APPLICATION FORM FOR GAVI NVS SUPPORT

Submitted by

The Government of Lesotho

for

HPV routine, with multi-age cohort in the year of introduction and Measles-rubella follow-up campaign

Gavi
The Vaccine Alliance

Reach Every Child
www.gavi.org

1 Gavi Grant terms and conditions

1.2 Gavi terms and conditions

1.2.1 Gavi terms and conditions

The terms and conditions of the Partnership Framework Agreement (PFA) between Gavi and the Country, including those provisions regarding anti-corruption and anti-terrorism and money laundering, remain in full effect and shall apply to any and all Gavi support made pursuant to this application. The terms and conditions below do not create additional obligations or supersede those of the PFA. In the event the Country has not yet executed a PFA, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.

GAVI GRANT APPLICATION TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES
The applicant country ("Country") confirms that all funding provided by Gavi will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by Gavi. All funding decisions for the application are made at the discretion of Gavi and are subject to IRC processes and the availability of funds.

AMENDMENT TO THE APPLICATION
The Country will notify Gavi in its Joint Appraisal, or in any other agreed annual reporting mechanism, if it wishes to propose any change to the programme(s) description in its application. Gavi will document any change approved by Gavi according with its guidelines, and the Country's application will be amended.

RETURN OF FUNDS
The Country agrees to reimburse to Gavi all funding amounts that Gavi determines not to have been used for the programme(s) described in its application. The Country's reimbursement must be in US dollars and be provided, unless otherwise decided by Gavi, within sixty (60) days after the Country receives Gavi's request for a reimbursement and be paid to the account or accounts as directed by Gavi.

SUSPENSION/ TERMINATION
Gavi may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programme(s) described in the Country’s application, or any Gavi-approved amendment to the application. Gavi retains the right to terminate its support to the Country for the programme(s) described in its application if a misuse of Gavi funds is confirmed.

NO LIABILITY
The Country shall be solely responsible for any liability that may arise in connection with: (i) the implementation of any programme(s) in the Country; and (ii) the use or distribution of vaccines

and related supplies after title to such supplies has passed to the Country.
Neither party shall be responsible for any defect in vaccines and related supplies, which remain the responsibility of the relevant manufacturer. Gavi shall not be responsible for providing any additional funding to replace any vaccines and related supplies that are, or became, defective or disqualified for whatever reason.

INSURANCE
Unless otherwise agreed with Gavi, the Country shall maintain, where available at a reasonable cost, all risk property insurance on the Programme assets (including vaccines and vaccine related supplies) and comprehensive general liability insurance with financially sound and reputable insurance companies. The insurance coverage will be consistent with that held by similar entities engaged in comparable activities.

ANTI-CORRUPTION
The Country confirms that funds provided by Gavi shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

ANTI-TERRORISM AND MONEY LAUNDERING
The Country confirms that funds provided by Gavi shall not be used to support or promote violence, war or the suppression of the general populace of any country, aid terrorists or their activities, conduct money laundering or fund organisations or individuals associated with terrorism or that are involved in money-laundering activities; or to pay or import goods, if such payment or import, to the Country’s knowledge or belief, is prohibited by the United Nations Security Council.

AUDITS AND RECORDS
The Country will conduct annual financial audits, and share these with Gavi, as requested. Gavi reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.
The Country will maintain accurate accounting records documenting how Gavi funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of Gavi funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY
The Country and the signatories for the Country confirm that its application, or any other agreed annual reporting mechanism, is accurate and correct and forms legally binding obligations on the Country, under the Country's law, to perform the programme(s) described in its application, as amended, if applicable.

COMPLIANCE WITH GAVI POLICIES
The Country confirms that it is familiar with all Gavi policies, guidelines and processes relevant

to the programme(s), including without limitation the Transparency and Accountability Policy (TAP) and complies with the requirements therein. All programme related policies, guidelines and processes are available on Gavi's official website and/or sent to the Country.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage Gavi cash-based support. The Country confirms that it will take all responsibility for replenishing Gavi cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and Gavi arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either Gavi or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by Gavi. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: Gavi and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

Gavi will not be liable to the country for any claim or loss relating to the programme(s) described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. The Country is solely responsible for all aspects of managing and implementing the programme(s) described in its application.

1.3 Gavi Guidelines and other helpful downloads

Guidelines and documents for download

Please refer to the relevant guidelines concerning your request for support.

Please ensure to consult and download all documents. It is important to note that some documents must be completed offline, and will need to be uploaded in the final steps of your application.

This application form is designed to collect information needed by Gavi to process requests for support, plan procurement of vaccines, plan technical assistance, track data for future reporting, and more.

A key component of the application is a solid operational plan (New Vaccine Introduction Plan for routine support, or Plan of Action for campaign support), explaining how the country will

introduce the vaccine or conduct the envisaged campaign, with a corresponding budget. The New Vaccine Introduction Plan or Plan of Action must be submitted together with this application form and will be considered as the foundation of the support request.

For more information on the documents to submit with your application and what they should contain, please refer to the appropriate guidelines: http://www.gavi.org/support/process/apply/

2 Review and update country information

2.1 Country profile

2.1.1 Country profile

Eligibility for Gavi support

Eligible

Co-financing group

Preparatory transition

Date of Partnership Framework Agreement with Gavi

30 November 2012

Country tier in Gavi's Partnership Engagement Framework

3

Date of Programme Capacity Assessment

No Response

2.1.2 Country health and immunisation data

Please ensure your Country health and immunisation data is up to date. If not, please go to the Overall expenditures and financing for immunisation section of the portal to submit this information.

	2019	2020
Total government expenditure		

Total government health expenditure	
Immunisation budget	

2.1.3 National health planning and budgeting cycle, and national planning cycle for immunisation:

The government planning cycle starts on the

1 April

The current National Health Sector Plan (NHSP) is

From	2018
To	2023

Your current Comprehensive Multi-Year Plan (cMYP) period is

2012-2017

Is the cMYP we have in our record still current?

Yes☒ No☐

If you selected “No”, please specify the new cMYP period, and upload the new cMYP in country documents section.

Note 1

From	2018
To	2023

If any of the above information is not correct, please provide additional/corrected information or other comments here:

n/a

2.1.4 National customs regulations

Please describe local customs regulations, requirements for pre-delivery inspection, and special documentation requirements that are instrumental for the delivery of the vaccine.

There are no special documents required for delivery of MR into the country because we are not introducing a new vaccine whereby we may require a waiver. The usual documents which accompany the vaccine i.e., Airway Bill, Certificate of Origin and Pre-alert are acceptable. These documents have to be available at least 2 to 3 weeks before delivery so as to enable EPI to apply for tax exemption following which, customs clearance can take place.

2.1.5 National Regulatory Agency

Please provide information on the National Regulatory Agency in the country, including status (e.g. whether it is WHO-certified). Please mention a point of contact with phone number and e-mail address. UNICEF will support the process and may need to communicate licensing requirements to the vaccine manufacturers where relevant.

The ministry of health doesn't have NRA but the pharmacovigilant unit monitors vaccines , medicine, and medical equipment.

2.2 National Immunisation Programmes

2.2.2 Financial Overview of Active Vaccine Programmes

IPV Routine

Note 2

	2019	2020	2021	2022
Country Co-financing (US$)				
Gavi support (US$)	121,889	123,356	124,703	125,947

PCV Routine

	2019	2020	2021	2022	2023
Country Co-financing (US$)	37,455	40,136	46,460	53,966	62,637
Gavi support (US$)	374,978	346,644	342,768	339,079	334,003

Pentavalent Routine

2019	2020	2021	2022	2023

Country Co-financing (US$)	8,806	8,481	9,888	11,485	13,331
Gavi support (US$)	95,761	78,320	78,104	77,370	76,337

Rota Routine

	2019	2020	2021	2022	2023
Country Co-financing (US$)	15,570	37,687	43,642	50,678	30,445
Gavi support (US$)	158,121	327,227	323,729	320,263	162,894

Summary of active Vaccine Programmes

	2019	2020	2021	2022	2023
Total country co-financing (US$)	61,831	86,304	99,990	116,129	106,413
Total Gavi support (US$)	750,749	875,547	869,304	862,659	573,234
Total value (US$) (Gavi + Country co-financing)	812,580	961,851	969,294	978,788	679,647

2.3 Coverage and Equity

2.3.1 Coverage and equity situation analysis

Note: If a recent analysis of the coverage and equity analysis is already available, for example as part of a Joint Appraisal report, you may simply reference the report and section where this information can be found.

Describe national and sub-national evidence on the coverage and equity of immunisation in the country and constraints to improvement. In particular, identify the areas and groups of low coverage or high inequity linked to geographic, socioeconomic, cultural or female literacy considerations, as well as systematically marginalized communities. Specify both the areas and/or populations with low coverage (%) and those with the largest absolute numbers of un-/under-vaccinated children. Among data sources, consider administrative data, coverage surveys, DHS/MCS, equity analyses, Knowledge-Attitude-Practice surveys, and patterns of diseases like measles.

Describe the challenges underlying the performance of the immunisation system, such as:

- Health work force: availability and distribution;
- Supply chain readiness;
- Gender-related barriers: any specific issues related to access by women to the health system;
- Data quality and availability;
- Demand generation / demand for immunisation services, immunisation schedules, etc;
- Leadership, management and coordination: such as key bottlenecks associated with the management of the immunisation programme, the performance of the national/ regional EPI teams, management and supervision of immunisation services, or broader sectoral governance issues;
- Financing issues related to the immunisation programme that impact the ability to increase coverage, including bottlenecks related to planning, budgeting, disbursement and execution of resources;
- Other critical aspects: any other aspect identified, for example based on the cMYP, EPI review, PIE, EVM or other country plans, or key findings from available independent evaluations reports.

Describe lessons learned and best practices on the effectiveness of implemented activities to improve coverage and equity; recommendations on changes or new interventions that might be required to accelerate progress (include data to support any findings or recommendations).

Human resources: Equity
This section gives an overview of the demand and supply side factors influencing equity of access to immunization services by the populace. At the onset, factors that make communities vulnerable and therefore predisposed to poor access to immunization services have been examined to enable appropriate targeting of interventions that can enhance immunization coverage as well as equity in all districts.
Demand Side (community related) factors influencing Coverage and Equity at sub-national level
The following are the key vulnerability factors- on the demand side- that predispose communities to poor access to immunization- as identified from recent assessments, including LDHS 2014, EPI Review 2014, the MNCHN KAP Study 2017, EVM Assessment Reports 2014 and 2018, and Equity and Coverage Analysis study by EPI in 2018:
The level of the mothers' education and wealth plays a significant role in the probability of a child accessing immunization services. For mothers with incomplete primary education the estimated coverage for a fully immunized child was 61.8%, while for mothers who completed primary education and secondary school the coverage was 70% (LDHS 2014)- giving 9% difference. Which is big.
Wealth Quintile: Children from wealthy households are more likely to be vaccinated than their counterparts from poor homes. Households in the middle wealth quintile had the highest coverage (81.5%) for a fully immunized child followed by those in the highest wealth quintile (68.4%), while households in the lowest wealth quintile had 59.7% coverage. This gives a difference of nearly 22% between households in the middle and lowest wealth quintiles. High level of education coupled with stable livelihoods might have contributed to the good coverage

in the households I the middle wealth quintile.
Geographical Residence: In Lesotho, populations with high risk of being under-served with vaccination services are those residing in mountainous districts, urban poor quarters, and remote rural communities that are often hard to reach.
• Urban and Rural Residences: The 2014 Lesotho DHS indicated that the difference in coverage of a fully immunized child between urban residence and rural residence is 10%, with urban coverage being 92% while rural coverage was 82%.
• Districts with highly challenging geo-topographies: Lesotho is a highly mountainous country, with some districts having very challenging terrains with hardly any vehicular roads: this is especially common in Mokhotlong, Mohale's Hoek, Quthing and Thaba Seka districts. The available roads in such districts have poor conditions that compel use of alternative means of accessing immunization services, e.g. walking on foot for several kilometres or taking the arduous journey on horses or donkeys, and occasionally medical supplies to the isolated health facilities and communities are dropped by helicopters. The impact of the challenging terrains on immunization coverage is quite manifest: while Mokhotlong had immunization coverage of only 47.5% , Mafeteng that has a fairly non-challenging topography) recorded coverage of 78.5% for a fully immunized child.
Access of transport to the health facility: Access of health facilities for many mothers and caregivers is a big challenge. This makes many families to look at immunization as an option that can be postponed to an opportune moment. This in turn leads to missed opportunities or total drop out. (MNCHN KAP survey, 2017).
Distance to and from health facilities: Distance to health facilities in rural areas is a common challenge for those seeking immunization and other health services, Sometimes mothers and caregivers travel so long a distance that they have to sleep over and return home the following day (MNCHN KAP survey, 2017). This is more so for the 20% caregivers who are in their old age, and sometimes each has more than one child to take to the health facility for immunization services .
Engagement of parents in trade as main livelihood: Topic Parents who are street vendors, whether in urban or rural areas, often take their young children, especially those aged less than 24 months (two years), along to their places of work. This type of livelihood prevents hinders parents from taking their children for regular immunization, making such children to miss opportunities of getting immunized (KAP Survey 2017).
Employment in factories: The MNCHN KAP survey (2017) found out that there are many female factory workers who are mothers with children under-five years of age, especially in urban districts. Such mothers usually leave their children with caregivers / elderly women who cannot bear the responsibility of taking the children for immunization, let alone knowing the immunization schedule of the particular child under their care. This often either delays completion of the immunization of the child or selects the child out of the immunization program.
Trans-frontier Labour Emigration with children under-five years of age: In districts bordering the Republic of South Africa (RSA), like Quthing and Mohale's Hoek, many mothers migrate with their under-five children to work in the RSA- often returning after one year. While there, accessing immunization services is often difficult for such mothers'/care givers who are seasonal labourers in spite of their children being eligible for immunization with the different antigens. Upon return to Lesotho, many of the children would have missed their scheduled immunizations. Coupled with insufficient knowledge of some health professionals on how to handle late dose administration, these instances increase the level of missed opportunities- and sometimes dropouts from the EPI program in the country.
Trans-frontier Labour Emigration without children under-five years of age: Some mothers / caregivers seasonally migrate to work in the RSA, leaving their immunization-age children under the care of elderly relatives, often grandmothers. Often, these elderly caregivers find it difficult to follow immunization schedules in addition to transport difficulties they encounter in

accessing health facilities. This is worsened lack of regular outreach services in most districts.
Cultural barriers tend to undermine access to immunization: Even though there is not sufficient data to quantify, there is evidence of some cultural barriers in timely accessing vaccination services whereby in-laws make decisions on when the child should be presented for vaccination services, or whereby consultation is required from the father, as head of the household, for presenting children for immunization services. Based on the results of the MNCHN KAP study conducted in three districts, knowledge on immunization services was high despite the fore-mentioned challenges.

Supply Side (Health Facility and health system management related) factors influencing Coverage and Equity at sub-national level

From recent assessments, including LDHS 2014, EPI Review 2014, the MNCHN KAP Study 2017, EVM Assessment Reports 2014 and 2018, and Equity and Coverage Analysis study by EPI in 2018, the following supply side factors influencing coverage and equity of immunization services have been identified:

Micro-plans are not being carried out in most districts: In addition to lack of MOH Micro-Planning Guideline, most health professionals at sub-national level have no skills for carrying out micro-plans. This makes it difficult for districts and health facilities to profile, identify and target various communities in their catchment area for immunization services, including outreaches (EPI Review 2014; cMYP 2018-2022);

Lack of outreach services; predominant relying on static services: Currently most health facilities in nearly all districts hardly conduct EPI or integrated outreaches to needy communities. Delivery of EPI outreach services is constrained by limited access to means of transport, which seems to be due to lack of efficient transport management system in place at national and district levels. Lack of access to transport for EPI outreaches often leads to cancellation of scheduled outreaches; this in turn deprives hard-to-reach (HTRs) areas of priority MNCH services, including EPI (cMYP 2018-2022; EPI C&E Study, 2018; MNCHN KAP Study 2017).

Vaccine Stock outs contributing to missed-opportunities: Episodes of vaccine and other EPI commodities still occur at both national and sub-national levels. Episodic vaccine stock outs have been mentioned as one of the causes mothers / caregivers encounter missed opportunities for having their children immunized (MNCHN KAP 2017; EVM Assessment Reports 2014 & 2018).

Shortage of staff coupled with high staff turnover: Shortage of health workers at all levels of care and not practising the supermarket approach also contributes to the levels of accessing care.

Weak EPI Specific Support Supervision, especially at lower levels / operational level: EPI support supervision has been found to be week by the following studies: EVM 2011, 2014 & 2018; cMYP 2018-2022). There is no clear MOH EPI Support Supervision Guideline. The manner in which EPI support supervision is carried attests to skill deficits in support supervision. This echoes the finding in the current cMYP that there has been no training carried out in the recent past in supportive supervision and mentoring. Good support supervision should be regular and supportive to improvement of staff performance in EPI services., and lack of it undermines performance of staff at sub-national levels.

Protracted challenges undermining effective vaccine management (EVM): Since first detected by EVM 2011, poor vaccine stock management, especially at sub-national levels still persists as identified by EVM 2014 and 2018. These manifest as follows: vaccine overstocking; high vaccine wastage rate in health facilities; lack of tracking and documentation of vaccine utilization and wastage rates; no system in place for real-time data transmission for vaccine stock management at DVS and health facilities; and persisting poor vaccine temperature

management at CVS, DVS and health facility levels. These practices predispose health facilities to stock out of vaccines in addition to threatening potency of vaccines at CVS, DVS and health facilities; both of these can influence coverage and equity.
Notable Skill Deficits in health professionals: There is widespread skill deficits noted in health professionals manning EPI services. Skill deficits in the following areas all have the potential to directly or indirectly impede good coverage of and equity of access to EPI services to the populace: vaccine and EPI commodity forecasting & quantification; micro-planning; support supervision; and management of nationwide stock distribution.
Out dated Pre-service EPI Curriculum The curriculum for pre-service training of various health professionals (Nursing Cadre, Medical Students and Allied Health Professionals) has not been updated to include recent developments in technology and practices in immunization. Hence, most newly qualified health professionals find it hard to initially cope with immunization in health facilities. The pre-service EPI curriculum therefore is overdue for updating.
Lack of access to means of transport for last mile distribution and outreach services: The EPi program does not benefit from the last-mile distribution of other medical commodities overseen by NDSO. Due to difficulty in accessing transport at district level, intra-district distribution of vaccines to health facilities is currently hampered. Some health facilities experience stock outs of vaccines due to lack of transport for last-mile distribution of vaccines from the DVS (cMYP 2018-2022; EVM 2014 and 2018; EPI Review, 2014).

Risks posed to EPI coverage and equity by non-optimised CCEs in many health facilities: In all districts, to varying extents, obsolete CCE still exist. The following table illustrates the burden of non-optimised CCE in the ten districts of the country.
1.1 Key drivers of sustainable coverage and equity at the national level
1) Vaccine supply chain and logistics
Inadequate and inappropriate storage space at the central level remains challenging; housing the central store within the MoH building comes with unrestricted access to the store to anyone outside the EPI team, and a lack of sufficient space to store received new CCE equipment or one needing repairs. The lack of an EPI Logistician Officer at the central level (although recommended in the 2014 EVMA) and district supervision obscures the central level from having visibility on district vaccine management. The central level does not have visibility on health facility wastage factors, and timely visibility on district level issuance of stock to the health facility. The 2018 programme audit revealed inaccurate recording of stock, with variances between the CVS deliveries and DVS receipts, and DVS issuing records and the HF receipts. Furthermore, inaccurate assumptions used for the national level forecasting and quantification were seen to have led to overstocking and wastage of antigens . Stock-outs have also been evident at the district and health facility level due to transport challenges, even though antigens were available in the tiers above.
2) Data quality, availability and use
The routine immunization data captured into the DHIS2 at the district level by the district data clerk. The central level's mandate is to analyse the data to monitor for inconsistencies and timelines in reporting, and subsequently provide districts with feedback on performance and the quality of data. The entry of data exclusively by Data Clerks at the district level has been experiencing teething problems. Inconsistencies in the reported data have been continuous flagged. Once inconsistencies are identified, feedback has to be provided to the district and data verification needs to be undertaken through district visits. Routine data has only been exclusively entered at the district level from January 2018. There exists no standard mechanism in provided feedback to the district or clear standard operating procedures on how to correct data inconsistencies within the system.

3) Surveillance of vaccine preventable diseases (VPDs)

Transportation of samples to NCID in South Africa remains challenging, as the contracted courier does not comply with the set IATA standards to specimen shipping. MoH is currently exploring options and opportunities to directly engage a courier service that complies with the IATA standards.

4) Demand generation/community mobilization
At the national level, the Health Education unit is responsible to provide integrated support to all programs on health education, promotion and communication. The public relation office in the ministry arranges slots in TV and radios for messages on EPI and VPD surveillance, and most of these is undertaken during campaigns. Despite the high level use of technology in the country and more than 80% of households owning mobile devices, there are no routine social mobilization activities leverage on the afore mentioned.

5) Leadership, management and coordination (LMC)
Despite recommendations from various HR assessments, staff/health workers involved in EPI remain untrained, and professional development trainings are implemented in a haphazard manner. The unavailability of job descriptions for the entire EPI team continues to pose challenges for accountability in instances where there is no implementation of activities. ICC meetings have not been sustained on a regular basis, often limited to fulfil the requirements of proposal application process to Gavi, with the existence of an unclear relationship between the EPI TWG and ICC .

6) Financial Management
Over expenditure on activity budgets was experienced for the MR operational budget. The campaign took longer than the envisaged two weeks (campaign was from 13th February to 24th April 2017) and as such funds targeted for human resources payments were retired by the Ministry of Finance at the end of the financial year on 31st March 2017. Contributing to the over expenditure was the lack of cost control measures, and other financial management challenges. The inadequate cost control measures have been attributed to lack of a dedicated staff member within PAU to manage Gavi funds, no requirement for periodic monitoring of funds; comparative analysis between budget and expenditure. The absorption of the different cash grants has yielded mixed results. A detailed narrative on the absorption on the different cash grants will be provided on the section on progress updates.
1.2 Key drivers of sustainable coverage and equity at the sub-national level

1) Vaccine supply chain and logistics
Unnecessary wastage and lack of wastage monitoring were prominent challenges identified in country as there are no systems at the health facilities to estimate wastage. Furthermore, inaccurate assumptions used for the district level forecasting and quantification were seen to have led to overstocking and wastage of antigens ; districts and health facilities do not conduct vaccine forecasting and wastage calculations. Stock-outs have also been evident at the district and health facility level due to transport challenges, even though antigens were available in the tiers above.
Inadequate and inappropriate storage space at the district level remains challenging, lack of supportive supervision and trainings in vaccine supply chain management . The 2018 programme audit revealed inaccurate recording of stock, with variance between the DVS issuing records and the HF receipts. These variances are not timely picked up by the central level.
2) Data quality, availability and use
Timeliness of reporting remains a challenge and there are not mechanisms to deal with late reporting. 88.5% and 88.1% of health facilities and districts respectively reporting, all were

timely in reporting (timeliness = 100%). Mokhotlong, Quthing, and Mohale's Hoek districts, with their respective facilities has continuously been flagged for data management issues in the 2018 DQR; lack of 100% timeliness in reporting, some facilities not reporting. The failure to reach a 100% reporting rate can be attributed to the private sector reporting, which is challenging as their facilities do not have DHIS2 for reporting and reports are subsequently delivered to DHMTs at the convenience of the private health facility.

There is data inconsistency between same antigens with 46.2% of the assessed facilities recorded divergent scores of Penta 1 and 3, with evidence of negative drop-out rates, while 43.4% of facilities showed inconsistencies between MCV1 and Penta. accessing immunizations services outside their catchment area, due to convenience and proximity, as one of the reasons in addition to lack of proper guidance for health workers in handling cases of children who missed a schedule and are presented for services in later weeks contributes. The use of health facility (community level) data for decision making is usually undertaken only during campaigns. What exacerbates the situation is the low implementation of recommendations from one review to another.

3) Demand generation/community mobilization
Health promotion at the district level is tasked to Environmental Health Officers and Assistants. Health care workers remain the most vital source of all health related information, including immunization services, at the community level. Previous experience indicates that social mobilization activities are mostly limited to SIAs and not sustained for routine immunization which could be attributed to health workers having to be in charge of other primary health care services. In addition, the 2017 KAP study (carried out in 3 districts) indicated that communities prefer health related communication be delivered by health care workers and non-governmental organizations (NGOs) during community gatherings with continuous community based health education highlighted as a requirement.

4) Leadership, management and coordination (LMC)
Monitoring of EPI services at the district level has been traditionally charged with Public Health nurses of the respective districts who are also in charge of other programmes. Plans are in place to identify EPI Child Health Officers in all 10 districts who will then be re-assigned from their various roles to fully manage all EPI related activities in their respective districts. 4 EPI Child Health Officers (CHO) have been identified thus far. Processes are continuing to identify, orient and train EPI CHOs in the remaining 6 districts. Once these positions are fully functional, continuous mentoring and training on EPI, leadership and management, is critical.

5) Service delivery
Nurses account for roughly 73% of the total population of health workers however the density of nurses per 1, 000 populations in Lesotho is 0.0623 versus 1.172 for other countries in Sub-Saharan Africa . Findings by the 2011 Nursing Education Partnership Initiative (NEPI) report indicated that Lesotho has only 43% of nurse and midwives of the minimum standard recommended by WHO. Immunization services are provided in 193 of the total health facilities. Health facilities schedule the delivery of immunization services. This is mostly done in order to group children to ensure maxim utilization of vaccine vials once opened in order to minimize wastage. Not providing immunization on a daily basis however does increase the risk of missed opportunities for immunization.

2.4 Country documents

Upload country documents

Please provide **country documents** that are relevant for the national immunisation programme and for multiple vaccines, to be taken into account in the review of your application. If you have already provided one or more of these country documents, you do not need to upload it/them again unless the document version changed. If documents cannot be provided, please use the comment functionality to explain why, or by when they will be available.

Note that only general country documents are uploaded here; at the end of section 3 (sub-section “Upload new application documents”) you will be required to provide those documents that are specific to the support requested (for example the new vaccine introduction plan and/or campaign plan of action, new budget, application endorsements etc.)

Country and planning documents

✓	**Country strategic multi-year plan** Comprehensive Multi-Year Plan for Immunisation (cMYP) or equivalent country strategic plan	LESOTHO cMYP 20182022 costed MoH Final endorsed ready for_printing22 00000002_24-01-20_09.40.29.pdf
✓	**Country strategic multi-year plan / cMYP costing tool**	Copy of Copy of Lesotho cMYPCostingTool9 Feb2018_24-01-20_10.38.13.xlsx
✓	**Effective Vaccine Management (EVM) assessment**	Lesotho EVMA ReportJune 201826_24-01-20_10.45.51.docx
✓	**Effective Vaccine Management (EVM): most recent improvement plan progress report**	Copy of cIP2019Update_24-01-20_14.29.37.xls

✓	**Data quality and survey documents: Final report from most recent survey containing immunisation coverage indicators**	Lesotho2018MICSreport 00000002_24-01-20_14.30.41.pdf
	Data quality and survey documents: Immunisation data quality improvement plan	**No file uploaded**
✓	**Data quality and survey documents: Report from most recent desk review of immunisation data quality**	Final Lesotho Immunization Information System Assessment DQRCurrent_24-01-20_13.29.22.docx
✓	**Data quality and survey documents: Report from most recent in-depth data quality evaluation including immunisation**	Lesotho2018MICSreport 00000002_24-01-20_14.34.27.pdf
	Human Resources pay scale If support to the payment of salaries, salary top ups, incentives and other allowances is requested	**No file uploaded**

Coordination and advisory groups documents

✓	**National Coordination Forum Terms of Reference** ICC, HSCC or equivalent	Lesotho ICC TORs merged18122019Banda Comments 00000002_24-01-20_14.43.21.docx
✓		Minutes of the ICC meeting held on 8th January 2020_24-01-20_10.31.39.docx

National Coordination Forum meeting minutes of the past 12 months

Other documents

Other documents (optional) No file uploaded

Please also provide other country documents to support the review of the applications, for example Health Facility Assessment Reports, Knowledge-Attitude-Practice surveys or other demand-related surveys, if available.

3.1 HPV routine, with multi-age cohort in the year of introduction

3.1.1 Vaccine and programmatic data

Choice of presentation and dates

For each type of support please specify start and end date, and preferred presentations.

Note 3

HPV routine

Preferred presentation	HPV4, 1 dose/vial, Liquid
Is the presentation licensed or registered?	Yes ☒ No ☐
2nd preferred presentation	HPV9, 1 dose/vial, Liquid
Is the presentation licensed or registered?	Yes ☒ No ☐
Required date for vaccine and supplies to arrive	30 October 2021
Planned launch date	3 January 2022
Support requested until	2023

HPV multi-age cohort vaccination (MAC)

Preferred presentation	HPV4, 1 dose/vial, Liquid
Is the presentation licensed or registered?	Yes ☒ No ☐
2nd preferred presentation	
Is the presentation licensed or registered?	Yes ☒ No ☐
Required date for vaccine and supplies to arrive	30 October 2021
Planned launch date	3 January 2022
Support requested until	2022

3.1.1.2 Vaccine presentation registration or licensing

If any of the selected presentations are not yet licensed or registered, please describe the duration of the registration or licensing procedure, whether the country's regulations allow the expedited procedure for national registration of WHO-pre-qualified vaccines, and confirm whether the licensing procedure will be completed ahead of the introduction or campaign.

n/a

3.1.1.3 Vaccine procurement

Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund.Does the country request an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or Gavi)?

Yes☐ No☒

If you have answered yes, please attach the following in the document upload section:* A description of the mechanism, and the vaccines or commodities to be procured by the country through this mechanism.* A confirmation that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. OR, for

the procurement of locally-produced vaccines directly from a manufacturer which may not have been prequalified by WHO, a confirmation should be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality problems reported to WHO, and for which compliance is assured by a fully functional National Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

3.1.2 Target Information

3.1.2.1 Sources

For HPV, Gavi supports the vaccination of girls aged 9-14 years (as For the text on data source - Countries are encouraged to work with their national statistical office, the Ministry of Education and refer to additional sources of data (e.g. UNPOPULATION (WHO), UNPD, UNESCO data estimates) for assistance in estimating the size of the national target population. In case of significant differences between estimates, countries should take the estimated average of a national and a UN data source (e.g. UNPD) to avoid underestimation as well as overestimation.

Source 1 : e.g. Ministry of Education

2016 Lesotho Census

Source 2 : e.g. UNESCO

2017 Education Statistics Bulletin by the Ministry of Education

Source 3 : e.g. UN Population estimates (WHO)

UN Population estimates

3.1.2.2 Phasing

If the country is not doing a phased introduction, then kindly fill out the multi age cohort targets in the Targets for multi-age cohort vaccination table, only for the year of introduction.

Will the country do a phased introduction?

Yes☐ No☒

3.1.2.3 Targets Information

For HPV, Gavi supports the vaccination of girls aged 9-14 years (as recommended by WHO), based on the following cohorts:Routine cohort - countries are required to identify a single year cohort of girls to be immunised on a routine basis. (e.g. 9 years old)Additional multi-age cohort –

in the first year of routine introduction (or initial year of each phase, if the country chooses a phased introduction), countries also have the option to immunise additional girls within the recommended age groups (e.g. 10-14 years), that are older than the routine cohort.Note: Countries may choose proxy age of girls based on a school grade (e.g. grade 5 corresponds to approximately 10 year olds). However, grades usually have a range of different aged girls so it is important to keep in mind that girls under 9 years should not be vaccinated, and doses for girls older than 14 years are not provided by Gavi.The base year information should be completed for the year in which the application is being completed.

3.1.2.4 Targets for routine vaccination

Please describe the target age cohort for the HPV routine immunisation:	9

	2022	2023
Population in the target age cohort (#)	26,109	27,308
Target population to be vaccinated (first dose) (#)	24,804	22,344
Target population to be vaccinated (last dose) (#)	24,804	22,344
Estimated wastage rates for preferred presentation (%)	5	5

3.1.2.5 Targets for multi-age cohort vaccination

Please describe the target age cohort for the additional multi-age cohort in the year of introduction. Keep coverage estimates high if you choose to continue vaccinating in the subsequent year.

From	10
To	14

	2022
Population in target age cohort (#)	105,754

Target population to be vaccinated (first dose) (#)	99,212
Target population to be vaccinated (last dose) (#)	99,212
Estimated wastage rates for preferred presentation (%)	5

3.1.3 Co-financing information

3.1.3.1 Vaccine and commodities prices

Price per dose (US$) - HPV routine

	2022	2023
1 dose/vial,liq	4.05	4.05

Commodities Price (US$) - HPV routine (applies only to preferred presentation)

	2022	2023
AD syringes	0.036	0.036
Reconstitution syringes		
Safety boxes	0.005	0.005
Freight cost as a % of device value	1.04	1.04

Price per dose (US$) - HPV multi-age cohort in the year of introduction

	2022	2023
1 dose/vial,liq	4.05	4.05

Commodities Price (US$) - HPV multi-age cohort in the year of introduction (applies only to preferred presentation)

	2022	2023
AD syringes	0.036	0.036
Reconstitution syringes		
Safety boxes	0.005	0.005
Freight cost as a % of device value	1.04	1.04

3.1.3.2 Country choice of co-financing amount per vaccine dose

The table below shows the estimated financial commitment for the procurement of vaccines and supplies for the country, and the portion of Gavi support.
Please note that the values represented in this table do not account for any switches in co-financing group. The calculations for the entire five year period are based on the countries co-financing group in the first year.

Note 4

	2022	2023
Country co-financing share per dose (%)		
Minimum Country co-financing per dose (US$)	0.57	0.66
Country co-financing per dose (enter an amount equal or above minimum)(US$)	0.57	0.66

3.1.3.3 Estimated values to be financed by the country and Gavi for the procurement of supply

HPV routine

	2022	2023
Vaccine doses financed by Gavi (#)	56,200	38,400
Vaccine doses co-financed by Country (#)	9,000	7,300
AD syringes financed by Gavi (#)	59,500	40,200
AD syringes co-financed by Country (#)	9,500	7,600
Reconstitution syringes financed by Gavi (#)		
Reconstitution syringes co-		

financed by Country (#)		
Safety boxes financed by Gavi (#)	675	475
Safety boxes co-financed by Country (#)	125	100
Freight charges financed by Gavi ($)	2,892	1,978
Freight charges co-financed by Country ($)	463	372

	2022	2023
Total value to be co-financed (US$) Country	37,500	30,000
Total value to be financed (US$) Gavi	233,000	160,000
Total value to be financed (US$)	270,500	190,000

HPV multi-age cohort vaccination (MAC)

	2022
Vaccine doses financed by Gavi (#)	
AD syringes financed by Gavi (#)	
Reconstitution syringes financed by Gavi (#)	
Safety boxes financed by Gavi (#)	
Freight charges financed by Gavi ($)	

	2022
Total value to be financed (US$) Gavi	
Total value to be financed (US$)	

3.1.3.4 Co-financing payment

Please indicate the process for ensuring that the co-financing payments are made in a timely manner.

The co-financing is included within the EPI budget

If your country is in the accelerated transition phase for Gavi support, please answer the following question:

Please provide evidence that the co-financing obligations for the new introduction have been budgeted for, and elaborate on how the country plans to pay for the fully self-financing amounts. Please discuss the extent to which medium-term immunisation/health plans and medium-term expenditure frameworks incorporate the additional costs associated with this introduction. Discuss any co-financing defaults that may have happened in the last five years.

n/a

Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of:	May

The payment for the first year of co-financed support will be made in the month of:

Month	May
Year	2021

3.1.4 Financial support from Gavi

3.1.4.1 Routine Vaccine Introduction Grant(s)

HPV routine

Number of girls in the target population

26,109

Gavi contribution per targeted girl (US$)

2.4

Total in (US$)

100,000

Funding needed in country by: 31 May 2021

3.1.4.2 Multi-age cohort operational costs support grant(s)

HPV multi-age cohort vaccination (MAC)

Population in the target age cohort (#)

Note 5

105,754

Gavi contribution per girl in the target age cohort (US$)

0.55

Total in (US$)

58,164.7

Funding needed in country by: 31 May 2021

3.1.4.3 Operational budget

Please complete the Gavi budgeting and planning template to document how the **Gavi Vaccine Introduction Grant** and the **MAC Operational Costs support** grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the MAC and the introduction of the HPV vaccine. Please ensure to upload the completed budgeting and planning template as part of this application.

If Gavi's support is not enough to cover the full needs please indicate how much and who will be complementing the funds needed in the Operational Budget template. In the following fields please provide an overview of your request.

Budget for the vaccine introduction activities

Total amount - Gov. Funding / Country Co-financing (US$)

851860

Total amount - Other donors (US$)

0

Total amount - Gavi support (US$)

174080

Amount per girl - Gov. Funding / Country Co-financing (US$)

6.32

Amount per girl - Other donors (US$)

0

Amount per girl - Gavi support (US$)

0.55

Budget for the MAC operational costs support

Total amount - Gov. Funding / Country Co-financing (US$)

851860

Total amount - Other donors (US$)

0

Total amount - Gavi support (US$)

74080

Amount per girl - Gov. Funding / Country Co-financing (US$)

6.32

Amount per girl - Other donors (US$)

0

Amount per girl - Gavi support (US$)

0.82

3.1.4.4 Key Budget Activities

List the key budgeted activities to be undertaken in implementing the requested support. Please provide details on the key cost drivers, inputs and assumptions required for these activities.

Training and step down training for MoH and MoET: Meals and accommodation
School board sensitization: Meals and accommodation for meetings
Development and pretesting of HPV communication materials: Meals and accommodation for pretesting

3.1.4.5 Financial management procedures

Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including any procurement to be incurred.

Funds will be managed by the MoH Projects Accounting Unit. Procurement will follow government procedures for procurement. 3 quotations are sourced for procurement above $2, 076 ($/14.45). The lowest quotation is selected . Following authorization by designated personnel, a purchase order is provided to the supplier. Following the rendering of services or delivery of goods an invoice (and delivery note for goods) is sent to the MoH Projects Accounting Unit for payment following certification by the head of family health

3.1.4.6 Compliance with guidelines for use of Gavi financial support for human resources (HR) costs

Does the submitted application and budget comply with existing guidelines, criteria and requirements for use of Gavi financial support for human resources (HR) costs?

Yes☒ No☐

Please provide further information and justification concerning human resources costs, particularly when issues and challenges have been raised regarding the compliance with Gavi guidelines.

Human resource costs have not been requested

3.1.4.7 Fiduciary management

Please indicate whether funds for operational costs should be transferred to the government or WHO and/or UNICEF and when funding is expected to be needed in country. Attach banking form if funding should be transferred to the government. Please note that UNICEF and WHO will require administrative fees as follows.

- **UNICEF Tripartite Agreement: 5%**
- **UNICEF Bilateral Agreement: 8%**
- **WHO Bilateral Agreement: 7%.**

Government

3.1.4.8 Use of financial support to fund additional Technical Assistance needs

Gavi funds through its Partner Engagement Framework / TCA, tailored and differentiated technical assistance in response to specific country needs. Please review the currently approved technical assistance plan (also referred to as the "One TA plan") with a view to assess that required support for the implementation of the new vaccine support is contained in the approved technical assistance plan. If gaps in technical assistance are identified for the new vaccine support, the additionally required technical assistance may be funded through the vaccine introduction grant or campaign operational costs support. In this case, the relevant costs must be reflected in the budgeting and planning template.

In addition, please indicate the programmatic areas for additional technical assistance needs and the respective agencies providing the technical assistance (if already identified) below.

Note 7

No additional Technical Assistance has been included in the budget

3.1.5 Strategic considerations

3.1.5.1 Rationale for this request

Describe the rationale for requesting these new programme(s), including the burden of disease. If already included in detail in the Vaccine Introduction Plan or Campaign Plan of Action, please cite the sections only.

Rationale included in the HPV implementation plan page 1 to 2: Justification for reintroduction, and Programme goals

3.1.5.2 Alignment with country strategic multi-year plan / comprehensive multi-year plan (cMYP)

Please describe how the plans and key assumptions in this request align with the most recent country strategic multi-year plan (cMYP) and other national health and immunisation plans.

The goal of the HPV vaccine programme is to contribute to the reduction in cervical cancer morbidity and mortality to ensure a healthy nation as enshrined in the constitution of Lesotho, the Lesotho National Health Strategic Plan (NHSP) (2017 – 2022), the Reproductive, Maternal, Neonatal, Child and Adolescent Health & Nutrition (RMCAH&N) strategic plan (2017 – 2027), and the 2019 Lesotho National Control Strategy. HPV vaccination forms part of the comprehensive cervical cancer prevention and control strategy. For Lesotho this would imply reintroducing the HPV vaccine into the routine schedule as the primary prevention strategy. The secondary prevention strategy is screening and the treatment of pre-cancerous lesions in country, and the tertiary strategy treatment of invasive cancer and palliative care referrals to South Africa due to lack of adequate health facilities for treatment in the country.

3.1.5.3 Coordination Forum (ICC, HSCC or equivalent) and technical advisory committee (NITAG)

Provide a description of the roles of the national Coordination Forum (ICC, HSCC or equivalent body) and national immunization technical advisory group (NITAG) in developing this request.
If any of Gavi's requirements to ensure basic functionality of the relevant national Coordination Forum (ICC, HSCC or equivalent) were not met, please describe the reasons and the approach to address this. Requirements can be found in the general application guidelines.

In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG.

The Lesotho NITAG was instrumental in conducting research to inform the justification for reintroduction which included the cost benefit analysis of reintroduction, selection of the target cohort, selection of the delivery strategies, and vaccine safety, efficacy, cold chain requirements and combination with other vaccines among others
The ICC reviewed the developed proposal, provided feedback, and subsequently endorsed the application. In addition, the ICC was instrumental in identifying and committing funding for the programme

3.1.5.4 Financial sustainability

Please discuss the financing-related implications of the new vaccine programs requested, particularly how the government intends to fund the additional co-financing obligations. Please mention if any defaults occurred in the last three years and, if so, describe any mitigation measures that have been implemented to avoid future defaults. Additionally has the country taken into account future transition from Gavi support?

There were no co-financing defaults that occurred in the last year
Co-financing funding is included within the EPI recurrent and capital budget
Financing for the programme, will be funded under the EPI budget. Additional funding is to be financed through the national cancer prevention budget

3.1.5.5 Programmatic challenges

Summarise programmatic challenges that need to be addressed to successfully implement the requested vaccine support, and describe plans for addressing those. These may include plans to address the barriers identified in the coverage and equity situation analysis section, and include vaccine supply chain, demand generation/ community mobilisation, data quality/ availability/ use and leadership, management and coordination, etc.

High staff turnover including, frequent rotation of staff to other areas/programs
 Most facilities are not staffed with Health Assistants, which compromises health promotion and social mobilization efforts. The ministry of Education, particularly teachers, and local chiefs and councillors (through the Ministry of Local Government and Chieftainship) will be capacitated to conduct HPV social mobilization within their respective communities
 Lack of interest in EPI by most Health Workers at Health Facility level
The human resources constraints were addressed by conducting a systematic HR assessment in 2016 and EPI program is working steadily towards the implementation of recommendations. Therefore, the additional human resources strengthening efforts will be addressed in the MR 5-year plan.
2. Service delivery challenges include;
 Frequent vaccine and supply stock-outs at multiple levels, attributed to limited forecasting skills at the health facility level. The immunization supply chain management (iSCM) is working on strengthening vaccine forecasting at district and health facility level. Districts are being

mentored on stock management practices and key stock availability indicators are being tracked gauge progress
 High vaccine wastage rates. EPI is to develop a vaccine wastage management policy for operationalization at the health facility level. The policy will provide a good balance between the goal of increasing immunization coverage that that of minimizing vaccine wastage
3. Demand creation
 Limited awareness by communities about immunization and other maternal and child health services. This has resulted in negative rumors and misconceptions about services delivered which especially impacted the 2017 Measles/Rubella SIA. An HPV communication plan has been developed to mitigate these challenges
Leadership
 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
and monitoring. MoH in collaboration with the Ministry of Local Government and Chieftainship is to develop HPV communication packages for parliamentarians and local councillors

3.1.5.6 Improving coverage and equity of routine immunisation

Explain how the proposed NVS support will be used to improve the coverage and equity of routine immunisation, by detailing how the proposed activities and budget will contribute to overcoming key barriers.

Social mobilization: Evidence from some LMICs has indicated that the lack of awareness of the importance of vaccines becomes a barrier for accessing immunization services. The proposed social mobilization will ensure that there is local ownership of the immunization programme
Training of health workers: Health workers will be trained on the reintroduction of HPV. The training will also include building health workers capacity to address any vaccine safety rumours that may emerge within their communities. As part of the training, health workers will be provided with short video materials that contain critical HPV vaccine information. The objective of these initiatives is to also increase health worker capacity to address all vaccine rumours, not just HPV vaccine, within their communities
School-based strategy for delivery of programe: The recent MoH study revealed that adolescent do not have health seeking behaviours, and are more likely not to visit health facilities. HPV vaccine (for girls only) will be co-administered with the routine Td vaccine (5th and 6th dose) for girls and boys aged 9 to 15 years of age.

3.1.5.7 Synergies

Describe potential synergies across planned and existing Gavi support, including planned introductions, campaigns and HSS support. If relevant, comment on capacity and appropriate systems to introduce multiple vaccines. Also describe how the country will mitigate any programmatic and financial risks associated with multiple introductions. Furthermore, how is the requested support complementary and creating synergies with the support of other Global Health Initiatives, such as the Global Fund and GFF?

Note 8

Outreaches have been selected as the third delivery strategy. Global fund and PEPFAR support 5 districts each in conducting outreaches to ensure that health services are brought closer to

communities. A primary health care package, is provided in all outreaches. The HPV vaccine programme will leverage on these outreaches to reach out of schools girls, and girls who may have missed their doses during the school visits

3.1.6 Report on Grant Performance Framework

Grant Performance Framework – Application Instructions

The Grant Performance Framework (GPF) contains all indicators that will be used to monitor programmatic performance for your requested type of support. Targets that were entered for number to be vaccinated in section 3 on the Target Information tab, have been carried over into their respective indicators in the GPF. Based on these numbers, coverage and dropout rate targets were calculated (where applicable). These appear as “calculated targets”. If you wish to revise these target values, please revise in the application form – they are not editable in the performance framework. In addition, as a part of your application, there are several items to be filled directly into the GPF. These are broken into required and optional items, below:

Required
1. In addition to the calculated targets, country targets are required to be submitted for outcome indicators. These targets should align to those in your cMYP or NHSP. If these targets are not in your cMYP or NHSP, or are the same as the calculated targets, please enter “NA” for each target value.
2. Additional indicators that appear in the Performance Framework that are not included in the application form. Please enter targets for these indicators.
3. For many indicators, reporting dates have been pre-populated. For those that have not yet been pre-populated, please add reporting dates.

Optional
1. Adding data sources to existing indicators: If there are data sources for indicators that you would like to include, you may add an additional source by clicking on the pencil icon next to the indicator name.
2. Adding new indicators: Gavi requires all countries to report on core indicators, which are already included in the GPF. If you wish to add supplemental indicators to monitor performance, you may do so by clicking the “Add indicator” button at the respective performance level (Outcome, Intermediate Result, or Process).

Please note that the GPF is filtered by default to only show indicators that are relevant to the specific types of support contained in the application. You may view the entire GPF by using the “Grant Status” filter. Please ensure your pop-up blocker is disabled when launching the GPF.

If you have any questions, please send an email to countryportal@gavi.org.

3.1.7 Upload new application documents

3.1.7.1 Upload new application documents

Below is the list of **application specific documents** that must be provided with your application.

In the case a document cannot be provided, please use the comment box to explain why, or by when it will be available.

Application documents

✓	**HPV implementation plan** Replaces the NVIP for the HPV vaccine application	Lesotho HPV Implementation planFinal_24-01-20_07.08.29.docx
✓	**Gavi budgeting and planning template**	LSOVIGMACHPVBudgetFINAL_23-01-20_19.24.42.xlsm

Endorsement by coordination and advisory groups

✓	**National coordination forum meeting minutes, with endorsement of application, and including signatures**	ICC endorsement_24-01-20_09.54.44.zip
✓	**NITAG meeting minutes** with specific recommendations on the NVS introduction or campaign	NITAG minutes_24-01-20_11.10.13.zip

Vaccine specific

✓	**HPV region/province profile**	HPV ApplicationLesotho Regions Profile_24-01-20_09.47.40.xlsx

✓	**HPV workplan**	HPV workplanFinal_23-01-20_19.25.30.xlsx
✓	**Other documents (optional)** Kindly upload any additional documents to support your HPV application	communication strategypending endorsement_24-01-20_09.43.59.docx

3.2 Measles-rubella follow-up campaign

3.2.1 Vaccine and programmatic data

Choice of presentation and dates

For each type of support please specify start and end date, and preferred presentations.

Note 9

Measles-rubella follow-up campaign

Preferred presentation	MR, 5 doses/vial, Lyophilised
Is the presentation licensed or registered?	Yes ☒ No ☐
2nd preferred presentation	MR, 10 doses/vial, Lyophilised
Is the presentation licensed or registered?	Yes ☒ No ☐
Required date for vaccine and supplies to arrive	1 April 2021
Planned launch date	1 October 2021

Support requested until	2022

3.2.1.2 Vaccine presentation registration or licensing

If any of the selected presentations are not yet licensed or registered, please describe the duration of the registration or licensing procedure, whether the country's regulations allow the expedited procedure for national registration of WHO-pre-qualified vaccines, and confirm whether the licensing procedure will be completed ahead of the introduction or campaign.

n/a

3.2.1.3 Vaccine procurement

Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund.Does the country request an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or Gavi)?

Yes☐ No☒

If you have answered yes, please attach the following in the document upload section:* A description of the mechanism, and the vaccines or commodities to be procured by the country through this mechanism.* A confirmation that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. OR, for the procurement of locally-produced vaccines directly from a manufacturer which may not have been prequalified by WHO, a confirmation should be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality problems reported to WHO, and for which compliance is assured by a fully functional National Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

3.2.2 Target Information

3.2.2.1 Targets for campaign vaccination

Please describe the target age cohort for the Measles-rubella follow-up campaign:

Note 10

From	9	weeks ☐	months ☒	years ☐
To	59	weeks ☐	months ☒	years ☐

2021 2022

Population in target age cohort (#)	195,202
Target population to be vaccinated (first dose) (#)	195,202
Estimated wastage rates for preferred presentation (%)	10

3.2.2.2 Targets for measles-rubella routine first dose (MR1)

To be eligible for measles and rubella vaccine support, **countries must be fully financing with domestic resources the measles mono-valent vaccine component of MCV1** which is already in their national immunisation schedule, or have firm written commitments to do so. Please provide information on the targets and total number of doses procured for measles first dose.

	2021	2022
Population in the target age cohort (#)		
Target population to be vaccinated (first dose) (#)		
Number of doses procured	1	1

3.2.3 Co-financing information

3.2.3.1 Vaccine and commodities prices

Price per dose (US$) - Measles-rubella follow-up campaign

	2021	2022
5 doses/vial,lyo	0.82	0.74

Commodities Price (US$) - Measles-rubella follow-up campaign (applies only to preferred presentation)

	2021	2022
AD syringes	0.036	0.036
Reconstitution syringes	0.008	0.008
Safety boxes	0.005	0.005

Freight cost as a % of device value	1.83	2.03

3.2.3.2 Country choice of co-financing amount per vaccine dose

The table below shows the estimated financial commitment for the procurement of vaccines and supplies for the country, and the portion of Gavi support.
Please note that the values represented in this table do not account for any switches in co-financing group. The calculations for the entire five year period are based on the countries co-financing group in the first year.

Note 11

	2021	2022
Country co-financing share per dose (%)		
Minimum Country co-financing per dose (US$)		
Country co-financing per dose (enter an amount equal or above minimum)(US$)	0.04	0.037

3.2.3.3 Estimated values to be financed by the country and Gavi for the procurement of supply

Measles-rubella follow-up campaign

	2021	2022
Vaccine doses financed by Gavi (#)	206,800	
Vaccine doses co-financed by Country (#)	9,900	
AD syringes financed by Gavi (#)	205,000	
AD syringes co-financed by Country (#)	9,800	
Reconstitution syringes financed by Gavi (#)		

Reconstitution syringes co-financed by Country (#)	
Safety boxes financed by Gavi (#)	2,275
Safety boxes co-financed by Country (#)	125
Freight charges financed by Gavi ($)	4,201
Freight charges co-financed by Country ($)	201

	2021	2022
Total value to be co-financed (US$) Country	9,000	
Total value to be financed (US$) Gavi	182,500	
Total value to be financed (US$)	191,500	

3.2.3.4 Estimated projection of the required domestic financing for the measles monovalent component of MCV1

Countries are required to domestically finance the first dose in their measles containing vaccine routine (MCV1) in order to be able to receive Gavi support for any measles/ measles-rubella programmes. Below is the estimated projection of the required domestic financing for MCV1, based on the information provided in the previous sections.

Note 12

	2021	2022
Minimum number of doses financed from domestic resources		1
Country domestic funding (minimum)		0.74

3.2.3.5 Co-financing payment

Please indicate the process for ensuring that the co-financing payments are made in a timely manner.

It will be facilitated by the ministry of finance

If your country is in the accelerated transition phase for Gavi support, please answer the following question:

Please provide evidence that the co-financing obligations for the new introduction have been budgeted for, and elaborate on how the country plans to pay for the fully self-financing amounts. Please discuss the extent to which medium-term immunisation/health plans and medium-term expenditure frameworks incorporate the additional costs associated with this introduction. Discuss any co-financing defaults that may have happened in the last five years.

Country is in preparatory transition and not accelerated

Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of:	May

The payment for the first year of co-financed support will be made in the month of:

Month	May
Year	2021

3.2.4 Financial support from Gavi

3.2.4.1 Campaign operational costs support grant(s)

Measles-rubella follow-up campaign

Note 13

No Response

Gavi contribution per person in the target age cohort (US$)

0.55

Total in (US$)

107,361.1

Funding needed in country by	31 March 2021

3.2.4.2 Operational budget

Please complete the Gavi budgeting and planning template to document how the Gavi Vaccine Introduction Grant and the Campaign Operational Costs support grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the campaign and the introduction of the new vaccine. Please ensure to upload the completed budgeting and planning template as part of this application.

If Gavi's support is not enough to cover the full needs please indicate how much and who will be complementing the funds needed in the Operational Budget template. In the following fields please provide an overview of your request.

Total amount - Gov. Funding / Country Co-financing (US$)

0

Total amount - Other donors (US$)

0

Total amount - Gavi support (US$)

68862

Amount per target person - Gov. Funding / Country Co-financing (US$)

0.65

Amount per target person - Other donors (US$)

0

Amount per target person - Gavi support (US$)

0.65

3.2.4.3 Key Budget Activities

List the key budgeted activities to be undertaken in implementing the requested support. Please provide details on the key cost drivers, inputs and assumptions required for these activities.

Refer to budget and planning

3.2.4.4 Financial management procedures

Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including any procurement to be incurred.

Not Applicable

3.2.4.5 Compliance with guidelines for use of Gavi financial support for human resources (HR) costs

Does the submitted application and budget comply with existing guidelines, criteria and requirements for use of Gavi financial support for human resources (HR) costs?

Yes☒ No☐

Please provide further information and justification concerning human resources costs, particularly when issues and challenges have been raised regarding the compliance with Gavi guidelines.

The human resource cost will comply with GAVI guidelines

3.2.4.6 Fiduciary management

Please indicate whether funds for operational costs should be transferred to the government or WHO and/or UNICEF and when funding is expected to be needed in country. Attach banking form if funding should be transferred to the government. Please note that UNICEF and WHO will require administrative fees as follows.

- **UNICEF Tripartite Agreement: 5%**
- **UNICEF Bilateral Agreement: 8%**
- **WHO Bilateral Agreement: 7%.**

Funds will be transferred to the government

3.2.4.7 Use of financial support to fund additional Technical Assistance needs

Gavi funds through its Partner Engagement Framework / TCA, tailored and differentiated technical assistance in response to specific country needs. Please review the currently approved technical assistance plan (also referred to as the "One TA plan") with a view to assess that required support for the implementation of the new vaccine support is contained in the approved technical assistance plan. If gaps in technical assistance are identified for the new vaccine support, the additionally required technical assistance may be funded through the vaccine introduction grant or campaign operational costs support. In this case, the relevant costs must be reflected in the budgeting and planning template. In addition, please indicate the programmatic areas for additional technical assistance needs and the respective agencies providing the technical assistance (if already identified) below.

Note 15

Not applicable

3.2.5 Strategic considerations

3.2.5.1 Rationale for this request

Describe the rationale for requesting these new programme(s), including the burden of disease. If already included in detail in the Campaign Plan of Action, please cite the sections only.

Refer to Lesotho plan of action for 2021 MR Campaign application

3.2.5.2 Alignment with country strategic multi-year plan / comprehensive multi-year plan (cMYP)

Please describe how the plans and key assumptions in this request align with the most recent country strategic multi-year plan (cMYP) and other national health and immunisation plans.

The 2021 MR campaign align with compressive multi-year plan 2018 – 2020 and its clearly stated that this campaign will be conducted in 2021 based on the WHO recommendations that in one of the measles elimination strategy, the countries will have to conduct MCV campaign at least in 2 – 5 years interval to reduce measles susceptible individuals in the population

3.2.5.3 Coordination Forum (ICC, HSCC or equivalent) and technical advisory committee (NITAG)

Provide a description of the roles of the national Coordination Forum (ICC, HSCC or equivalent body) and national immunization technical advisory group (NITAG) in developing this request.
If any of Gavi's requirements to ensure basic functionality of the relevant national Coordination Forum (ICC, HSCC or equivalent) were not met, please describe the reasons and the approach to address this. Requirements can be found in the general application guidelines.
In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG.

 Members have a responsibility to provide the immunization Programme with high quality advice that is well synthesized on matters described in their terms of reference. These will guide the Programme to improve Programme performance in reducing morbidity, disability and mortality in preventing and controlling vaccine preventable diseases.
 Addresses immunization along with other health priorities and partnerships
 High-level decision making and approvals,
 Mobilizing resources and coordinating partners' interventions to better support programmes, including the EPI.
 Monitoring and on-going Programme performance oversight, receiving proposals made by the technical ICC and making the final decisions
 Identifying new partners, advocating for and mobilizing local resources for the EPI.
 The Lesotho ICC defines the rules and procedures for the management of the ICC's operations.
 Reviewing and monitoring of implementation of EPI-related, proposals (and documents), and recommendations from Immunization program reviews, annual desk reviews, and partner funded proposals such as Gavi supported activities etc.….
NITAG
The terms of reference have been provided by the Principal Secretary for Health. The LESNITAG serves as a scientific and technical advisory body to the MOH on matters relating to vaccines and immunization policy, within its overall terms of reference.
The terms of reference assigned to the LESNITAG are to provide technical expertise on the following:
• Policies and strategies relating to vaccination in general and to vaccines for children as well as the rest of the population
• Introduction of new vaccines and new technologies and their impact in the Health Systems and immunisation programme
• Updated information on the safety and quality of vaccines and on the fight against diseases that could be avoided through the use of new vaccines
• Any topics concerning vaccines and vaccination in general for which the MOH requires scientific and technical recommendations
The MOH will review, prioritize, and make final decisions on all recommendations provided by the LESNITAG.

3.2.5.4 Financial sustainability

Please discuss the financing-related implications of the new vaccine programs requested, particularly how the government intends to fund the additional co-financing obligations. Please mention if any defaults occurred in the last three years and, if so, describe any mitigation measures that have been implemented to avoid future defaults. Additionally has the country taken into account future transition from Gavi support?

NA

3.2.5.5 Programmatic challenges

Summarise programmatic challenges that need to be addressed to successfully implement the requested vaccine support, and describe plans for addressing those. These may include plans to address the barriers identified in the coverage and equity situation analysis section, and include vaccine supply chain, demand generation/ community mobilisation, data quality/ availability/ use and leadership, management and coordination, etc.

Refer to section 2.3: Coverage and equity under sub section situation analysis to this document

3.2.5.6 Improving coverage and equity of routine immunisation

Explain how the proposed NVS support will be used to improve the coverage and equity of routine immunisation, by detailing how the proposed activities and budget will contribute to overcoming key barriers.

NA

3.2.5.7 Synergies

Describe potential synergies across planned and existing Gavi support, including planned introductions, campaigns and HSS support. If relevant, comment on capacity and appropriate systems to introduce multiple vaccines. Also describe how the country will mitigate any programmatic and financial risks associated with multiple introductions. Furthermore, how is the requested support complementary and creating synergies with the support of other Global Health Initiatives, such as the Global Fund and GFF?

Note 16

NA

3.2.5.8 Indicative major Measles-rubella and rubella activities planned for the next 5 years

Summarise in one paragraph the indicative major Measles-rubella and rubella activities planned for the next five years that are reflected in the annual EPI plan (e.g. Measles-rubella second dose introduction, Measles-rubella or Measles-rubella-rubella follow up campaign, etc.).

Refer to CMYP addendum document attached

3.2.6 Report on Grant Performance Framework

Grant Performance Framework – Application Instructions

The Grant Performance Framework (GPF) contains all indicators that will be used to monitor programmatic performance for your requested type of support. Targets that were entered for number to be vaccinated in section 3 on the Target Information tab, have been carried over into their respective indicators in the GPF. Based on these numbers, coverage and dropout rate targets were calculated (where applicable). These appear as “calculated targets”. If you wish to revise these target values, please revise in the application form – they are not editable in the performance framework. In addition, as a part of your application, there are several items to be filled directly into the GPF. These are broken into required and optional items, below:

Required
1. In addition to the calculated targets, country targets are required to be submitted for outcome indicators. These targets should align to those in your cMYP or NHSP. If these targets are not in your cMYP or NHSP, or are the same as the calculated targets, please enter “NA” for each target value.
2. Additional indicators that appear in the Performance Framework that are not included in the application form. Please enter targets for these indicators.
3. For many indicators, reporting dates have been pre-populated. For those that have not yet been pre-populated, please add reporting dates.

Optional
1. Adding data sources to existing indicators: If there are data sources for indicators that you would like to include, you may add an additional source by clicking on the pencil icon next to the indicator name.
2. Adding new indicators: Gavi requires all countries to report on core indicators, which are already included in the GPF. If you wish to add supplemental indicators to monitor performance, you may do so by clicking the “Add indicator” button at the respective performance level (Outcome, Intermediate Result, or Process).

Please note that the GPF is filtered by default to only show indicators that are relevant to the specific types of support contained in the application. You may view the entire GPF by using the

“Grant Status” filter. Please ensure your pop-up blocker is disabled when launching the GPF.

If you have any questions, please send an email to countryportal@gavi.org.

3.2.7 Upload new application documents

3.2.7.1 Upload new application documents

Below is the list of **application specific documents** that must be provided with your application.

In the case a document cannot be provided, please use the comment box to explain why, or by when it will be available.

Application documents

✓	**New vaccine introduction plan (NVIP) and/or campaign plan of action (PoA), including checklist & activity list and timeline** If support for a campaign and routine introduction is requested at the same time, the new vaccine introduction plan and campaign plan of action can be combined into one document to minimise duplication.	LESOTHO PLAN OF ACTION FOR MEASLES AND RUBELLA CAMPAIGN_24-01-20_15.19.05.docx
✓	**Gavi budgeting and planning template**	Budgeting and Planning Template 4_24-01-20_15.22.41.xlsm
✓	**Most recent assessment of burden of relevant disease** If not already included in detail in the Introduction Plan or Plan of Action.	LESOTHO PLAN OF ACTION FOR MEASLES AND RUBELLA CAMPAIGN_24-01-20_15.23.17.docx
	Sources and justification of campaign target population estimates (if applicable)	**No file uploaded**

Endorsement by coordination and advisory groups

✓ **National coordination forum meeting minutes, with endorsement of application, and including signatures**

The minutes of the national coordination forum meeting should mention the domestic funding of MCV1

Minutes of the ICC meeting held on 8th January 2020_24-01-20_15.27.41.docx

✓ **NITAG meeting minutes**

with specific recommendations on the NVS introduction or campaign

nitag minutes 23 April 2019_24-01-20_15.28.11.docx

Vaccine specific

✓ **cMYP addendum**

Situation analysis and 5 year plan captured in the cMYP or as an addendum to the cMYP

LESOTHO cMYP 20182022 costed MoH Final endorsed ready for_printing22 00000002_24-01-20_15.28.42.pdf

✓ **Annual EPI plan**

Annual EPI plan detailing planning of all measles and rubella-related activities for the current year, including realistic timelines, designated responsible individual(s) and a budget

Lesotho Measles Elimination strategic plan WHO Lesotho final draft_223_24-01-20_15.29.27.pdf

MCV1 self-financing commitment letter

If the country is not yet financing the measles monovalent component of MCV1, a letter signed by the Minister of Health and Minister of Finance

No file uploaded

committing for the country to self-finance MCV1 from 2018 onwards.

✓ **Measles (and rubella) strategic plan for elimination**

If available

Lesotho Measles Elimination strategic plan WHO Lesotho final draft_223_24-01-20_15.30.06.pdf

Other documents (optional) **No file uploaded**

4 Review and submit application

4.1 Submission Details

Country vaccine funding summary

Please review the estimated projections for new vaccine programmes included in this application.

Active Vaccine Programmes

Note 17

IPV Routine

	2019	2020	2021	2022
Country Co-financing (US$)				
Gavi support (US$)	121,889	123,356	124,703	125,947

PCV Routine

	2019	2020	2021	2022	2023
Country Co-financing (US$)	37,455	40,136	46,460	53,966	62,637
Gavi support (US$)	374,978	346,644	342,768	339,079	334,003

Pentavalent Routine

2019	2020	2021	2022	2023

Country Co-financing (US$)	8,806	8,481	9,888	11,485	13,331
Gavi support (US$)	95,761	78,320	78,104	77,370	76,337

Rota Routine

	2019	2020	2021	2022	2023
Country Co-financing (US$)	15,570	37,687	43,642	50,678	30,445
Gavi support (US$)	158,121	327,227	323,729	320,263	162,894

Total Active Vaccine Programmes

	2019	2020	2021	2022	2023
Total country co-financing (US$)	61,831	86,304	99,990	116,129	106,413
Total Gavi support (US$)	750,749	875,547	869,304	862,659	573,234
Total value (US$) (Gavi + Country co-financing)	812,580	961,851	969,294	978,788	679,647

New Vaccine Programme Support Requested

Measles-rubella follow-up campaign

	2021	2022
Country Co-financing (US$)	9,000	
Gavi support (US$)	182,500	

HPV routine, with multi-age cohort in the year of introduction

	2022	2023
Country Co-financing (US$)	37,500	30,000
Gavi support (US$)	233,000	160,000

Total country co-financing (US$)	
Total Gavi support (US$)	
Total value (US$) (Gavi + Country co-financing)	

Total Portfolio Overview – Existing Programs + New Vaccine Support Requested (US$)

	2019	2020	2021	2022	2023
Total country co-financing (US$)	61,831	86,304	108,990	153,629	136,413
Total Gavi support (US$)	750,749	875,547	1,051,804	1,095,659	733,234
Total value (US$) (Gavi + Country co-financing)	812,580	961,851	1,160,794	1,249,288	869,647

Contacts

Person(s) who should be contacted in case Gavi needs to ask for more information in regard to the application.

Name	Position	Phone Number	Email	Organisation
Nthatisi Mothisi	EPI Manager	+266 58864571	nthatisimothisi@gmail.com	Ministry of Health

Comments

Please let us know if you have any comments about this application

No

Government signature form

The Government of Lesotho would like to expand the existing partnership with Gavi for the improvement of the immunisation programme of the country, and specifically hereby requests Gavi support for:

HPV routine, with multi-age cohort in the year of introduction and Measles-rubella follow-up campaign

The Government of Lesotho commits itself to developing national immunisation services on a sustainable basis in accordance with the national health and immunisation strategic plans. The Government requests that Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

The co-financing commitments in this application include the amount of support in either supplies or cash that is requested from Gavi, and the financial commitment of the Government for the procurement of this new vaccine.

Please note that Gavi will not review this application without the signatures of both the Minister of Health and Minister of Finance (and Minister of Education, if applicable) or their delegated authority.

We, the undersigned, affirm that the objectives and activities in this request are fully aligned with the national health and immunisation strategic plans (or equivalent), and that funds for implementing all activities, including domestic funds and any needed vaccine co-financing will be included in the annual budget of the Ministry of Health.

We, the undersigned, further affirm that the requested funding for salaries, salary top-ups/allowances, per diems and incentives does not duplicate funding from other sources (e.g. from other donors).

We, the undersigned, further affirm that the terms and conditions of the Partnership Framework Agreement between Gavi and the Country remain in full effect and shall apply to any and all Gavi support made pursuant to this application.[1]

Minister of Health (or delegated authority)	**Minister of Finance (or delegated authority)**
Name	Name
Date	Date
Signature	Signature

For countries requesting HPV support, with a school linked strategy, the signature of the Minister of Education (or delegated authority) is also required.

Minister of Education (or delegated authority)

Name

Date

Signature

[1] *In the event the Country has not yet executed a Partnership Framework Agreement, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.*

Appendix

NOTE 1
The new cMYP must be uploaded in the country document section.

NOTE 2
The purpose of these estimates is to provide visibility into the current and future vaccine funding requirements. The values reflected here are a combination of actuals and estimates. Specifically, current year values reflect values approved by the secretariat, while future values are based on data provided by the country – when data isn't available we rely on extrapolations to estimate funding needs. Please note that any future values might be subject to change, and for the official obligations a country should refer to its active Decision Letter.

NOTE 3
* For more information on the vaccine presentations available, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* Please note Gavi may not be in a position to accommodate all countries first product preferences. In such cases, Gavi will contact the country and partners to explore options.

* Due to a variety of factors, the launch date may vary compared to the date stipulated in the application. Gavi will work closely with countries and their partners to address these issues.

* For routine vaccine introduction, support is usually requested until the end of the country's valid cMYP, as per the guidelines and may be extended in the future. If you wish to request Gavi support for a shorter time period than the end of your cMYP you may do so.

* For campaigns the "support requested until" field will normally be one calendar year from the launch date, but can be extended for a phased campaign.

NOTE 4
Co-financing requirements are specified in the guidelines.

NOTE 5
Note: The population in the target age cohort used here is the number you entered for year one in the target information section.

NOTE 6
https://www.gavi.org/support/process/apply/additional-guidance/#leadership

NOTE 7

A list of potential technical assistance activities in each programmatic area is available here: http://www.gavi.org/support/pef/targeted-country-assistance/

NOTE 8

E.g. if two introductions are planned in the same year, there should be synergies at least in training and social mobilisation events.

NOTE 9

* For more information on the vaccine presentations available, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* Please note Gavi may not be in a position to accommodate all countries first product preferences. In such cases, Gavi will contact the country and partners to explore options.

* Due to a variety of factors, the launch date may vary compared to the date stipulated in the application. Gavi will work closely with countries and their partners to address these issues.

* For routine vaccine introduction, support is usually requested until the end of the country's valid cMYP, as per the guidelines and may be extended in the future. If you wish to request Gavi support for a shorter time period than the end of your cMYP you may do so.

* For campaigns the "support requested until" field will normally be one calendar year from the launch date, but can be extended for a phased campaign.

NOTE 10

* The population in the target age cohort represents 100% of people in the specified age range in your country.

* The target population to be vaccinated is the number of people in the cohort that are expected to be vaccinated.

* For indicative wastage rates, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* The wastage rate applies to first and last dose.

NOTE 11

Co-financing requirements are specified in the guidelines.

NOTE 12

*The price used to calculate costs is based on UNICEF-single dose per vaccine procurement cost for measles monovalent vaccine.** This value will differ from the total cost if the vaccine selection is MR, as a country is only required to finance the cost of the measles monovalent vaccine.

NOTE 13
Note: The population in the target age cohort used here is the number you entered for year one in the target information section.

NOTE 14
https://www.gavi.org/support/process/apply/additional-guidance/#leadership

NOTE 15
A list of potential technical assistance activities in each programmatic area is available here: http://www.gavi.org/support/pef/targeted-country-assistance/

NOTE 16
E.g. if two introductions are planned in the same year, there should be synergies at least in training and social mobilisation events.

NOTE 17
The purpose of these estimates is to provide visibility into the current and future vaccine funding requirements. The values reflected here are a combination of actuals and estimates. Specifically, current year values reflect values approved by the secretariat, while future values are based on data provided by the country – when data isn't available we rely on extrapolations to estimate funding needs. Please note that any future values might be subject to change, and for the official obligations a country should refer to its active Decision Letter.