

Internal Appraisal 2014

The Gambia

1. Brief Description of Process

The first draft of the internal appraisal was prepared by an external consultant using the APR and supporting documentation submitted by the country. The draft was reviewed by Senior Country Officer (SCO) and revised accordingly by the consultant. The revised draft was then circulated by the SCO to the internal appraisal group and partners at HQ and regional levels. The comments received were addressed by SCO and final draft was circulated to internal appraisal group. The appraisal was finalized by the SCO and submitted to the GAMR team.

2. Achievements and Constraints

The Gambia is a small country with a population of 1.7 million and an annual birth cohort of approximately 81,000. The EPI program is one of the priority programs for the Ministry of Health and Social Welfare and the country has been performing well with consistently high coverage.

The DPT 3 coverage has remained consistently high with no discrepancies between the country's own estimates and WHO UNICEF estimates. Both in 2012 were 98%. The house hold survey coverage in 2013 for DPT3 was 88%. The coverage in males and females was 89% and 86% respectively. The full immunization coverage was 76%.

The percentage of children who were fully immunized was higher in rural areas than in urban areas (84% compared with 67%). It was also higher among children whose mothers have no education or who only reached the primary level compared to children whose mothers reached secondary or higher level education.

The ICC Minutes included in the APR list the following major achievements for 2013:

- Men A campaign in November-December reached 1.1 million (1-29-year-olds);
- Introduction of Rotavirus vaccine nationwide in August 2013;
- 2 polio NIDs (May and October 2013) integrated with vitamin A supplementation and deworming;
- Expansion and maintenance of the cold chain;
- Training staff in RI;
- Approval of HPV demo project (due to start in Oct/Nov 2014).

Challenges in meeting some key targets have also been outlined – the MCV2 and TT2 targets were not fully met in 2013, the reasons provided are listed below:

- *The country is using surviving infants as the denominator for MCV2. This leads to overestimation of the target.*
- *Problems of recording for TT immunization*
- *Late antenatal booking of pregnant mothers*

Additional challenges include:

- Frequent changes in the Ministry of Health personnel at national level affects the continuity of work, at both national and regional levels.
- The monitoring and supportive supervision system are weak at all levels and there is no standardized way of monitoring the EPI performance on regular basis and to provide feedback to lower levels based on the monitoring information.

- A large number of outreach sessions are held in the country but many outreach facilities need to be refurbished as they lack basic amenities which can cause client dissatisfaction.
- Waste management is an issue as many facilities don't have incinerators.
- Cold chain equipment is sufficient, however some needs replacing. Due to lack of regular electricity, maintaining the cold chain is a challenge.
- Annual health review is not up to the mark.
- There is a high staff turnover at all levels
- Knowledge, skills and capacity of health workers (immunization practices, safety and data collection, analysis and use) need strengthening.
- There is an urgent need to improve the quality of service delivery

Plans to address these challenges include:

- Rehabilitating incinerators at the regional and health facility level
- Strengthened routine supervision
- The constraints related to infrastructure, capacity building, data management and use would be addressed through the GAVI HSS proposal to be submitted in Sep 14.

In addition to the constraints noted, the PCV13 targets were not met due to stock-outs, and Rotavirus vaccine targets were not met due to delays in the nationwide roll-out. Additionally, the denominator used to calculate TT coverage is underestimated because it corresponds to the number of surviving infants rather than the number of pregnant women, so TT coverage is likely to be even lower than reported.

There are some inequities (not major) in vaccine delivery (related to urban-rural, income, and maternal education), and the APR argues that there is little or no gender imbalance in the children receiving vaccines. Sex-disaggregated data is collected at the facility level but is not aggregated and reported at the regional or national level, but there are plans to aggregate it at all levels.

On the whole, the Gambian EPI program performs very well demonstrating a culture of evaluation and ability to response to identified challenges. The main focus of the program should be to sustain high coverage and improve the quality of program.

3. Governance

Due to the frequent changes in the officials at the MOH, the government is not able to provide a strong leadership to the ICC and the partners have to push for the meetings to be held. The ICC meetings are only held to review critical activities like the APR, new applications for vaccine introduction or HSS etc. it is not reviewing and guiding the program on a regular basis.

Minutes of one ICC meeting on 7 May 2014 were provided, and show that the ICC recently adopted new Terms of Reference in anticipation of the ICC's role in overseeing the development and management of HSS grants. There is no HSCC currently constituted in the Gambia.

Representation at the ICC meeting in May included government agencies, two Regional health teams, WHO, UNICEF and the Medical Research Council. The only Gambian CSO represented at this meeting was Gambia Red Cross, but on the ICC signature page, a local Rotary group was represented, as well as Action Aid and Riders for Health. The APR indicates that Catholic Relief Services and the Child Fund are also members. Minutes of the meeting did not indicate the content or authors of most comments, so it was difficult to assess the extent of CSO participation beyond attendance.

The minutes indicated the presentation of substantive information and noted that action items from previous meetings had been addressed. However, the ICC met only twice in 2013, which may be too infrequent for optimal governance.

4. Programme Management

Management of the programme appears to be very good based on the routine reporting of performance indicators relative to baselines and implementation of activities to budget. There are minor issues with specification of targets and implementation of activities to schedule, as evidenced by the slower-than-anticipated rollout of the rotavirus vaccine, but there are also clear strengths, such as surveillance for rotavirus illness and bacterial meningitis, training, and maintenance of infrastructure. The country has the cMYP (till 2016), however annual plans based on cMYP and monitoring of activities in cMYP are not prepared.

Programme Delivery

The MenA campaign went according to plan and schedule, with the exception that administrative coverage was 104%. The explanation given was that non-Gambians living near the border were vaccinated, but could also indicate an underestimation of the target population. Reported survey coverage was 97%, so by either measure, the campaign reached the target age group.

Rotavirus vaccine (Rotateq) was introduced in August 2013, with the ambitious target of vaccinating 92% of infants with 3 doses in the last quarter of 2013. However, the first dose was administered to only 1/3 of the original target population as rotavirus vaccine shipments were deferred because some regions introduced the vaccine later than expected, despite the planned nationwide introduction. Approximately 5,000 children received the full course of 3 doses by end of 2013. There were 50,745 vaccine doses in stock as of 1 January 2014, and subsequent coverage was expected to be on track. The rotavirus vaccine post-introduction evaluation is planned for November 2014.

Only 63% of the requested amount of PCV13 was received; there was a stock-out in late November/ early December due to low supply. However this didn't affect the coverage as there were 30,500 PCV 13 doses carried from 2012 to 2013 excluding the stock balance from facility and regional levels. Secondly, the wastage rate for PCV 13 is very low. PCV 13 shipment of 115,000 doses arrived in Feb 14 and another 207,000 doses will be shipped to the country in July 2014.

Country introduced MCV2 in August 2012. Reported coverage is 35% in 2012 and 53% in 2013. Yet, the country forecasts coverage of 94% for 2014. It would be important to know why the MCV2 remains low in the second year after introduction. Based on this analysis it is important that the country prepares specific plans to improve the coverage to effectively manage vaccine wastage or overstocking. The MCV2 post-introduction evaluation is planned for August 2014.

The Cold chain capacity has been enhanced and 10 regions were provided with solar direct drive (SDD) equipment, however due to erratic electricity supply in most parts of the country there is an urgent need to shift to SDD in the maximum number of facilities. The status report outlining the implementation of the EVM improvement plan is a few years making it difficult to assess these activities. The next EVM is scheduled in August 2014.

In general, there appears to be excellent maintenance and management of vaccine stocks, as indicated in the 2010 PCV PIE.

Supervision should be done through bi-monthly visits, but due to other competing priorities and lack of transport facility (fuel), this is not regular. There are no standard SOP and guidelines available, but the EPI intends to develop and use SS system based on other country experiences.

5. Data Quality

Facilities enter the program data on a monthly basis in the DHMIS which is used as a data management tool for all programs in the MoH. The EPI reports to the WHO monthly and thus received monthly reports from the regions and the data is entered in the DVD MT at national level. The reports are used for monitoring and review of the program.

There is no standardized data reporting form for EPI, the regions report using their own formats which at times leads to discrepancies. There is a need to develop a standard reporting format for monthly reporting (for DVD MT).

Data audit teams are in place to monitor data quality but need support, in terms of capacity building and transport. A CES has been done in 2014 and results are expected in July, the health facility staff are trained to conduct the CES and then sent to adjacent facilities to conduct the survey.

The quality of data in general appears to be good, although there are some minor concerns as noted regarding target populations and denominators. Recent EPI Cluster Survey, MICS, and EPI administrative data are all in the mid-to-high 90s and consistent with each other. Data quality audits at the central, regional, and health facility levels have been conducted to resolve data challenges, including questions about denominators, and on-going training on effective and timely data management is planned.

6. Global Polio Eradication Initiative, if relevant

The country had the last case of wild polio virus in 1986.

Two OPV NIDs were conducted in 2013. The country has applied to GAVI for IPV and its application will be reviewed in June/July 2014.

7. Health System Strengthening

The Gambia is not reporting on HSS fund utilization for 2013. Its HSS grant (2010) was not transferred because the aide-memoire wasn't signed, the country decided to forego the HSS grant and to reapply under the new funding window in Sep 2014. Minimal HSS activity is reported in the APR like: Project Coordination Unit strengthening and completion of ISS audits 2009-2012.

One of the main challenges the program faces is the high turnover of staff at all levels, leading to discontinuity in program planning, management, monitoring and supervision at regional and national levels. Service delivery at lower levels has also been compromised leading to quality issues (using of untrained vaccinators, cold chain management, planning etc.).

The staff (especially the mid-level managers). have not been trained for a long time and there is an urgent need to set up a mechanism for constant mentoring of new staff at the lower levels.

8. Use of non-HSS Cash Grants from GAVI

No new funds for ISS were disbursed in 2013, but \$377,394 was carried over from the 2012 ISS grant. The 2013 financial statement for the ISS funds details expenses for intended purposes and shows a small carry-over to 2014.

The Gambia was eligible for a vaccine introduction grant for the introduction of Rotateq, but these funds have not yet been disbursed as the aide memoire has not been finalized and signed by the country and GAVI.

The Gambia (through UNICEF) received a total of US\$ 1.52 million for Men A campaign in 2013 (\$727,500 for operational costs and US\$ 792,500 for campaign supplies). Table 5.5a of the APR shows expenditures of GAVI funds of \$1,518,200 for campaign costs. The APR

Section 7.6.3 shows categories of expenditure for \$516,428 in operational costs for the MenA campaign conducted in November-December 2013. However, no accounting of these funds has been provided.

9. Financial Management

There is so far no ISS audit for 2013. The 2012 ISS audit identified two medium-level findings. The first of these, the lack of a fuel register, was addressed at the time of the audit, but the second had not been resolved. This finding was that withheld tax deductions had not been refunded to the Gambia Revenue Authority. No update on this has been provided in the current APR.

There is so far no financial statement or audit provided for the Campaign Operational Support funds received in 2013, as noted above.

10. NVS Targets

Penta1 2015 target is 79,122. This is within 10% of 2013 which is acceptable.

For PCV the Country reached less infants with 3rd dose than targeted in 2013 (71,986 vs. 74,259); nonetheless, targets for 2015 are realistic and are within 10% of 2013 achievements (79,122 targeted in 2015). The Wastage rate for 2015 is 5%, which is within acceptable limits. But the country reported a wastage rate of 2% in 2013, so the country might be able to adjust this target downwards. The dropout rate for 2014 and 2015 is 0% and needs to be verified with the country.

Rota: the country introduced Rota in August 2013, explaining why the full year targets for 2013 were not achieved. (69,713 full year vs. 5,314 reached with 3rd dose). The 2015 targets seem realistic, and are in line with Penta targets. The wastage rate for 2015 is 5% which is within acceptable limits. The dropout rate for 2014 and 2015 is 0% and needs to be checked with country.

The May 2014 minutes show that the ICC discussed plans to request support for measles-rubella campaign.

Immunization Decision Support will draft the dose calculations for 2015 for all NVS programs using the approved targets (numbers of infants & wastage). The number of doses to be allocated (and planned for shipment) for 2015 for the pentavalent programmes are based on the approved targets (2015), reported opening stocks (Jan 2014), shipment plan (2014) and target closing stocks (2015). For other programmes, a stock analysis is carried out to determine the right level of stock to be deducted from the 2015 allocation. Syringes and safety box calculations are derived from dose calculation. All this is done in consultation with the Vaccine programme manager and (if there are any significant changes) the country, and are signed off by the CRO or Head.

11. EPI Financing and Sustainability

The total expenditure for immunization in 2013 was US\$ 5,589,641, out of which the government paid 11%; the remainder was supported by partners (GAVI-78%, UNICEF-7%, WHO-4%)

Per the cMYP, financial support for public health services including EPI comes from three (3) principal sources:

- (a) *Government recurrent and development budget (10 -14%).*
- (b) *Cost-recovery on drugs (effective in some of the Bamako Initiative health facilities)*
- (c) *External assistance*

Per the APR, GAVI ISS funds are not reported on the health sector budget.

The government currently provides about a quarter of the budget for health expenditures. Projected government contributions to the EPI budget remain steady, with slight fluctuations over the period covered by the current cMYP. Projected gaps result primarily from transport and campaign costs. Sustainability of the current excellent EPI performance is likely to depend on continued GAVI and other donor support.

The Gambia has consistently met GAVI co-financing obligations. Note that the narrative cMYP does not contain the budget tables from the costing tool.

12. Renewal Recommendations

Topic	Recommendation
NVS	<p>DTP-HepB-Hib, 10 doses per vial liquid, recommend for renewal of support in 2015, based on country's requested targets.</p> <p>Measles Second Dose, 10 doses per vial, lyophilized, recommended for renewal of support in 2015, based on country's requested targets.</p> <p>Rota, 3 dose schedule, recommend for renewal of support in 2015, based on country's requested targets.</p> <p>Pneumococcal, PCV (13), 1 dose per vial, liquid, recommended for support in 2015, based on based on country's requested targets</p>

13. Other Recommended Actions

Topic	Action Point	Responsible	Timeline
<i>Program</i>	Urgent need to focus on quality of service delivery, HR retention and capacity building and institutionalization of a supportive supervision and review process, specific plans to address immunization coverage in urban areas.	Gambia EPI (GEPI)	Ongoing
<i>Data Quality</i>	Adjust pregnant women targets	GEPI	Aug 2014
<i>Achievements & Constraints</i>	Collect, analyze and use equity (sex, income, education, residence) data	GEPI	Aug 2014
<i>Governance</i>	Strengthen ICC and use it to review and guide EPI.	MoH & ICC	Aug 2014
	Update EVM Improvement Implementation status report	GEPI	Aug 2014
	Provide financial statement/audit of 2013 COS	GEPI	Aug 2014
	Insert tables from cMYP costing tool into narrative cMYP		Aug 2014
	Revise or explain 2013 PCV13 coverage data given stock-out		Aug 2014
	Update re: status of payment of withholding tax deduction to GRA		Aug 2014
NVS	Country introduced MCV2 in August 2012. Reported coverage is 35% in 2012 and 53% in 2013. Yet, the country forecasts coverage of 94% for 2014. Submit plans to increase the coverage from 53% to 94% in 2014 and onwards.		