Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analysed, and explained where relevant.

Country	The Gambia
Reporting period	*January – December, 2015*
Fiscal period	*January – December,*
If the country reporting period deviates from the fiscal period, please provide a short explanation	
Comprehensive Multi Year Plan (cMYP) duration	*2012 – 2016*
National Health Strategic Plan (NHSP) duration	*2012 – 2020*

1. SUMMARY OF RENEWAL REQUESTS

[These tables will be pre-populated by the Gavi Secretariat. If there are any changes to be made, this should be discussed as a group during the joint appraisal and flagged in the report – see the guidance document for more details]

Programme	Recommendation	Period	Indicative amount paid by Country	Indicative amount paid by Gavi
NVS – *PCV* in new presentation	Extension	2017	US$	US$ 1,101,500
NVS – *Pentavalent* in existing presentation	Extension	2017	US$	US$ 143,000
NVS – *Rotavirus* in new presentation	Extension	2017	US$	US$ 458,500
NVS - IPV	Renewal	2017	US$	US$ 47,500
NVS – MCV2	Renewal	2017	US$	US$

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	MenA into the Routine	*September, 2016*	*2017*

**Not applicable for countries in final year of Gavi support*

2. COUNTRY CONTEXT *(maximum 1 page)*

N/A for JA update

3. GRANT PERFORMANCE AND CHALLENGES

3.1. New and underused vaccine (NVS) support

Current grant portfolio:

IPV:

The vaccine was successfully introduced in April 2015 and there have been no reported stock-outs over the period of review. A coverage of 71% has been registered which is relatively low but due in large part to the introduction in the second quarter of 2015. If the timing for introduction is considered the coverage is above 90%. Stock levels of IPV were very high at the beginning of 2016, because of large initial shipment in 2015 for introduction. The stock balance is estimated to last until December 2016. Due to the global shortage of IPV, the country is expected to stock-out before the last quarter of 2017 when it is estimated stock will once again be available. To date no plans have been made to prepare for the scenario of stock-out, but this will be addressed in the coming months with updates to health facilities and communication to health care workers.

Penta:

Penta was introduced in 2009 and since then the country has maintained high levels of coverage across the three doses. A coverage of 97% was realized in 2015 for Penta 3 as compared to the 96% achieved in 2014. This was as a result of several trainings conducted in 2015 coupled with supervision and effective vaccine management. There are adequate stocks of Penta in the country to last for the next 8 month period. A dropout rate of 2% has been recorded in 2015 and this has been confirmed in the NVS renewal responses for 2016.

PCV:

The country has continued to record a high level of coverage since the introduction of PCV in 2009 The country is currently using a one dose vial presentation which has been problematic from a cold chain storage perspective at both the central level and also in some regions. The regions receive quarterly vaccine supplies from the central level, but because of vaccine presentation, they are unable to accommodate quarterly PCV stock. Given the challenges and constraints with vaccine storage the country requested in the 2016 NVS Renewal to switch to the four dose vial presentation. The current stock PCV can last for 4 months, there is another shipment planned for September 2016. The country is eligible for a switch grant and will apply for that in preparation for the switch.

Rota:

The single- dose antigen was successfully introduced in 2013 and has been registering high coverage (97% in 2015). There are some outstanding issues in relation to rota that are currently being discussed with the Gavi Secretariat. The rota VIG was never disbursed to the country to support the vaccine introduction, the reason for this was outstanding issues in relation to the FMA. As a result of this WHO and UNICEF Country Offices provided financial support to the country in preparation for the vaccine introduction. The current presentation of Rota has been putting a strain on cold chain capacity – as a result the country has requested to switch from RotaTeq to RotaRix in the 2016 NVS Renewal. The country was expecting two large shipments of rota – however, in order to support a switch in presentation in early 2017, the country has cancelled shipments planned for September and December. This has been done in collaboration with the UNICEF Country Office and through UNICEF SD. Updated rota stock amounts have been supplied to Gavi – current stock in the country is expected to last until December 2016 with the planned switch moving forward as of January 2017. The country is not eligible for a switch grant for rota – however there are plans to use the PCV switch grant to also support health worker training on the new rota product.

Measles:

Measles 1st dose coverage is good (95%) while there is a marked decrease in 2nd dose coverage at 81%. This can be partly explained by the fact that the country uses surviving infants as the denominator, as there are no estimates for the number of children surviving up to age 2. The MR Campaign was carried out in April/May 2016 – the original date for the campaign was 2015, however there were outstanding FMA issues and as a result the campaign was postponed. There was a delay in conducting the post campaign evaluation due to difficulties in identifying an external consultant to lead the process. The post campaign evaluation was carried out in July/August with the final report due in September. The campaign had a coverage of 97.2% with initial results from the post campaign survey showing a coverage rate of 97.3%. All Regions but one in the country achieved above 95% coverage with Upper River Region achieving 92.4%.
The country plans to switch to Measles-Rubella in 2017. There have already been two shipments of MR vaccine, one for the campaign, and one for routine. There are 92,500 doses of measles left in the country which is expected to last for the next 6 months with no further shipments planned for this year. In terms of MR there are 129,180 doses remaining from the campaign shipment and an additional 46,300 doses which were received in November 2014 for the routine introduction. Based on current measles stock the country is expecting to introduce MR into routine in April 2017 and plans to switch to MR for both doses. There are on-going discussions to confirm timing for the switch and thereafter the VIG for MR will be released and managed by UNICEF.

The country is also in collaboration with WHO and CDC establishing a sentinel surveillance for Congenital Rubella Syndrome (CRS). This activity is being funded under the PEF support. The training for CRS is scheduled to take place in September 2016.

HPV Demo:
The country has successfully completed the 2nd year school based demonstration project. The Demo targeted 9459 grade 3 girls in school and girls outside school aged 9-13 years. The co-delivery of deworming tablets (Mebendazole) was targeting both girls and boys with target of 18141 These targets were established through a school and out of school census. Coverages of 95% and 93% (HPV and Mebendazole respectively) were achieved during the first dose. The second dose had coverage of 89% and 84% for HPV and Mebendazole respectively. The recently concluded coverage survey revealed a coverage of 91% for fully immunised and The percentage of girls who received the deworming tablets for both the first and second doses were 86% and 91% respectively. The Costing analysis revealed a total sum of $**115,604** (vaccine included) was spent in the second year. An incremental cost is estimated to be $ **104,550.52.** There were no additional cold chain costs. Cost per dose (vaccine cost included) was at $**6.63** for a fully immunised girl was (vaccine cost included) at $**13.69**.

There was a high uptake of HPV vaccine and in fact there have been numerous requests to extend the age group so that more girls could be covered. One of the key contributing factors to the high uptake of HPV vaccine was an effective communication strategy and also social mobilisation this resulted in the in a high acceptance by mothers and care givers. In addition there was a high level of political support to see the vaccine rolled-out successfully. The second year coverage survey and costing analysis are currently being analysed, and final results will be available by end of September 2016. PATH provided TA for both the 1st and 2nd year coverage survey while WHO supported the costing analysis of both years. The Gambia has submitted an official request for a Bridge Year of HPV support as it works out and does further analysis to support a national roll-out. There are concerns on the cost of delivery particularly of the schools based programme. The Cervical Cancer Strategic plan has been developed with stakeholders in preparation for national introduction.

Programmatic Enablers:

Equity:
Although no specific studies have been conducted, The DHS 2013 report did show variations in the immunization coverage across urban and rural areas. The reasons for the variation were however not analysed. There are variations in coverage in terms of both the fully immunised

child and drop-out rates between vaccines across rural and urban areas. The percentage of children who were fully immunized was higher in rural areas than in urban areas (84 percent compared with 67 percent). It was also higher among children whose mothers have no education (78.2%) or who only reached the primary level than among children whose mothers reached the secondary level or higher level education (68.3%). Supervisory visits have revealed that waiting times at urban health centres are a key factor in a mothers or caretakers decision on immunisation, in relation the total number of Reproductive and Child Health care centres in urban areas was deemed insufficient which was a major cause for the long waiting times. EPI cluster surveys do not have equity indicators – although they do explore coverage variation by region. There is a need in the country for some further analysis on equity related barriers to immunisation which would help the programme in developing strategies on how these can be addressed. In terms of issues related to the insufficient number of facilities and long waiting times in urban areas, the new HSS grant has made provision to construct 30 new outreach posts – the location of the posts has been agreed to address this barrier to immunisation and to further improve coverage in the urban areas.

Data quality:
Desk reviews and trainings on DQS have been conducted but no documentation or training reports have been produced. There are plans to conduct a DQS at regional level and reports will be compiled and shared. The Gambia has never done an in-depth data quality assessment for the EPI. However with support from BID Learning Network (BLN) under PATH's Better Immunization Data (BID) Initiative, the country plans to customise the E-Tracker of DHIS2 to register and track immunization clients in 2017. This will be piloted in 2 health facilities and lessons learned will guide national rollout. It is envisaged that the implementation will be useful in providing more insight into data quality issues and it will also stimulate improved data collection and usage at all levels.

AEFI surveillance:
There is an AEFI committee comprising of EPI, Medicines Control Agency, National Pharmaceutical Services and Epidemiology and Disease Control programmes. Since last year, the AEFI committee was trained at a national level and a training manual was adapted to the country context. Funding is needed to finalise the manual and also conduct training at health facility level. This was an area of work identified in the JA last year and although work has started to strengthen the AEFI surveillance this is a set of activities that are still on-going.

ICC committee:
Is chaired by the Honourable Minister of Health and Social Welfare. The Ministry of Finance, CSOs, UNICEF, WHO with other stakeholders are well represented in the ICC. CSO involvement has increased and improved the functioning of the group. A NITAG is being formed, with TORs drafted and proposals sent to West African Health Organisation (WAHO) for support in the implementation of the planned activities.

PEF Update:

UNICEF received the sum of USD$ 24,840 under the PEF to strengthen supply chain management through the implementation of the following three activities as highlighted in the previous JA.
1) Cold chain mapping study has been conducted to determine temperature variations within the cold room for vaccine potency
2) Multi loggers are in the process of being procured for the cold rooms
3) The remaining funds will be used to support the implementation the 2014 EVM recommendations.

WHO received USD$16,050 under the PEF for the Assessment of new vaccine (Rota, PBM, Men A) surveillance performances, Support undertaking of SARA/DQA in Q4 of 2016, support

CRS surveillance implementation; Comprehensive immunization; programme and surveillance reviews. This work is currently on-going.
An amount of USD$ 5,350 was used to support the preparations for sector review in Q1; Provide training for MoH staff on strategies to improve quality of services; Support the adaptation and use of community engagement tools; Organize ToTs of senior MoH staff on QA. A sum of USD$ 21,400 was also received for cMYP development and finalisation. Two consultants were recruited and the document is almost at it final stage of completion.

Programmatic Bottlenecks:

Despite the overall high coverage rates across vaccines, the programme still faces challenges which impact progress. The EVMA revealed that there is an inadequate cold chain storage capacity at national level, which affects vaccine distribution plans. There is also a lack of cold chain storage in two of the health regions and inadequate dry store for supplies at regional levels. These are critical in maintaining immunization coverage. The developed EVMA implementation plan is geared towards addressing the vaccine management and cold chain gaps. These are factored in the GAVI HSS (June 2015), UNICEF Work Plan and WHO Biennium.
Some of the key bottlenecks include:

- Inadequate cold chain capacity at national level
- Lack of cold stores in 2 out of the 7 health regions
- Inadequate dry stores in all the regions
- Inadequate training of health workers giving immunization services on EPI activities
- Inadequate and ill-equipped RCH outreach sites
- Inadequate funding of the EPI communication plan
- Inadequate capacity to keep up with the frequent updates in the immunization data collection tools as a result of new vaccine introductions
- Inappropriate outreach trekking vehicles
- Inadequate infrastructure and ICT equipment at central and regional levels
- Inadequate data management skills and analysis at regional and central levels
- Irregular monitoring and supportive supervision at regional and facility levels

These bottlenecks have been included in the HSS and the country intends to apply for the CCEOP in January 2017.

3.1.1. NVS future plans and priorities

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- The Gambia plans to switch from Rotateq to Rotarix in 2017
- Switch from PCV single dose to multi dose presentation
- Introduce MR into the routine in April 2017
- Apply for MenA in September 2016
- Apply for HPV national rollout in 2017
- Apply for support to conduct nationwide yellow fever campaign

The above switches, applications and introductions outline the vaccine priorities for The Gambia. The HSS grant has a strong focus on addressing some of the key supply chain challenges facing the country including cold chain equipment updates, improved vaccine storage and strengthened vaccine management. The implementation of the HSS grant will ensure that enhancements to the broader system are being undertaken in collaboration with the expanding vaccine portfolio.

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

The HSS grant has been recommended for approval for the 2016 – 2020 period, but implementation is yet to start. The arrangements for the FMR are being finalized. Implementation expected to start in January 2017. The HSS grant objectives are:

1. To maintain the high immunisation coverage of 95% and improve the quality and equitable access to RCH Service delivery

2. To strengthen the generation and timely use of quality data and information for decision making in RCH Service

3. To enhance the capacities and work environment of health workers for improved RCH Services

4. To empower communities, CSOs and other local actors to improve RCH Services including immunisation services

3.2.2. Grant performance and challenges

The process of finalising the financial management arrangements is currently underway with on-going discussions between Gavi, the MoH and the WHO and UNICEF Country Offices. The aim is to have all arrangements finalised by the end of 2016 so that grant implementation can begin in 2017.

3.2.3. Describe any changes to HSS funding and plans for future HSS applications

Given the delay in HSS grant implementation, the budget and workplan will be revised in line with the new grant timeline. The reallocated budget will be reviewed by the ICC and submitted to Gavi in Q4 2016.

The Gambia is planning to submit an application for CCEOP in January 2017.

3.3. Transition planning *(if relevant)*

NA

3.4. Financial management of all cash grants

Financial Management:

Gavi cash grants have been managed through WHO and UNICEF. The IPV and HPV budgets have been completely utilised as planned and the financial statements have been submitted. The MR OPC has been spent, however there are still some cash remaining with UNICEF – the financial statement for the MR Op Costs still needs to be submitted.

Financial statements have been submitted by UNICEF covering the IPV VIG, ISS and HPV cash grants.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous joint appraisal / HLRP process	Current status
Update EPI Policy to include all new vaccines	The updates to the EPI policy to include the new vaccines has been not been done in the last year – but this remains an activity that needs to be undertaken.
Establish an AEFI surveillance system	An EPI staff and a staff member from pharmacovigilance attended trainings on AEFI. The AEFI guideline has been reviewed and updated at the central level. Step-down training has not yet taken place and AEFI Surveillance is not systematic in the country.
Build regional stores for dry materials	Included in the HSS grant but implementation has not yet started.
Strengthen supportive supervision at Central and regional level	3 supportive supervision visits were conducted in 2015 and 1 in 2016. There is on-going work to ensure a more systematic approach to supportive supervision.
Expand Cold Chain system at all levels to accommodate RotaTeq supplies	Included in the HSS grant but implementation yet to start. The Gambia has applied to switch Rota presentation to alleviate cold chain constrains.
Institutionalize defaulter tracing systems at facility level	Training was conducted, but no systematic approach is in place for defaulter tracing.
Train staff on vaccine wastage, coverage and drop-out rates not being calculated at health facility level	Training conducted for 230 health facility staff on EVM and calculating wastage and drop-out rates
Construction and refurbishment of outreach services	Included in the HSS grant but implementation yet to be started

5. PRIORITISED COUNTRY NEEDS[1]

Prioritised needs and strategic actions	Associated timeline for completing the actions	Does this require technical assistance?* *(yes/no)* If yes, indicate type of assistance needed

[1] Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

Surveillance review and improvement plan	October 2017	Yes. TA needed for the review, and development of the improvement plan
Cold chain platform application	January 2017	Yes. TA needed to support the country with the CCEOP application
Fixing of the Multi loggers	December 2017	This is being undertaken by UNICEF through PEF support
DQS and the improvement plan	December 2017	Yes – TA needed to conduct a DQS in 2017 and support the development of an Improvement Plan
Training NITAG members	July 2017	Yes – support needed with reviewing and finalizing the TOR and training of NITAG members
Finalization of the EPI policy	July 2017	No
Customization of the E-tracker	December 2016	No
PIE for new vaccines introduced	December 2017	Yes – TA needed to support PIEs for the new vaccines PCV and Rota