry of Health including EPI.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

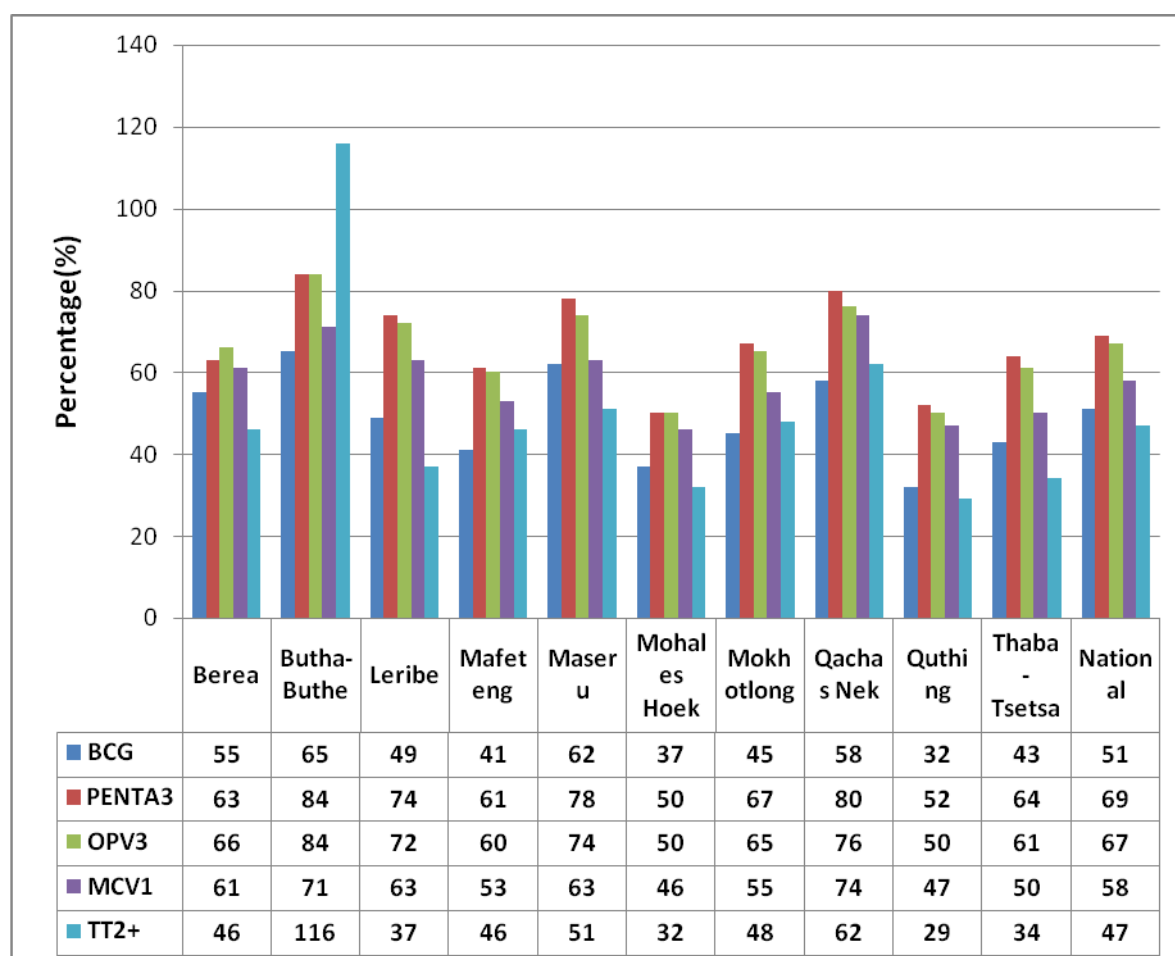
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3.1. New and underused vaccine support

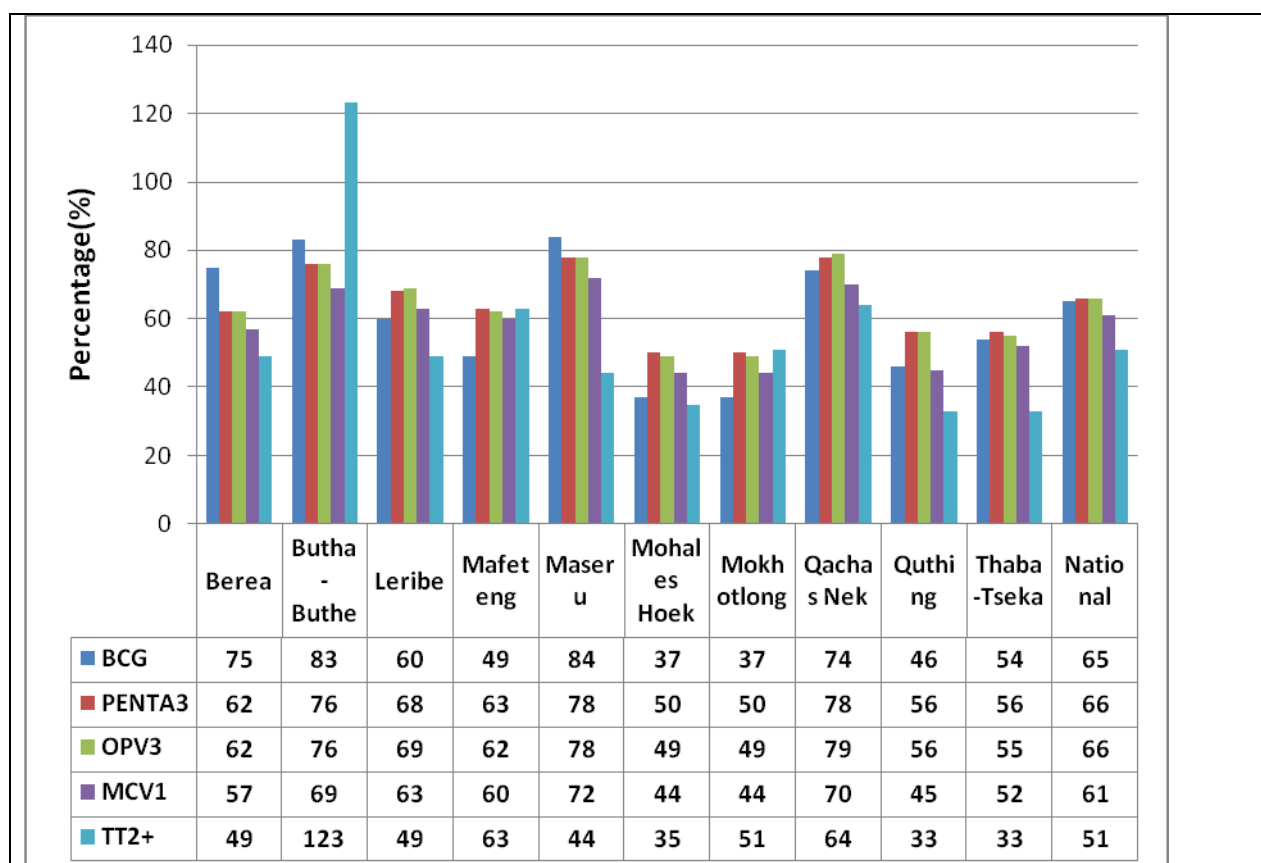
3.1.1. Grant performance and challenges

Lesotho with support from Gavi, introduced pentavalent vaccine in fully liquid, single dose vial throughout the country on the 1st of December 2008. It is administered at 6, 10 and 14 weeks. A Post Introduction Evaluation was conducted in December 2010. The administrative coverage for 2013 and 2014 is shown in graphs below. There is a wide inter district variation. For e.g. the Penta 3 coverage in 2013 varied from 50-84% and similarly from 50-78% in 2014.

District wise coverage in 2013



District wise coverage for 2014



Unvaccinated children with pentavalent vaccine ranged from 400 to as high as 2860 children in 2014 with Maseru, Berea, Mohales Hoek and Leribe being the districts with highest number of unvaccinated children in 2014. The general coverage for Penta-3 declined from 73% in 2010 to 66% in 2013. 2014 has witnessed an upward swing in coverage to 69%. Till, June 2015 the Penta 3 coverage is at 69%. This upward trend is expected to continue in 2015 and 2016

Government was able to get the Vaccine Introduction Grant (VIG) from Gavi to introduce PCV in 2014. Although the decision letter was sent in Oct 2013, preparation for introduction suffered some challenges leading to eventual launch of the vaccine in July 2015. The VIG was not spent in 2014. The challenges and suggested action for the grant performance have been detailed in the country context section.

3.1.2. NVS renewal request / Future plans and priorities

- The country is requesting extension of Penta vaccine in the existing presentation. As mentioned above the coverage for 2014 was 69% and it expects to achieve coverage of 70% in 2015 and the target for 2016 is 75% which, seems to be achievable if the recommended actions of the JA are implemented.
- The country is requesting renewal for PCV vaccine in the existing presentation: the vaccine has been introduced now, and it is expected that it can achieve the same coverage as Penta in 2016 if the recommended actions of the JA are implemented.
- IPV- introduction is planned for 2015 but may be postponed to 2016 depending on the availability of vaccines
- Delayed procurement and release of finances to EPI unit may affect introduction of IPV and achievement of targets for PCV
- Expected new applications are for Rotavirus in Sep 2015 and Rubella and Measles campaign in 2016

The JA has identified several systemic weaknesses (as mentioned above) in the EPI program. If these are not ameliorated then the program will not be able to meet the objectives.

Actions needed:

- Prepare and implement plans to avoid delays in introduction of vaccine
- Prepare good quality applications with complete documentation
- Respond to IRC clarifications in time
- Partners to provide quality TA
- Top management to monitor the application, introduction and post introduction process
- Complete PIE in time and use findings for improvement of EPI program

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

GoL applied for Gavi support to resolve the health systems challenges to increased immunization coverage and sustainability. The approved budget of \$2,707,134 is to cover a period of 4 years (2014 - 2017). Broadly the HSS grant is to support and strengthen cold chain and associated logistics by making available requisite equipment and infrastructure; improve health sector capacity of providing vaccination and other MCH services by equipping health workers with requisite skills and knowledge; strengthen MCH interventions aimed at reaching hard to reach populations in Lesotho; and contribute to strengthening monitoring and evaluation of EPI performance. The first tranche of funds for 2014 total of US\$ 791,168 had been disbursed to the country in Nov 2014. Implementation of activities under the grant has not commenced due to a number of challenges including the delay to develop a procurement plan.

The challenges identified above needs to be addressed in order to get the HSS project running and to bring it on track.

The corrective actions needed are as follows

- **Start implementation immediately- otherwise there is a risk of losing the support**
- Depute/deploy a HSS coordinator to manage (planning, implementation and monitoring) of the HSS grant
- Constitute a technical core group (EPI, Planning, HSS, PAU, WHO, Unicef, CHAL, LRCS) to oversee implementation, bottlenecks and advice on way forward
- Prepare annual work plan and procurement plans and have these be endorsed by ICC
- Prioritize activities based on needs and use of data.
- Hire consultants for specific TA needs (cold chain and data) on performance based contracts
- Project Accounting Unit (PAU) to prepare activity budget execution and submit to Gavi on quarterly basis
- If the implementation is delayed by over 6 months then explore alternate implementation mechanism- WHO and Unicef or CHAL (Collective management)
- ICC chaired by Minister of Health should monitor implementation on quarterly basis

3.2.2. Strategic focus of HSS grant

HSS grant focus is relevant and will address access and equity concerns.

3.2.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

No new request

3.3. Graduation plan implementation (if relevant)

NA

3.4. Financial management of all cash grants

The MoH manages the funding through a Project Accounting Unit. The mandate of the PAU is to oversee implementation of donor projects including Gavi. The Unit has a Gavi focal point.

The country proposed to employ a separate accountant for managing the GAVI funds, who will also be involved in all accounting work in the Unit including the production of financial reports. He or she will be the focal person for issues to do with GAVI funds. The account at the commercial bank has been opened. The authorisation of any expenditure on this project will be done by the Director of Planning and Statistics and the Head of Family Health Division. Once the payments have been authorized, they will be sent to PAU for payments. None of the members of the PAU is a signatory on the account: signatories on this account, as is the case with all other MoH accounts, are senior officials in the MoH namely the Principal Secretary, the Director General, The Director of Planning and Statistics, the Director of PHC and Director of Finance. The PAU will be accountable for all the funds. In accordance with financial regulations in the GoL Gavi will be provided a financial report at the end of the financial year. In addition to providing this to GAVI there will also be a consolidated financial report covering all the funds handled by the PAU.

The Auditor General of the GoL shall arrange the auditing of the GAVI funds and normally this exercise is done by private auditors hired by the Auditor General.

In terms of procurement the Procurement Unit handles all the procurement activities in the MoH following established governments rules and regulations. GoL has introduced the position of Finance Managers who will be responsible for managing these funds.

Some of the challenges mentioned by the PAU and EPI program include

- Delay in implementation of the FMA and PFA recommendations
- The procurement procedures can take up to 6 months or more for any procurement exceeding 100,000 Maloti's. This can lead to delays in program implementation. Late requests from EPI exacerbates these delays.
- There is little support to EPI on procurement related issues, which may require

<p>technical knowledge in other areas than EPI (e.g. specifications of equipment's or buildings)</p> <p>Action needed</p> <ul style="list-style-type: none"> • PAU to provide support to EPI on technical issues other than EPI • PAU should monitor activity wise fund execution, • EPI program needs to prepare plans well in advance for any procurement • District Accounts departments need to be strengthened to keep proper records of activities & budget execution.
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3.5. Recommended actions

Actions	Responsibility (government, WHO, UNICEF, civil society organizations, other partners, Gavi Secretariat)	Timeline	Potential financial resources needed and source(s) of funding
<p>HSS:</p> <ul style="list-style-type: none"> • Depute/deploy a HSS coordinator to manage (planning, implementation and monitoring) of the HSS grant • Annual work plan and Procurement plans need to be prepared and to be endorsed by ICC • ICC chaired by minister of health should monitor implementation on quarterly basis 	<p>Government ICC</p>	<p>Immediate</p>	<p>HSS</p>
<p>Capacity Building of staff on Program Planning, implementation in all areas and monitoring (use of data for action)</p>	<p>Government WHO, Unicef, CHAL, LRCS</p>	<p>As planned in HSS</p>	<p>HSS</p>
<p>Governance and Oversight Mechanism</p> <ul style="list-style-type: none"> • Strengthen ICC • Strengthen monitoring and supervision mechanisms using institutional mechanisms at all levels • Create indicator dashboard to monitor implementation of EPI and HSS at the office of minister 	<p>Government WHO, Unicef, CHAL, LRCS</p>		<p>Partly through HSS</p>

<p>Vaccine Logistics Management</p> <ul style="list-style-type: none"> • Build capacity of cold chain technicians and health facility staff • Complete the inventory of CCE and deploy new CCE as per need 	<p>Government WHO, Unicef</p>		<p>Government HSS WHO Unicef</p>
<p>Service Delivery</p> <ul style="list-style-type: none"> • Get HF and District micro plan before start of each FY • Implement and monitor microplans 	<p>Government WHO, Unicef</p>		
<p>Demand Creation and Social Mobilization:</p> <ul style="list-style-type: none"> • Conduct a KAP survey to establish evidence • Engage communities in planning, implementation and monitoring of the program • Implement the social mobilization and communication plan 	<p>Government Unicef, CHAL, LRCS</p>		

4. TECHNICAL ASSISTANCE

(MAXIMUM 1 PAGE)

4.1 Current areas of activities and agency responsibilities

WHO, UNICEF, CHAL and LRCS are the main partners supporting the EPI unit, Ministry of Health on immunization programme in Lesotho. Support in 2014 included technical and financial support for planning, vaccine management, social mobilization and communication and logistics. Specific support included:

- WHO provided technical assistance in effective vaccine management
- UNICEF provided technical assistance in communication – social mobilization mainly to prepare the plans and communication material for the PCV introduction which was supposed to be introduced in 2014.
- Technical Assistance in forecasting and procurement of vaccines
- WHO provided TA through a dedicated person based in EPI unit to support on logistics
- WHO and UNICEF provided technical support to develop IPV proposal which has been approved by GAVI
- Technical support was also provided by CHAL and LRCS to implement the EPI activities through their respective health centers.

4.2 Future needs

- Technical assistance to support the EPI Manager on programme management
- Technical assistance on training EPI staff at all levels to develop both district and facility level microplans
- Technical assistance in data management and use
- Technical assistance for effective vaccine management including training of cold chain assistants at all levels

- Technical assistance to conduct KAP survey to establish evidence for social mobilization and communication
- Technical assistance to support implementation of social mobilization and communication interventions including those planned in HSS
- Technical assistance for introduction of new vaccines: WHO (planning, training) and UNICEF (social mobilization and communication, IPC training for HWs)
- Technical Assistance in forecasting and procurement of vaccines -UNICEF

5. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT & ADDITIONAL COMMENTS

(MAX. 1 PAGE)

<p>The JA team presented the findings of the mission to the ICC on 14th Aug. The ICC was headed by the minister of health. The report was well received and the country agreed to form a task group to look into the recommendations and draft a work plan to address the issues.</p>
<p>Issues raised during debrief of joint appraisal findings to national coordination mechanism:</p>
<p>Any additional comments from</p> <ul style="list-style-type: none"> • Ministry of Health: • Partners: • Gavi Senior Country Manager:

6. ANNEXES

[Please include the following Annexes when submitting the report, and any others as necessary]

- **Annex A. Key data** (this will be provided by the Gavi Secretariat)
- **Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
<p>Develop coverage improvement plan at all levels using data and evidence</p> <ul style="list-style-type: none"> - Set realistic targets for all vaccines. - Strengthen the management of transport in the MoH especially for EPI to undertake regular outreach services - The programme should target those areas with high numbers on un-immunized children and move from RED to REC by using CHWs' 	<p>The country targets seem to be realistic Rest of the actions not taken</p>

Data Quality: Give special priority to the development of a data quality improvement plan, as this seems to be an on-going, overriding challenge. The plan should be based on focused group discussions and/or interviews with personnel in health centers and at district prior to any drafting of the plan, be set within a time frame and costed.	Not done
Financial Management : Implement the recommendations of the FMA assessment conducted by GAVI in January 2014	Partly Implemented
EPI Financing and Sustainability: Technical assistance for developing financial sustainability strategies, mobilizing funding for immunization and co-financing	No done

- **Annex C. Description of joint appraisal process** (e.g. team composition, how information was gathered, how discussions were held)
- **Annex D. HSS grant overview**

General information on the HSS grant							
1.1 HSS grant approval date		Sep 2014 (decision letter)					
1.2 Date of reprogramming approved by IRC, if any							
1.3 Total grant amount (US\$)		2,707,135					
1.4 Grant duration		2014-17					
1.5 Implementation year		Not Started					
(US\$ in million)	2014	2015	2016	2017			
1.6 Grant approved as per Decision Letter	791,168	638,665	639,360	637,942			
1.7 Disbursement of tranches	Nov 2014						
1.8 Annual expenditure	Nil						
1.9 Delays in implementation (yes/no), with reasons		Yes					
1.10 Previous HSS grants (duration and amount approved)		No					

1.11 List HSS grant objectives

General Objective: To reduce morbidity and mortality due to vaccine preventable diseases through increasing immunization coverage from 83% to 90% by 2016.

1. To strengthen cold chain and associated logistics by making available requisite equipment and infrastructure: The key activities under this objectives are (1) Procurement of fridges for the immunisation program; (ii) Purchase of fridge tags; (iii) Construction of vaccine storage space at district level; (iv) Purchase of vaccine carriers for the private sector.(v) Purchase of cold boxes for CHAL and the Private sector
2. To improve health sector capacity of providing vaccination, MCH and other health services by equipping health workers with requisite skills and knowledge: The key activities are as follows: (i) Training of cold chain assistants; (ii) Training DHMT, Health Centre staff, Village Health Workers and Community Leaders on RED. (iii) Training DHMT/ health centre staff in vaccine management. (iv) Training Health Centre personnel on planning outreach services.
3. To strengthen MCH interventions aimed at reaching hard to reach populations in Lesotho: The activities under this objective are as follows: (i) Provision of vaccination services in all health facilities using a supermarket approach; (ii) Carrying outreach services for hard to reach areas and under-served populations; (iii) Launching of the mobile immunisation teams in low performing districts; (iv) Construction of health posts ; (v) Purchase 4X4 vehicles for the low performing districts and headquarters; (vi) Provide MCH services (antenatal care, PMTCT, Postnatal care, growth monitoring, health education, Family Planning) in hard to reach areas; and (vii) Supportive supervision at all levels.
4. To contribute to strengthening monitoring and evaluation of health sector interventions: The activities under these objectives are as follows: (i) Training VHW on data collection (ii) Purchase of cell phones for VHW; and (iii) Carrying out DQA (iv) Carrying out the impact assessment of GAVI HSS interventions.

1.12 Amount and scope of reprogramming (if relevant)

- **Annex E. Best practices (OPTIONAL)**

Future TA needs: Prioritization of technical assistance needs

TA need	Justification / Actions	Intended outcome	Modalities	Possible provider	Included in HSS
Technical assistance to support the EPI Manager on programme management	Weak program management at central level leading to delays in planning, implementation, monitoring	Capacity building of national staff in planning, implementation, monitoring of EPI	Long Term TA	WHO/Unicef/ Expanded partner	No
Technical assistance in data management and use	Weak data management and use at all levels	Improved data collection, compilation, analysis and use	Short term TA	WHO	No
Technical assistance for effective vaccine management including training of cold chain assistants at all levels	Weak vaccine and logistics management at all levels	Improved vaccine and logistics management	Long term TA	WHO/Unicef	Partly in HSS
Technical assistance on training EPI staff at all levels to develop both district and facility level microplans	No microplans for EPI exist at any level	Better microplans at all levels	Short term TA/Training	WHO	Use RED training funds from HSS
Technical assistance to conduct KAP survey to establish evidence for social mobilization and communication	No social data available to guide communication plan and strategies	Data on social aspects made available to guide communication strategies	Survey	Unicef	No
Technical assistance for introduction of new vaccines: WHO (planning, training) and UNICEF (social mobilization and communication, IPC training for HWs)	Weak country capacity for planning and implementing, leading to delays in vaccine introduction			WHO/UNICEF	Through VIG

Annex F: Status of DTP-HepB-Hib from 2013 to 2015

Table 1

Ending Balance 2013		
Batch No	Expiry	Doses
137P2025D	Apr-14	3,800
1453208	Apr-16	30,950
1453158	Nov-15	19,650
Total		54,400

This table shows the number of doses of DTP-HepB-Hib which remained in 2013 and the total is **54,400** doses.

Table2

Beginning balance 2014		
Batch No	Expiry	Doses
137P2025D	Apr-14	3,800
1453208	Apr-16	30,950
1453158	Nov-15	19,650
Total		54,400

This table shows number of DTP-HepB-Hib doses at the beginning of 2014.

Table 3

New Arrivals 2014			
Arrival Date	Batch No	Expiry	Doses
10/4/2014	1453251	Aug-16	6,150
20/06/2014	30115D13	Nov-15	9,397
20/06/2014	30116A13	Dec-15	91,703
23/12/2104	30161A14	Jun-16	40,800
Total			148,050

This table shows the total number of doses received in 2014. The total number of doses at the beginning of 2014 (54 400) and doses received (148,050) in the same year is **202,450** doses.

Table 4

Batch No	Doses 2014	Issued 2014	Balance	Opening balance 2015
137P2025D	3,800	3,800	-	-
1453208	30,950	30,950		-
1453158	19,650	41,680	(22,030)	-
1453251	6,150	7,520	(1,370)	-
30115D13	9,397	6,997	2,400	-
30116A13	91,703	56,978	34,728	28,000
30161A14	40,800	-	40,800	36,268

- The table above shows the total doses in 2014 and amounts issued. That is; Batch No 1453208 was issued in 2014 but instead of writing the correct batch, 1453158 was written. The country acknowledges batch numbers mentioned and doses issued which resulted in the excess of 22,030 doses issued from batch no 1453158 instead of batch number 1453208.
- The table further depicts that for batch no 1453251, an excess of 1,370 doses was issued whereas there was only 6,150 doses in stock.
- Ending balance for batch no 30116A13 in 2014 was 34,728 doses and beginning balance in 2015 of the same batch was 28,000. Therefore 6,728 cannot be traced.
- The same applies for batch no 30161A14. Ending balance in 2014 was 40,800 doses and beginning balance in 2015 was 36,268 doses. There are also 4,532 doses which again cannot be traced.
- From batch no 30115D13 there are 2400 doses are also missing.
- This gives a total of 13,660 doses which cannot be traced from 2014.
- Based on the observations above, the Ministry of health took initiative and requested technical support from UNICEF and WHO hence engagement of logistics assistant to address identified gaps

Reasons for not receiving number of Pentavalent doses as originally agreed on the 2014 Decision Letter

- According to the 2014 GAVI Decision Letter on Pentavalent vaccine, Lesotho was to receive a total number of doses of **202,300** Pentavalent vaccine. Contribution by GAVI = 141, 900, and contribution by GOL = 60, 400
- By December 2014, the MOH had received a total of 148,050 Pentavalent doses for 2014 (both as GAVI contribution and GOL contribution)
- The total number of doses brought forward at the beginning of the 2014 was 54, 400
- Total amount for 2014 was therefore **202,450**. This stock was adequate for 2014 as per the target population and the 2014 Decision Letter (as shown in bullet no.1)
- The MOH, through EPI Programme, therefore, instructed UNICEF to defer the remaining shipment to avoid overstock of Pentavalent vaccine for 2014.
- This is also explained under table 3

