Joint Appraisal report 2017

The italic text in this document serves as guidance, it can be deleted when preparing the Joint Appraisal report.

Country	Lesotho
Full Joint Appraisal or Joint Appraisal update	Full Joint Appraisal
Date and location of Joint Appraisal meeting	August 8-10, 2017, UN House, Maseru, Lesotho
Participants / affiliation[1]	See Annex
Reporting period	
Fiscal period[2]	
Comprehensive Multi Year Plan (cMYP) duration	2012-2017

1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

1.1. New and Underused Vaccines Support (NVS) renewal request(s)

Type of support (routine or campaign)	Vaccine	End year of support	Year of requested support	Target (population to be vaccinated)	Indicative amount to be paid by country	Indicative amount to be paid by Gavi

1.2. New and Underused Vaccines Support (NVS) extension request(s)

Type of Support	Vaccine	Starting year	Ending year
Extension	DTP-HEPB-HIB	2018	2022
Extension	ROTAVIRUS	2018	2022
Extension	PCV 13	2018	2022

1.3. Health System Strengthening (HSS) renewal request

Total amount of HSS grant	US$ 2,719,999
Duration of HSS grant (from…to…)	2014-2017
Year / period for which the HSS renewal (next tranche) is requested	2017 - 2018
Amount of HSS renewal request (next tranche)	US$ 1, 585, 507

1.4. Cold Chain Equipment Optimisation Platform (CCEOP) renewal request

Total amount of CCEOP grant	US$

[1] If taking too much space, the list of participants may also be provided as an annex.
[2] If the country reporting period deviates from the fiscal period, please provide a short explanation.

Duration of CCEOP grant (from…to…)		
Year / period for which the CCEOP renewal (next tranche) is requested		
Amount of Gavi CCEOP renewal request	US$	
Country joint investment	**Country resources**	US$
	Partner resources	US$
	Gavi HSS resources[3]	US$

1.5. Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[4]

	Programme	Expected application year	Expected introduction year
Indicative interest to introduce new vaccines or request HSS support from Gavi	HSS NCE	2017	2017
	HPV	2018	2019
	CEF	2018	2018
	PCV Multi-doze vial	2017	2018

CHANGES INCOUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

Background

Lesotho is a small, land-locked country completely surrounded by South Africa. Its population is estimated at 2,003,546 million out of which 51% are females. The country is divided into 10 districts. His Majesty King Letsie III is the Head of State. In 2017, Lesotho had a peaceful change of government when it elected a new Prime Minister Dr. Thomas Motsoahae Thabane. The country continues to battle HIV/AIDS, a significant challenge to the country. National HIV prevalence is at 25%.

There are 372 health facilities in Lesotho: 1 referral hospital, 2 specialist 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 (public and private) providing immunization in the country out of which, 79 health facilities are owned and managed by CHAL and 4 by Lesotho Red Cross Society and rest by MoH.

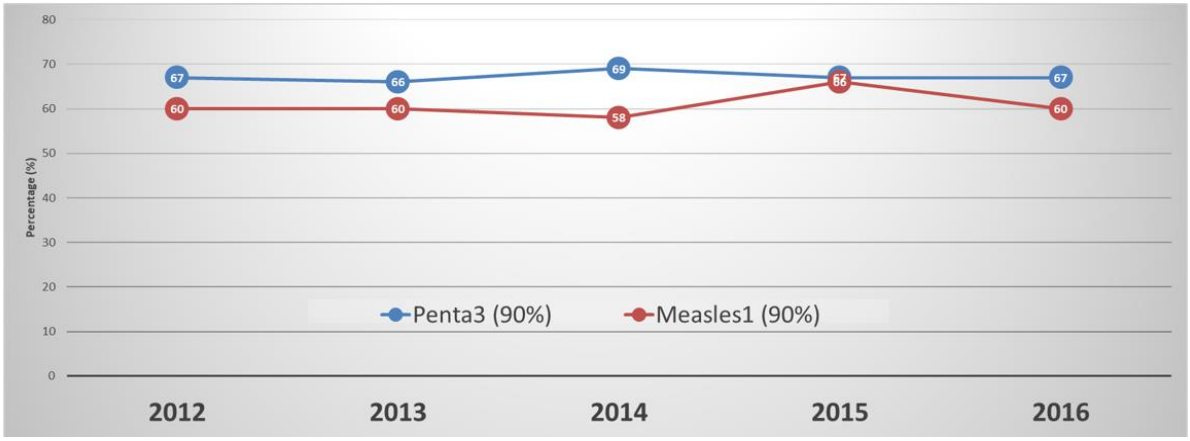
2. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

2.1. Coverage and equity of immunisation

[3] This amount must be included either in an earlier HSS approval or else in the current HSS renewal request in section 1.4 above.
[4] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

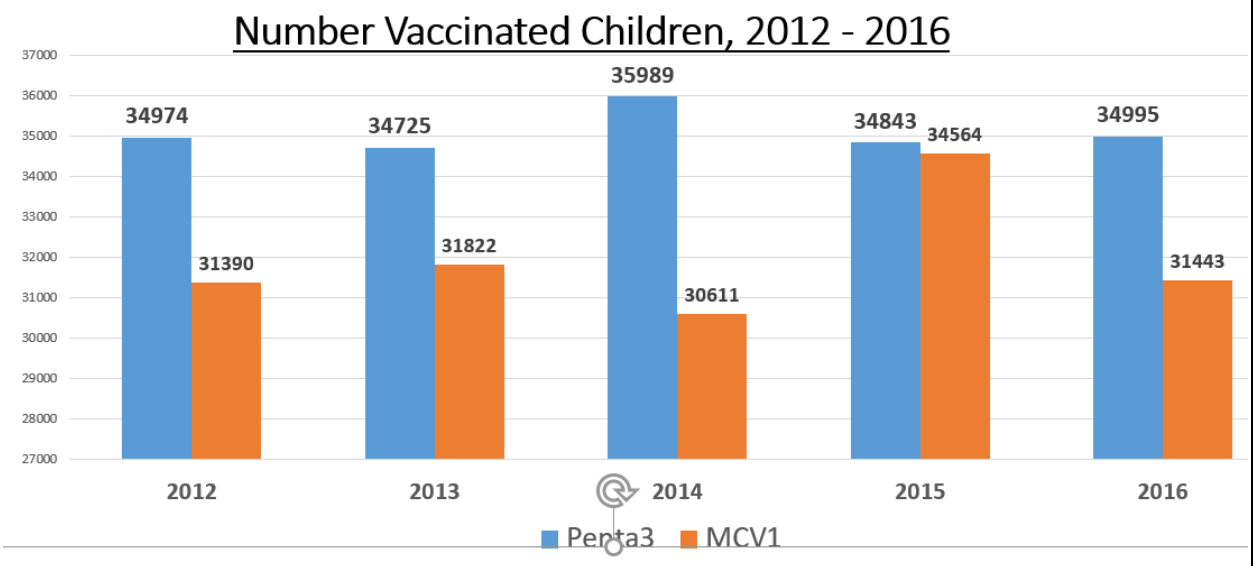
EPI Coverage

According to administrative data, Lesotho's national coverage has stagnated below 70% over the last five years. The graph below shows coverage against Penta3 and MCV1 from 2012-2016.

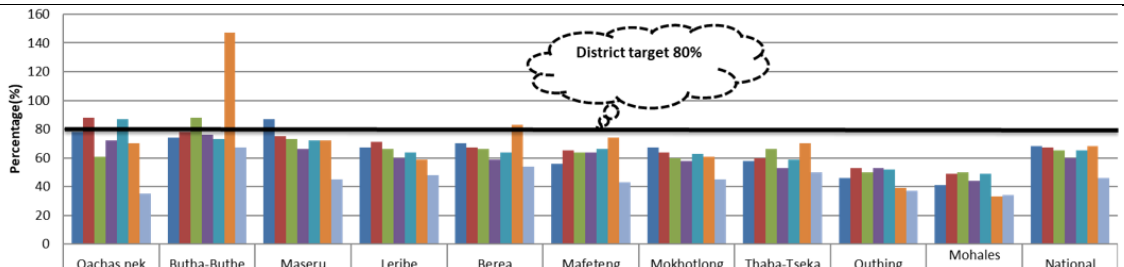


The trend on number of children immunized shows stagnating immunisation coverage despite the positive population growth over this period. Further investigation is needed to interrogate the routine data on immunisation coverage to determine whether the programme is performing weakly or whether data collection, management and use is affecting overall coverage estimates.

The data is demonstrated by the graph below.



While coverage varies by district but it is generally below 80% against all antigens. In addition, the graph below shows disparities among vaccines administered at the same time. MCV1, which is normally a challenging vaccine to achieve high coverage, given that it is administered later, shows a higher performance compared to antigens administered earlier. This may be another indicator of data management challenges.



	Qachas nek	Butha-Buthe	Maseru	Leribe	Berea	Mafeteng	Mokhotlong	Thaba-Tseka	Quthing	Mohales Hoek	National
BCG (80%)	78	74	87	67	70	56	67	58	46	41	68
Penta3 (80%)	88	78	75	71	67	65	64	60	53	49	67
Pneumo3 (80%)	61	88	73	66	66	64	60	66	50	50	65
OPV3 (80%)	72	76	66	60	59	64	58	53	53	44	60
MCV1 (80%)	87	73	72	64	64	66	63	59	52	49	65
TT2+80%	70	147	72	59	83	74	61	70	39	33	68
VITA (80%)	35	67	45	48	54	43	45	50	37	34	46

Looking specifically at Penta3 and MCV1 across districts, only one district, Qacha's Nek has achieved the 80% target against both antigens. It is not immediately evident what factors contributed to the differences in the districts' performance. The country needs to further analyse factors influencing coverage discrepancies across districts. There are planned interventions namely the DQR and Equity Assessment which will provide additional information on possible drivers behind the performance variability.

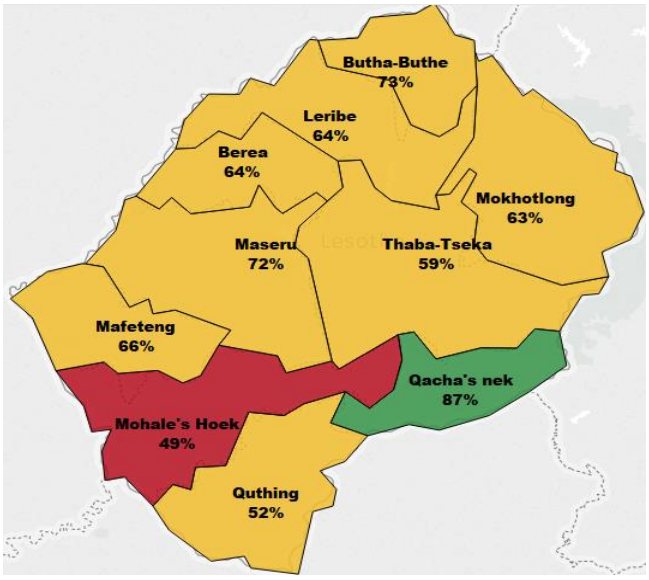


Figure 1: MCV1

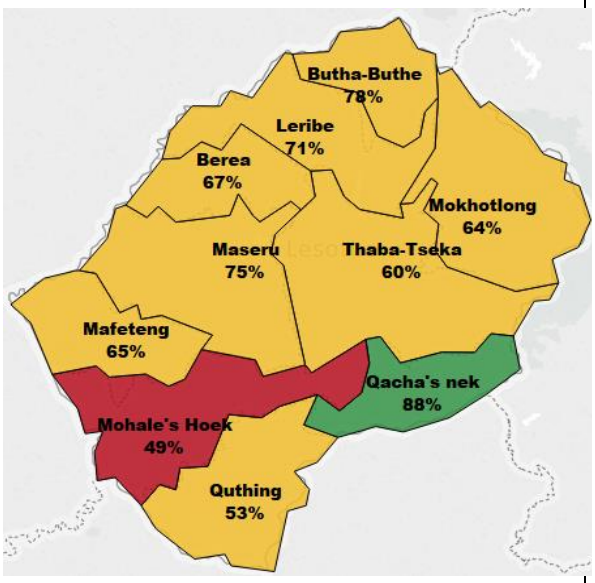
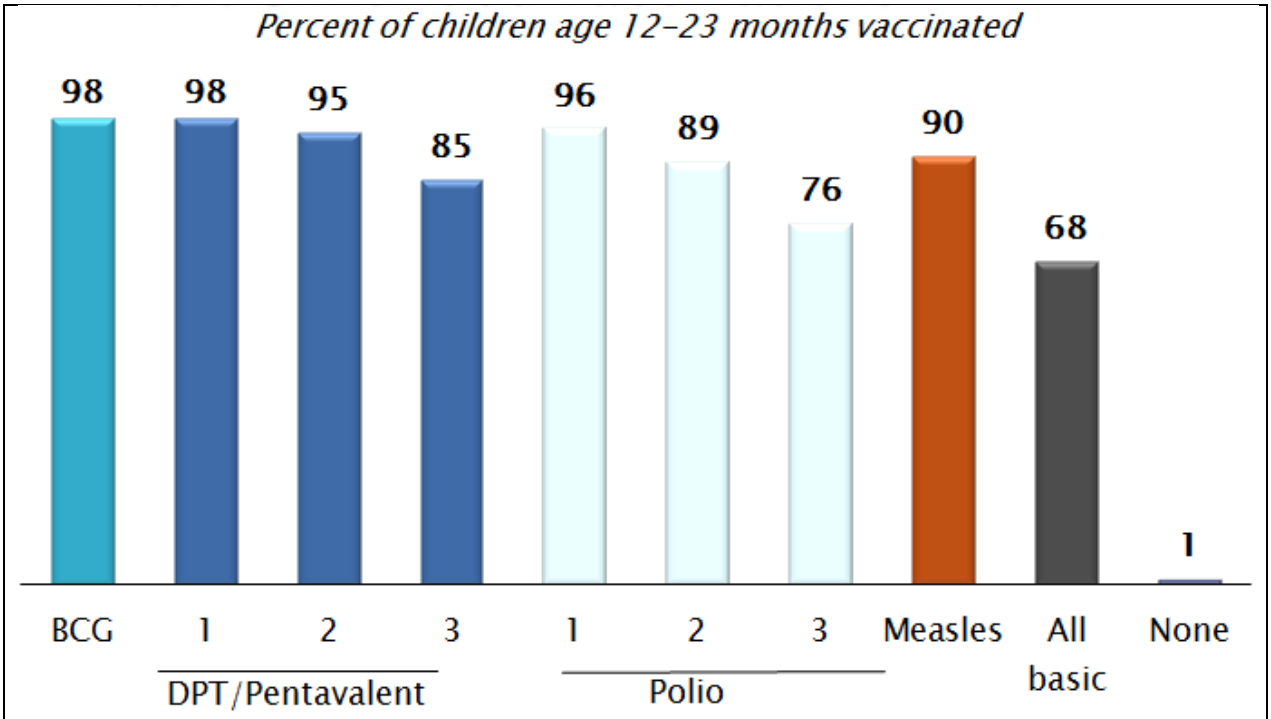


Figure 2 PENTA3

Green: 80+ Yellow: 50-80 Red:<50

The Lesotho DHS 2014 shows a higher coverage against Penta3 and MVC1 when compared to routine data. This highlights again continues that data management is a key challenge. It is expected that implementing the DQIP and using DHIS2 to report EPI data will help address data quality problems. MoH will also collaborate with BoS to examine denominator assumptions in use for the target population.



The program has reported 100% completeness and comprehensiveness in monthly reporting across all the 10 districts in 2016.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Berea	100	100	100	100	100	100	100	100	100	100	100	100
Butha-Buthe	100	100	100	100	100	100	100	100	100	100	100	100
Leribe	100	100	100	100	100	100	100	100	100	100	100	100
Mafeteng	100	100	100	100	100	100	100	100	100	100	100	100
Maseru	100	100	100	100	100	100	100	100	100	100	100	100
Mohales Hoek	100	100	100	100	100	100	100	100	100	100	100	100
Mokhotlong	100	100	100	100	100	100	100	100	100	100	100	100
Qachas nek	100	100	100	100	100	100	100	100	100	100	100	100
Quthing	100	100	100	100	100	100	100	100	100	100	100	100
Thaba-Tseka	100	100	100	100	100	100	100	100	100	100	100	100
National	100	100	100	100	100	100	100	100	100	100	100	100

There is an outstanding issue of late submission of data, which will be addressed by the implementation of DHIS2 where data will be entered into the web system and immediately accessible at all levels.

Equity

Lesotho DHS data from 2009 and 2014 shows no major discrepancies on DPT3 coverage when correlated with key equity related indicators. However, the program has scheduled an in-depth equity analysis to attain a better understanding of equity issues at the sub-nation levels.

- **Key drivers of low coverage/ equity**

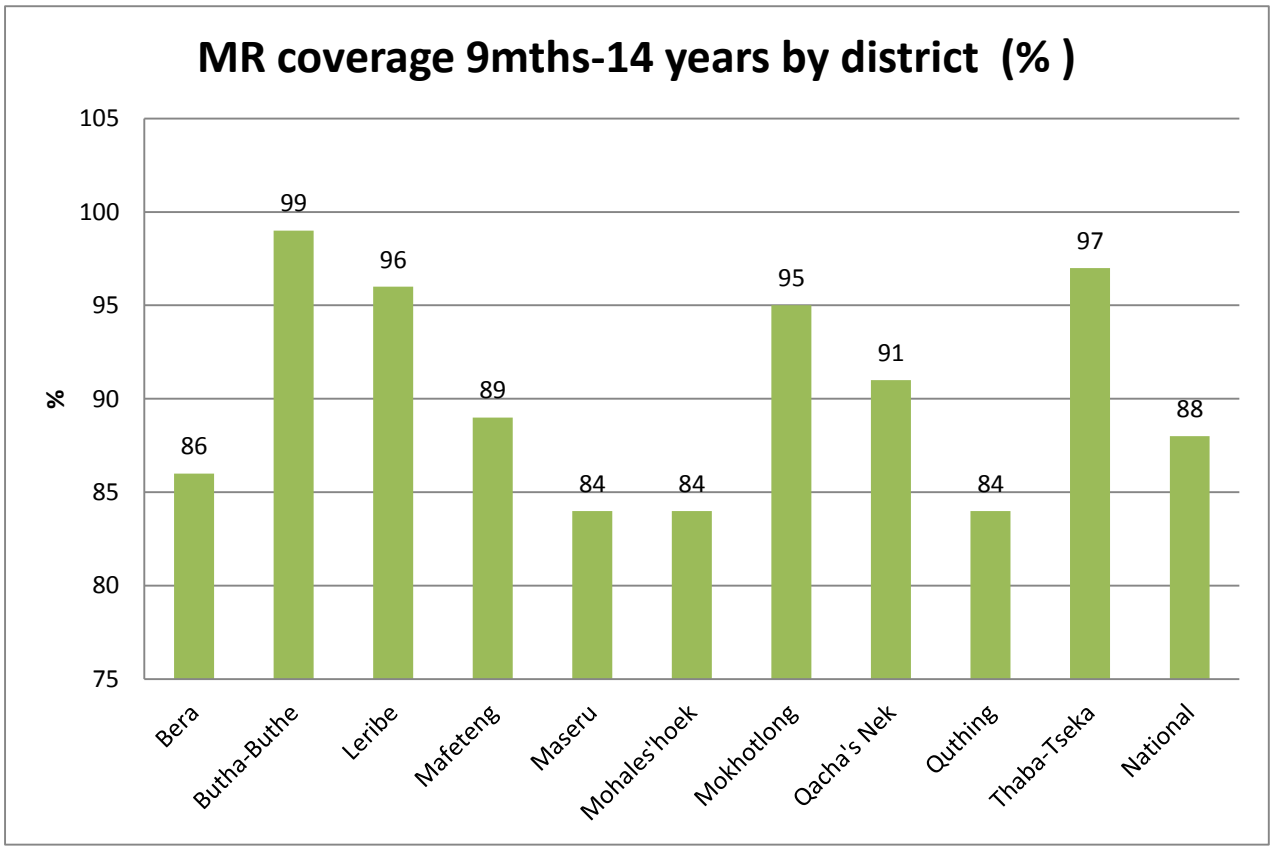
Key Challenges

The evidence base investigating the key drivers of low coverage and equity in immunisation is not as robust as it needs to be. There are strategic interventions identified and proposed through the JA process to help to build this evidence base. However the programme has observed the following:

- **Health Work Force**
  - It is recommended that facilities be staffed with 3 Registered Nurses, 2 Nursing Assistants, and 1 Health Assistant. Some facilities are not adequately staffed, which bring challenges to service delivery. For instance, outreach services and data management are compromised.
  - Most facilities are not staffed with Health Assistants, which compromises health promotion and social mobilization efforts.
- **Demand Generation**
  - There is inadequate health promotion being conducted at Health Facilities and insufficient health promotion materials related to EPI that are currently available.
  - Use of technology, e.g., information screens, at service points to provide health education is limited
  - There is limited use of different social platforms for health promotion, e.g., social media
- **Leadership**
  - Leadership at local level, for instance, health center committees are not adequately informed about EPI priorities and goals.
  - Political leaders, such as members of parliament and councilors are not regularly informed about the performance and challenges encountered by facilities regarding immunization. They are not sufficiently involved in community engagement and mobilization.
- **Management and Coordination**
  - Although there is an improvement, there is still a need to strengthen coordination between EPI and key supporting departments within the Ministry of Health.
  - EPI focal persons have been identified in all districts, but have not been assigned EPI specific responsibilities. For instance, they do not conduct supervision and mentoring services resulting in poor cold chain and vaccine management.
- **Supply Chain**
  - 41% of cold chain equipment is not functioning optimally, a routine maintenance arrangement has not been effectively rolled-out and a large proportion of this equipment will need to be replaced.
  - Frequent artificial stock-outs at district and health facility level are due to transport challenges which result in distribution plan not being adhered to.
  - Districts and health facilities do not conduct vaccine forecasting, therefore are unable to plan based on their needs.
  - Vaccine usage and wastage rates are not calculated by health facility and district level, and this contributes to vaccine stock-outs at the same levels

Overview of the Measles and Rubella campaign

The Ministry of Health (MoH) introduced the measles and rubella (MR) vaccine into the country's immunization routine schedule. For the introduction a campaign, were MR was administered for the first time, was held from 13th February to 28th April 2017. An 86% coverage was achieved nationally. The diagram below indicates performance by district.



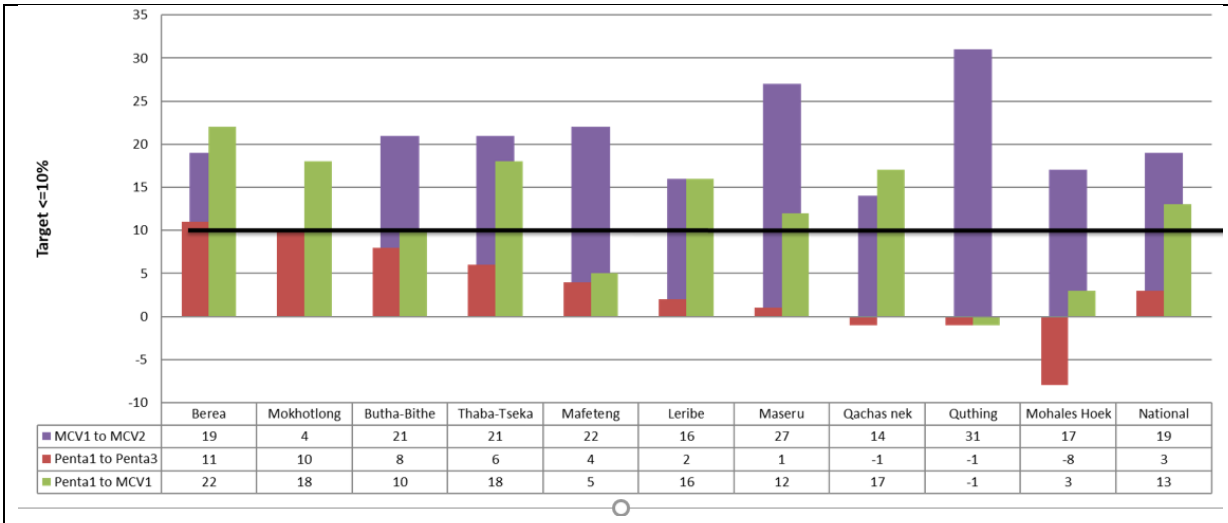
In the midst of the campaign adverse effects following immunization (AEFI) surfaced. To address these rumours MoH engaged in intense social mobilization. High advocacy meetings were held with various NGOs, the Christian Council of Lesotho (CCL), Media Houses, DHMTs, Chiefs, Health Center nurses. In addition, an AEFI committee was established. Although the committee was established following the MR AEFI rumours, it will remain functional moving forward.

2.2. Data

Data Quality

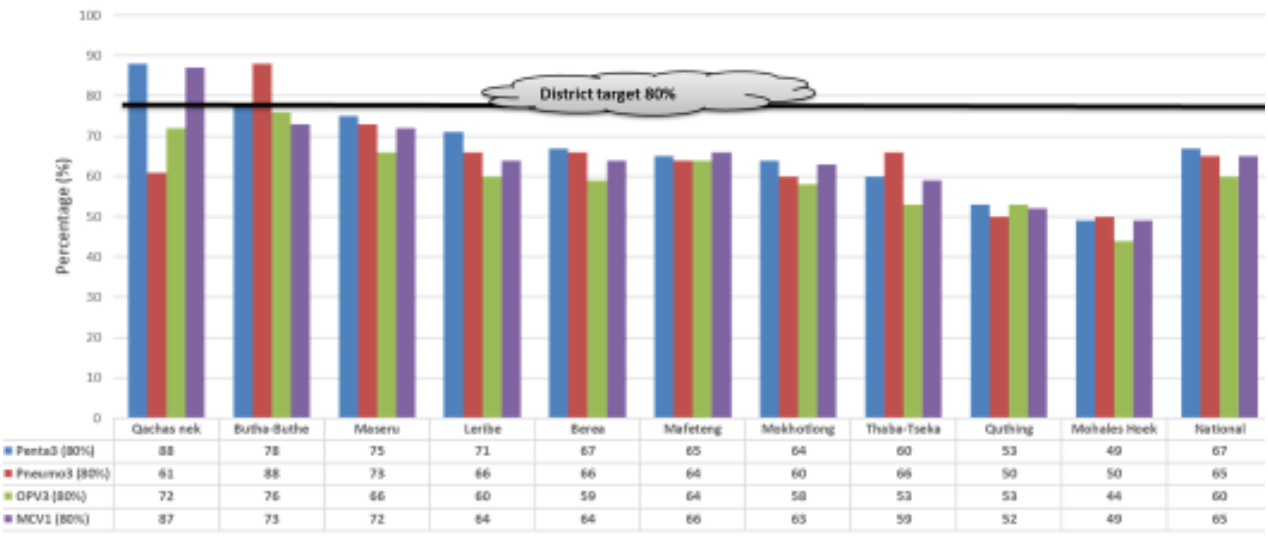
The program has noted data inconsistencies that may point to issues with data quality. E.g, negative drop-out rates, disparities on coverage against vaccines administered at the same time and the low number of AFP and Measles cases not being consistent with the reported low coverage against OPV3 and MCV1.

Negative drop-out rates may be related to data management challenges because there are no known migration issues during the reporting period. High drop-out rates may suggest issues with either utilization, that is, caregivers are not taking their children for subsequent dose or are a result of weak data management practices.



	Berea	Mokhotlong	Butha-Bithe	Thaba-Tseka	Mafeteng	Leribe	Maseru	Qachas nek	Quthing	Mohales Hoek	National
MCV1 to MCV2	19	4	21	21	22	16	27	14	31	17	19
Penta1 to Penta3	11	10	8	6	4	2	1	-1	-1	-8	3
Penta1 to MCV1	22	18	10	18	5	16	12	17	-1	3	13

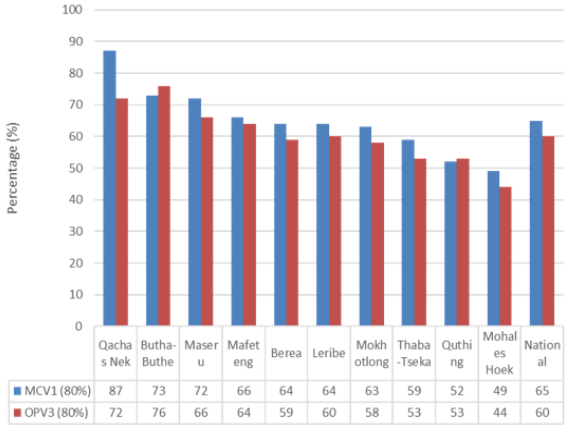
Disparities in coverage against vaccines administered at the same time indicate data management and supply chain challenges, or both. The graph below shows coverage against OPV3, PENTA3 and PCV3, it also shows coverage against MCV1. While the differences might be caused by stock outs, there were no reported stock outs of these antigens.



	Qachas nek	Butha-Buthe	Maseru	Leribe	Berea	Mafeteng	Mokhotlong	Thaba-Tseka	Quthing	Mohales Hoek	National
Penta3 (80%)	88	78	75	71	67	65	64	60	53	49	67
Pneumo3 (80%)	61	88	73	66	66	64	60	66	50	50	65
OPV3 (80%)	72	76	66	60	59	64	58	53	53	44	60
MCV1 (80%)	87	73	72	64	64	66	63	59	52	49	65

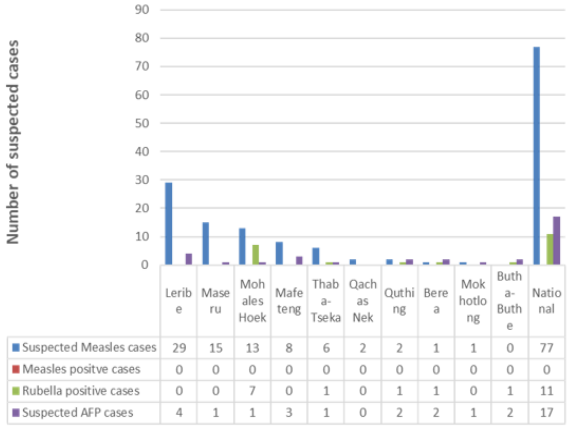
In most districts, MCV1 and OPV3 coverage figures have been consistently lower than 70% in the last five years. There were suspected measles cases identified in most districts. However, contrary to the expected occurrence of measles cases resulting from low immunization coverage, the graph shows that there were no measles cases isolated from laboratory investigation. This suggests that data management is a challenge and that the coverage might be higher than what the administrative data portrays.

Measles1 and OPV3 coverage



	Qacha s Nek	Butha-Buthe	Maseru	Mafeteng	Berea	Leribe	Mokhotlong	Thaba-Tseka	Quthing	Mohales Hoek	National
MCV1 (80%)	87	73	72	66	64	64	63	59	52	49	65
OPV3 (80%)	72	76	66	64	59	60	58	53	53	44	60

Suspected AFP and Measles cases



	Leribe	Maseru	Mohales Hoek	Mafeteng	Thaba-Tseka	Qachas Nek	Quthing	Berea	Mokhotlong	Butha-Buthe	National
Suspected Measles cases	29	15	13	8	6	2	2	1	1	0	77
Measles positve cases	0	0	0	0	0	0	0	0	0	0	0
Rubella positive cases	0	0	7	0	1	0	1	1	0	1	11
Suspected AFP cases	4	1	1	3	1	0	2	2	1	2	17

Main Efforts/Innovations

Ministry of Health has built a data collection platform using DHIS2, which allows health facilities to enter their reports directly to a central database using tablets. This is not currently being used for EPI reporting data, but there are plans to incorporate all necessary EPI indicators into the database including stock management and wastage. The MoH has also initiated capacity building efforts geared towards health facility level in data use.

Key Mitigations

- Implement the planned DQR
- Collaborate with BOS to address issues related to the denominator
- Improve data management at central and district level
- Incorporate EPI data into DHIS2
- Strengthen data utilization at facility level in order to improve use of data for decision making.

2.3. Role and engagement of different stakeholders in the immunisation system

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Inter-agency Coordination Committee (ICC)

- Provide guidance on EPI activities
- ICC should meet quarterly to review EPI performance
- Endorse key decisions on EPI plans: New Vaccine Introductions, SIA's, and Annual Plans.
- Supports the EPI in overcoming bottlenecks within the system and provides advocacy for EPI in upper echelons of the government
- Mobilizes resources towards EPI activities

Government Ministries and Departments

- Ministry of Education and Training, Ministry of Finance
  - Members of the ICC
- Other Government Departments

BOS

- Provides national statistics
- Supports monitoring and evaluation

Civil Society Organizations (CSO's)

- CHAL, Red Cross of Lesotho, World Vision, Rotary Club International
- Members of the ICC and the technical working group
- Provide support in the planning and implementation of EPI activities
- Participate in the review and monitoring of the EPI program

UN Partners

- WHO, UNICEF
- Provide technical support to the EPI program
- Advocacy for the program
- Resource mobilization
- Support the monitoring and evaluation of the program
- Provides coordination on global and regional strategies

Other Partners

- CHAI
- Members of the ICC and technical working group
- Support program implementation through
- Provide coordination on HSS implementation
- LENASO
- Support program implementation at community level

Private Sector

- Private Facilities providing immunization
- Provide monthly reports to the EPI

3. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

3.1. Programmatic performance

HSS work plan

The HSS work plan focuses 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. A fifth area provides administration support to carrying out the first four objectives.

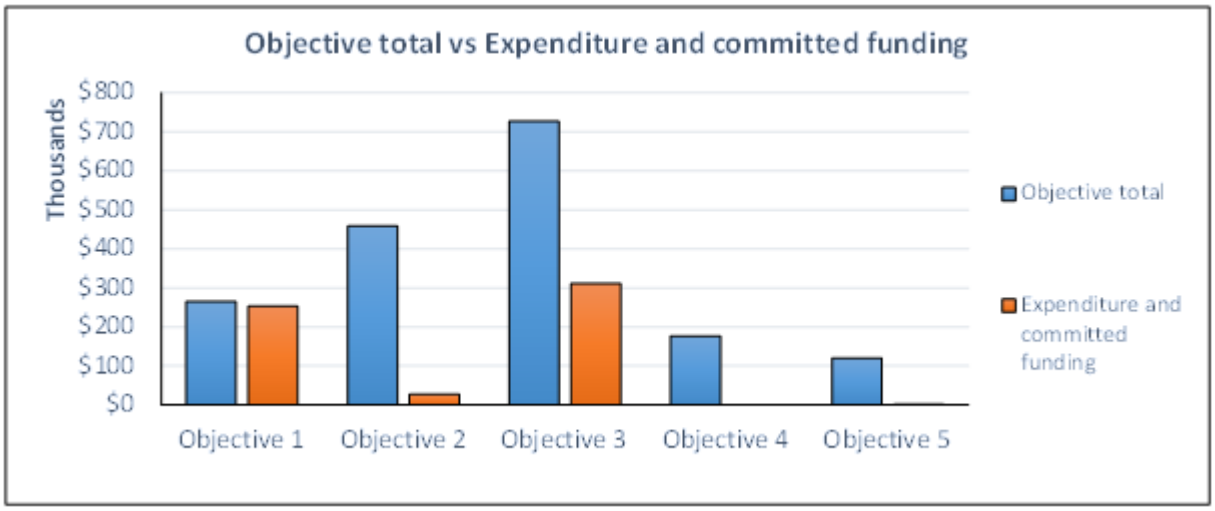
All four objectives jointly contribute to improving coverage and equity access to immunization.

Grant performance

The HSS grant was awarded in 2014, with the first tranche amounting to $791, 168 disbursed to the country in November of the same year. As of July 2017 an 82% absorption rate of the first tranche was achieved. Below is the implementation status of the grant;

	Planned	Actual	Variance
Objective 1	$ 277,530	$ 7,751	$ 269,779
Objective 2	$ 458,199	$ 125,472	$ 332,727
Objective 3	$ 726,773	$ 518,645	$ 208,128
Objective 4	$ 176,855	$ -	$ 176,855
Objective 5	$ 120,373	$ 234	$ 120,139
	$ 1,759,730	**$ 652,102**	**$ 1,107,628**

The expended $652,102 based on the expenditure report equates to 37% of the revised work plan total. The actual expenditure is however not reflective of the amount of implementation that has been undertaken by EPI. The graph below provides an overview of implementation taking into account actual expenditure and funding that has been committed for work under way.



Under objective one there is funding committed for the procurement of cold chain equipment and the rehabilitation of district vaccine stores amounting to $240,382. EPI has received cost estimates for the cold chain to be procured under the HSS work plan. An order will be placed in September 2017 through direct disbursement of funds, from Gavi to UNICEF, of $160,118. Significant progress has been made with regard to the rehabilitation of district vaccine stores. MoH Procurement Unit has concluded the evaluation of submitted bids for the rehabilitation of the three district vaccine stores (DVSs); the evaluation will be presented and signed off by the MoH tender panel. Once the procurement evaluation process has been signed-off the MoH will sign an MoU with the selected service provider. The rehabilitation/construction of the three DVSs

has been quoted at $80, 264 based on Bill of Quantities submitted by the selected suppliers/contractors.

There is a funding commitment of $108, 913 for the procurement of two 4 X 4 vehicles. All the tendering processes have been concluded and MoH is awaiting delivery of the vehicles.

Challenges of implementation: HSS

The challenges for implementation were identified as follows;

Competing priorities that delayed implementation of some activities: The MR campaign that took longer than expected shifted priorities from other activities as EPI, with support of partners, had to engage in a major social mobilization effort to address the MR rumors about adverse events following immunization (AEFIs).

Non-compliance on internal processes: Guidelines on internal procurement processes exist however there is a need to orientate implementing officers to facilitate their understanding and compliance. Limited understanding of internal processes results in significant delays in activity implementation. It was recommended that different departments are consulted when initiating activities so that internal processes are well understood and correctly followed, and that training between these departments and EPI staff is strengthened.

EPI Focal Person not yet allocated solely for EPI at district level: Prioritization of EPI activities becomes challenging due to lack of active focal persons allocated solely for EPI at district level. It was herein proposed that there should be an assignment of focal persons and their terms of reference (TORs) are drawn up.

Request for a no-cost-extension

MoH has increased implementation of the HSS work plan. Although there had not been any implementation in 2014 and 2015 there has been significant progress between June 2016 and July 2017. The late start implied that the Ministry had limited time for implementation. There has been significant progress made in expediting implementation. As of July 2017 MoH has achieved a utilization rate of 37% ($652,102) of the total revised work plan. In addition to the amount reflected in the expenditure report of $652,102, there is a funding commitment of $349, 295. This is funding that is targeted towards the procurement of cold chain equipment, rehabilitation of district vaccine stores (DVSs) and procurement of two 4 X 4 vehicles. Based on the progress made, MoH has thus expressed an interest in requesting a no-cost-extension from Gavi to undertake implementation until December 2018 to build on the gains already made. The NCE request will be submitted, with a costed work plan for the period of the NCE, with the JA report.

3.2. Financial management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

HSS grant utilization rates

MoH has achieved an 82% utilization rate of the first tranche of funding totaling $791, 168

IPV and PCV VIG

There was under spending of the IPV and PCV VIGs respectively. MoH had achieved a utilization rate of 26% and 25% for IPV and PCV respectively. The utilization variance for both grants amounted to $148, 308.58. The afore-mentioned variance was re-allocated to cover the MR VIG and Rota VIG.

Financial reporting and audit requirements

An updated expenditure report was submitted to Gavi in April 2017. Submission of the expenditure report served as a request for the disbursement of the second tranche

MoH is currently conducting an annual audit for the financial year ending March 2017 Results of the audit are expected in late September.

3.3. Sustainability and (if applicable) transition planning

The Lesotho government is committed to financing the EPI program. The country has been buying the traditional vaccines through UNICEF and has been meeting the co-financing obligations. 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.

EPI operational funds are included within funds allocated to the Family Health Division. In the year 2014/15, US$ 27,525 275.41 was allocated towards the family health division. The amount declined slightly in 2015/6 to US$ 24,525,485.44. In 2014/5 and 2015/6 the total amount allocated towards EPI was US$5,066,387.55 and US$ 2,626,328.51 respectively. The government is the main funding source towards the EPI. Financial support from Gavi remains instrumental towards the program achieving its objectives.

3.4. Technical Assistance (TA)

No changes

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Provide the status of the prioritised strategic actions identified in the previous Joint Appraisal[5] and any additional significant IRC or HLRP recommendations (if applicable).

Prioritised actions from previous Joint Appraisal	Current status
1. Develop training plan for central EPI	• Training plan was developed and has been minimally implemented
2. Construct Health Posts	• MoH through the support of partners have responded to queries raised by Gavi and Global Fund with regard to the proposed road map following a meeting between MoH, Gavi, and Global Fund that was held in Lesotho on 10th August 2017 • The roadmap was submitted and sent to both funders with the revised bill of quantities and timelines on August 18th. • The road map was submitted was sent to all funding agents with the revised billing of quantities and timeline
3. Procure cold chain equipment as per the 2015 Cold Chain Expansion and Replacement Plan (CCERP)	• The CCERP was updated to reflect current gaps and detailed equipment list was generated. • A procurement order was placed through UNICEF as per updated plan

[5] Refer to the section "Prioritised Country Needs" in last year's Joint Appraisal report

4. Develop a proposal for HPV introduction	• Request for eligibility has been sent to Gavi in January 2017 and MoH is awaiting response • Stakeholders to be involved in the application process have been identified • Application has been postponed to January 2018
5. Strengthen outreaches	• The four vehicles have been deployed to the selected districts; Qacha, Quthing, Thaba-Tseka and Mokhotlong • Challenges still persist on the right use of vehicles at district level • There is need to engage with the DHMT's to strengthen outreach programmes at district level. Processes are underway to capacitate DHMT's through Red/Rec trainings.
6. Rehabilitate space at district vaccine stores	• An architect was engaged to develop technical drawings of the DVSs • The procurement unit advertised, for a one month period, in local newspapers calling for bids • An evaluation of submitted bids has been conducted
7. Conduct a supply chain assessment	• The supply chain assessment has been conducted and results have been analysed • The results are due to be shared with other MoH departments and partners and recommendations will be developed during the dissemination workshop targeted for September 2017
8. Conduct an analysis to understand the discrepancy between coverage and routine immunization data	• EPI has noted data quality and denominator issues as a possible cause, it is recommended that there is collaboration between BoS and HMIS to review denominator assumptions
Additional significant IRC / HLRP recommendations (if applicable)	**Current status**

5. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for the next year:

Key finding 1	There is a need for the ICC to be strengthened in the country
Agreed country actions	1. Review of ICC ToRs including membership, schedule of meetings – responsibility: EPI; 2. Enhancing the Secretariat function of the ICC – responsibility: Head Family Health Division (regularising the meetings) 3. Advocacy for roll-out of EPI structure from central to lower levels – responsibility: Head Family Health Division (ICC at district level)
Associated timeline	1. March 2018 2. March 2018 3. Tbd based on further discussions with Directorate of Human Resources-HFHD
Technical assistance needs	Review the ToRs and orientation of ICC members UNICEF/WHO (RO)-Request by September 2017
Key finding 2	Strengthen management of EPI data
Agreed country actions	1. Review of the data collection tools and Integration of EPI data in the DHIS2 – responsibility: HMIS/EPI/IT 2. Denominator assumptions reviewed – responsibility: HMIS/EPI; 3. DQR finalised and development of costed DQIP – organised through TA; 4. Capacity building on data management including utilisation for decision making for health workers – responsibility: EPI/HMIS.
Associated timeline	1. Review data collection tools and including in integration in to DHIS2-Dec 2017 2. Denominators-March 2018 3. DQR-March 2018 4. Capacity building –April 2018
Technical assistance needs	TA required on the denominator assumptions and follow-up discussions with BoS (triangulation of various data points) – WHO/UNICEF/UNFPA
Key finding 3	Ensure continuity of EPI services across all levels of the system
Agreed country actions	1. Directive from senior management on roles and responsibilities of the EPI Focal Persons; Empowerment of the EPI Focal person – responsibility: Director Primary Health Care and Head of Family Health; 2. Activating outreach services including development of schedules and also access to financial means for conducting the outreach services – responsibility: EPI; 3. Conduct routine supportive supervision from central to district and then district to facility level – responsibility: EPI; 4. Engagement with the CSOs with a focus on strengthening demand generation, community engagement and supporting defaulter tracing – responsibility: EPI, PAU, Procurement, TWG.
Associated timeline	1. End of September 2017 2. June 2018 and ongoing after that 3. November 2017 and ongoing after that

	4. Q1 of 2018
Technical assistance needs	
Key finding 4	Frequent stock-out at district and health facility level;
Agreed country actions	1. Outsource transport for vaccine distribution and CC maintenance – responsibility: EPI, PAU, Procurement; 2. Plan for integration with "Informed Push" and delivery to the facility.-EPI SCCU, CHAI, UNICEF 3. Vaccine management training for health workers - responsibility: EPI, UNICEF, WHO, CHAI; 4. Assessment of vaccine wastage rates - responsibility: EPI; 5. Development of SOPs for vaccine management- responsibility: EPI, UNICEF; 6. Replace 30 % of non-PQS CC equipment - responsibility: EPI.
Associated timeline	1. End of November 2017 2. Q3 2018 3. Q1 in 2018 4. Q1 in 2018 5. September 2017 6. Q3 in 2018
Technical assistance needs	TA will be needed for 3, and 4 (UNICEF/WHO)
Key finding 5	Limited implementation of HSS 1 proposal
Agreed country actions	1. Orient the MoH, MoF and MoDP senior management (WHO Rep, UNICEF Rep) – to be clarified by the EPI programme – responsibility: Head Family Health 2. Develop costed needs based work plan with timelines and assigned responsibilities for 2018 submitted along with the JA report and the request for the non-cost extension – responsibility: EPI, UNICEF, WHO, CHAI; 3. Central level to engage lower levels and provide visibility on the availability of funds towards their implementation – responsibility: EPI, UNICEF, WHO, CHAI. 4. Development of cMYP aligned with NHSP responsibility: EPI, UNICEF, WHO, CHAI 5. Preparation for CEF responsibility: EPI, UNICEF, WHO, CHAI
Associated timeline	1. December 2017 2. By end of August 2017 (ICC endorsement needed) 3. September 2017 linked to rota training 4. QR 1st 2018 5. CEF-Sept 2018
Technical assistance needs	cMYP 2018-2022 development; Development of M&E Plan for NHSP (to be discussed with Department of Planning through the EPI TWG); Roll-out of CEF process in 2018.

6. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT)AND ADDITIONAL COMMENTS

The Joint Appraisal took place in Lesotho from 8-10 August. The meeting was led and chaired by the Ministry of Health, but brought together all the key partners that participate and engage with the EPI programme. The WHO and UNICEF Country Offices were represented as were colleagues from both WHO and UNICEF Regional Offices. There were a range of NGOs and CSOs that participated in the JA – including CHAI, Red Cross and CHAL.

The Joint Appraisal report was tabled for endorsement at the ICC meeting on the 6th September 2017.

7. ANNEX

Compliance with Gavi reporting requirements

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal.

It is important to note that delayed reporting may impact the decision by Gavi to renew its support.

	Yes	No	Not applicable
Grant Performance Framework (GPF) reporting against all due indicators	X		
Financial Reports			
Periodic financial reports		X	
Annual financial statement		X	
Annual financial audit report			X
End of year stock level report	X		
Campaign reports		X	
Immunisation financing and expenditure information		X	
Data quality and survey reporting			
Annual desk review		X	
Data quality improvement plan (DQIP)			X
If yes to DQIP, reporting on progress against it			
In-depth data assessment (conducted in the last five years)	X		
Nationally representative coverage survey (conducted in the last five years)	X		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	X		
Post Introduction Evaluation (PIE)			X
Measles-rubella 5 year plan	X		
Operational plan for the immunisation program	X		
HSS end of grant evaluation report			X
HPV specific reports			X
Transition Plan			X

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.
