# Internal Appraisal 2014

# Eritrea

## 1. Brief Description of Process

The first draft of the internal appraisal was prepared by an external consultant. The consultant, following discussions with the Senior Country Officer (SCO) reviewed the APR and supporting documents submitted by the country. The draft was reviewed by SCO and initial comments provided to the consultant. Following which the consultant revised the draft. This 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

Eritrea has had many achievements -- it introduced HBV vaccine in 2002, Hib vaccine in 2008, measles second dose in 2012 (PIE anticipated last quarter of 2014), and plans to introduce rotavirus vaccine in July 2014 (a year behind schedule – because of vaccine supply constraint) and PCV in July 2015. In addition, it plans to submit a request for MR vaccine in June 2014 (to IST/AFRO), and one for IPV in September 2014. The country has eliminated MNT, controlled measles, is polio-free, and has a strong disease surveillance system. It has implemented SOS to reach out to geographically marginalized populations, and reports sex-disaggregated data which show that in 2013, 93.4% of boys and 92.2% of girls in a coverage survey had received DTP3.

The coverage reported in the JRF for last 2 years are given in the table below. There are some discrepancies in the DPT3 and Penta 3 targets and achievements for 2012 & 2013.

| | | BCG | DPT3 | OPV3 | Penta 3 | MCV 2 |
|---|---|---|---|---|---|---|
| **JRF 2012** | Target (%) | 85 | 85 | 85 | 77 | 78 |
| | Achievement (%) | 74 | 80 | 80 | 80 | 38 |
| **JRF 2013** | Target (%) | 85 | 85 | 85 | 66 | 73 |
| | Achievement (%) | 74 | 75 | 75 | 75 | 72 |
| **APR 2013** | Target (%) 2014 | 90 | 90 | 90 | 93 | 80 |
| | Achievement Estimates 2014 (%) | 90 | 90 | 90 | 93 | 80 |

Some of the main constraints Eritrea is grappling with are inadequate transport, high staff turnover, financial constraints to conduct regular outreach in hard to reach areas and uncertain population estimates. HSS funds have been delayed (due to late submission of necessary programmatic and financial reports on time).

## 3. Governance

The ICC met three times in 2013. At the May 2014 meeting for which minutes were provided, there were seven attendees: 2 from WHO, 4 from the central government, and 1 member of PLC. CSO involvement seems to be minimal, although the signature page shows involvement of the National Union of Eritrean Women and JICA, and the EPI review states that National Union of Youths and Students, Vision Aid Eritrea, and Catholic Church are also members.

Only one set of HSCC minutes, from a meeting in March 2014, was provided. All HSCC signatories were from the MOH. The HSCC reviewed implementation status of activities for the first half of the first year (not clear what timeframe this referred to) and reasons why some

activities hadn't been implemented. Some activities implemented by Family health unit have been delayed. A concern was raised about the need to reward high performers. On a positive note, medical equipment for strengthening diagnostic and treatment capacity at the health facility was being procured through GAVI HSS funds, and an incinerator had been provided through the Global Fund.

Neither the ICC nor HSCC minutes were very detailed, and – although ICC and HSCC members signed off on the APR – neither committee's minutes reported discussion of it or an explicit endorsement, although it was stated that ICC members had the opportunity to read and comment on a draft. Of note, the recommendation made in the 2011 EPI review that the ICC membership should be strengthened to include professional bodies and health training institutions does not seem to have been implemented.

## 4. Programme Management

The ministry of health runs the program through a dedicated EPI unit reporting to Director of Family and Community Health Division. The MOH is responsible for policy standards, priority setting, capacity building, and links with other stakeholders and donor partners for resource mobilization. At the Zoba level, the EPI is managed by Family and Community Health Division. EPI service delivery is integrated with other MCH services and it is delivered as a package in all health facilities in static and out reach services.

The vaccines included in the program are against eight vaccine preventable diseases namely – Tuberculosis, Diphtheria, Whooping Cough, Tetanus, Polio, Measles (2 doses), Hepatitis B & Haemophilus influenza type B.

The EPI unit has a central cold chain store and cold chain stores at each of the Zoba. The Zoba cold chain stores collect vaccines from the central EPI cold chain store quarterly, and the health facilities collect vaccines from the Zoba cold chain stores monthly. Procurement of routine vaccines and injection is entirely carried out by UNICEF. WHO provides technical assistance for training and surveillance activities. Both provide operational funds for routine and supplementary immunization activities. GAVI supports new and under used vaccines with bundles of injection safety materials and funds for ISS, and HSS.

Eritrea had an excellent EPI review in 2011 that provided a comprehensive list of key recommendations. This review was to be the basis for the EPI strategic action plan for 2012-2016, but that document was not included in the APR materials, and so it is not possible to assess whether it is costed, reviewed by the ICC, and updated annually.

As noted in section 8, below, in the case of the HSS grant, the baselines and performance indicators are not always clear.

## 5. Programme Delivery

The EVM conducted in December 2012 reported several strengths, namely, sufficient cold and dry storage for the vaccines delivered at the time; adequate buildings and equipment; and good knowledge and understanding of vaccine management by staff. The EVM addressed the cold chain capacity taking into account the introduction of MSD and rotavirus vaccine, but not PCV and IPV. The documents available at the time of this APR do not assess cold chain capacity for these anticipated introductions. The next EVM is planned in December 2015.

Weaknesses identified in the EVM were temperature monitoring, preventive maintenance, stock management, and distribution between levels. The progress report on implementation of the improvement plan shows excellent progress on implementation, with only a few items incomplete or partially so. The items that had yet to be completed included the distribution of SOPs for temperature monitoring, which should be a priority given that this was one of the primary weaknesses identified, the implementation of scheduled maintenance, and the training of 2 engineers.

The EPI report from 2011 points to overstocking of TT and Penta and under stocking of BCG and MCV; the Dec 2012 EVM reported that in general, stocking was well managed, but that there was some consistent under stocking and rare stock-outs (BCG stock-out x 2 weeks in April 2012).

The rotavirus vaccine introduction is currently planned for July 2014.

## 6. Data Quality

Eritrea has never had a census since its independence in 1991. There is great uncertainty about the size of the target population, and discrepancies between administrative and WHO coverage estimates. The denominator may be over-estimated because of population displacement and mobility, so administrative estimates underestimate coverage, often by more than 10 percentage points compared with coverage surveys.

Eritrea conducted an EPI review in 2013 that provides a comprehensive list of key recommendations.

The EPI coverage survey in 2013 showed that the national coverage by antigen was as follows

| | BCG | Penta 1 | OPV 1 | Penta 3 | OPV 3 | Measles |
|---|---|---|---|---|---|---|
| **Crude Coverage (%)** | 100 | 100 | 100 | 100 | 98 | 97 |
| **Valid coverage (%)** | | | | 92 | 87 | 88 |
| **Coverage by card only (%)** | 94 | 94 | 93 | 92 | 93 | 91 |
| **Admin coverage (May 11-Apr12) %** | 44 | 53 | 53 | 53 | 54 | 47 |
| **Admin coverage reported in JRF 2013** | 74 | | | 75 | 75 | 72 |

The administrative coverage is lower than the survey finding, this might be attributed to inaccuracies in population projection and lack of recent census data. Access to immunization services in Eritrea could be considered high, the crude Penta1 coverage of above 90% in all zobas is an indication. The reported Penta3 for boys was 93.4% and the girls was 92.5%

Non adherence to immunization schedule was significantly high in South Red Sea zone compared to other zones.

Key Recommendations of the EPI survey in 2013 include

- Further support of outreach services (SOS) in the hard to reach areas, through mobilization of resources, ensuring continuous and more frequent visits.
- Train health workers on proper recording on the health passport and further strengthen the use of EPI Registers.
- Refresher course for health workers on immunization schedule and need to adhere to the stipulated schedule
- Intensify health education and behavioural changes so as to reduce the number of non-vaccinated children.
- Validate administrative data to iron out issues of recording and tallying through a Data Quality Self Audit.
- Engage the department of statistics for a more realistic population projection for the country.

Data improvement activities are included in the HSS budget, but do not appear to have been implemented yet. DQA training in all zobas planned for 2014.

## 7. Global Polio Eradication Initiative, if relevant

Eritrea is classified polio-free, and plans to request support for IPV in September 2014; also plans cross-border meeting with Sudan to coordinate and strengthen surveillance.

The 2011 EPI review refers to pockets of unreached children where risk of polio may be high. Outreach services were interrupted in 2010 due to lack of funds for fuel; per 2013 APR, SOS has been implemented.

There is difficulty with surveillance, since stool samples have to be shipped to KEMRI in Nairobi and can only be shipped once/week.

Polio committees don't sit often enough, so there is a backlog of AFP cases waiting to be classified.

## 8. Health System Strengthening

The country started the GAVI funded HSS implementation in 2008. The program implementation has been delayed due to various administrative reasons (delayed implementation, reporting and disbursements) and currently the program is to receive it's last tranche of US$ 715,250.

The last tranche of US$ 715,250 was approved by the IRC and the DL was sent to the country in Oct 2013, however due to late submission of the required reports, the disbursement has not been made.

The documentation of planned HSS activities, actual expenditures, and progress and constraints is quite thorough. However, there seems to be a disconnect between the amounts expended per the worksheet entitled Planned Activities for 2014 and the narrative report of progress and plans for future put forth in the APR. Specifically, it seems there is insufficient absorptive capacity for the HSS funds disbursed by GAVI, so that even without the disbursement of the 2013 tranche, the HSS fund carries over more than $783,000. Nonetheless, the APR explains the delay in HSS activity implementation by saying, "Because of the small amount of money allocated for the many and fragmented activities, some of them could not be implemented as set out in the action plan." This clearly indicates that the planning, implementation and monitoring of the HSS activities was inadequate and it should be a lesson when the country applies for the next HSS support in 2015.

As noted above, the documentation of the activities and progress toward them is very thorough. Despite this, and despite the desirability of the proposed HSS activities, it seems unlikely that the country will be able to use the requested funds in timely manner.

Another reason provided for the delays in implementation is the large number and fragmented nature of the proposed activities; some of these have been consolidated with consultation with GAVI.

It did not appear that there was a budgeted plan for recurrent maintenance and running of HSS-funded capital items.

There are provisions for performance-based funding, but per HSCC minutes, these have not been implemented and will be implemented next year.

There appears to be no CSO involvement in HSS; all HSCC signatories are MOH. The APR confirms this, while acknowledging the importance of youth and women's organizations' volunteer involvement.

Performance indicators for the seven indicators reported in Table 9.3 were met in 2013.

MOH/Eritrea does not have HSS Health Sector report, but will conduct the health sector strategic review in 2015.

## 9. Use of non-HSS Cash Grants from GAVI

No ISS grant currently, but $6689 was carried over from MSD VIG, of which $5567 was spent on transport and capacity building in 2013, leaving $1122 at the start of 2014. The country is not eligible for any ISS award.

Eritrea will introduce Rotarix in July 2014, and received the rotavirus VIG in April 2014.

## 10. Financial Management

GAVI/HSS external auditing for the period June 01-2013 to May 31, 2014 is fixed and arranged to be done in 3rd week of June 2014 and will be sent to GAVI/HSS following the Audit report submission by the external auditing firm

## 11. NVS Targets

The reported Penta3 coverage for 2013 is 75%, and the target for 2014 is 90%. The survey coverage was 92%. The target for 2014 and 2015 are 104,889 and 104,246 respectively and seem to be realistic (if the current coverage as per surveys is maintained).

Country introduced MCV2 in July 2012. Reported coverage is 38% in 2012 and 72% in 2013. The country forecasts coverage of 80% for 2014 and 2015, which seems realistic. Country also has a very good MCV1 2012 coverage of 99%.

For Rota, 2014 first dose target in the APR (90,227) is not achievable due to the mid-year introduction. APR Table 7.11.1 sets 80% as the 3-year target for Rota2 coverage, but this clearly is adjusting for the inflated denominator using a margin of error factor, since coverage surveys have estimated vaccination with other antigens to be above 90%.The dropout rate has been set at zero for 2014, 2015 and 2016 and needs to be checked with the country.

For PCV (to be introduced in July 2015), country has not provided new targets for 2015 and 2016, the DL sent recently assumed a January 2015 introduction, so if country will introduce in July 2015 instead, the budget needs to be adjusted.

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 programmes pentavalent are based on the approved targets (2015) as well reported opening stocks (Jan 2014), shipment plan (2014) and target closing stocks (2015). For others programmes, a stock analysis is carried out to determine the right level of stock to be deducted from 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.

## 12. EPI Financing and Sustainability

The total expenditure for immunization in 2013 was US$ 3,199,792, out of which the government paid 14%, rest was supported by partners (GAVI-18%, UNICEF-23%, WHO-30% and JICA-14%).

UNICEF funds the procurement of traditional vaccines and GAVI supports the new and underutilised vaccines. The Government of Eritrea pays its co-financing commitments for new vaccines. The government is in discussions with UNICEF to co-finance traditional vaccines.

## 13. Renewal Recommendations

| Topic | Recommendation |
|---|---|
| HSS | Release of last tranche of funds, US$ 715,250 (already approved by IRC and DL sent in Oct 2013). |
| NVS | DTP-HepB-Hib,1 dose per vial liquid, recommend the renewal of support in 2015, based on country's requested targets.<br><br>Measles Second Dose, 10 doses per vial lyophilized, recommended the renewal of |

| | |
|---|---|
| | support in 2015, based on country's requested targets.<br><br>Rota (Introduction in July 14), recommend the renewal of support in 2015, based on country's requested targets.<br><br>Pneumococcal, PCV (13), 1 dose per vial, liquid, recommended for support in 2015, based on revised targets (July 15 introduction). |

## 14. Other Recommended Actions

| Topic | Action Point | Responsible | Timeline |
|---|---|---|---|
| | Provide minutes of all HSCC meetings in 2013 | Country | 15 Aug 14 |
| *NVS* | For PCV, if country introduced in July 2015 as stated in the APR, the DL will have to be revised in consultation with country | GAVI | 15 Aug 14 |
| *HSS* | Provide annual work plan and procurement plan for next HSS tranche. | Country | 15 Aug 14 |
| | Country to submit approved financial statements for financial year ending 31 May 2013, and external audit report. | Country | 15 Aug 14 |
| | Country to confirm whether they have adequately budgeted for maintenance and recurrent costs of equipment and plans for government to take over these costs. | Country | 15 Aug 14 |
| | Country to provide completed M&E framework with complete reporting of all indicators, with explanation for any targets not met and how country plans to address | Country | 15 Aug 14 |
| | Country to complete the evaluation the current HSS grant and use the findings for next application (if the country wants to apply) | Country | Q4 2014 |
| *EPI financing and sustainability* | Country to start allocating government funding to traditional vaccines and progressively increasing it. | Country | |