

The Gambia Joint Appraisal Update Report 2019

Country	The Gambia
Full JA or JA update ¹	<input type="checkbox"/> full JA <input checked="" type="checkbox"/> JA update
Date and location of Joint Appraisal meeting	Banjul 1 st – 4 th October 2019
Participants / affiliation ²	MoH, EPI, HMIS, Regional Health Directors, UNICEF, WHO, HePDO , ACTION AID
Reporting period	January – December 2018
Fiscal period ³	January - December
Comprehensive Multi Year Plan (cMYP) duration	2017-2021
Gavi transition / co-financing group	Initial self-financing

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	
Does the vaccine renewal request include a switch request?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input type="checkbox"/>
HSS renewal request	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input type="checkbox"/>
CCEOP renewal request	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input type="checkbox"/>

2. GAVI GRANT PORTFOLIO

Existing vaccine support

Introduced / Campaign	Date	2018 Coverage (WUENIC) by dose	2019 Target		Approx. Value \$ (2020)	Comment
			%	Children		
IPV	April 2015	61% (IPV1)	95 %	81,651 (1 st dose)	182,500	
MenA	April 2019	Not available	70 %	60,164 (1 st dose)	25,500	
PCV	January 2009	93% (PCV3)	95 %	81,651 (last dose)	15,000	
Penta	January 1997	93% (DTP3)	95 %	81,651 (last dose)	38,500	
Rota	August 2013	91% (RCV1) 93% (RotaC)	95 %	81,651 (last dose)	253,500	
HPV	N/A	Not available	73 %	26,485 (2 nd dose)	270,500	To be introduced in Q4 2019

Existing financial support

Grant	Channel	Period	First Disbursement	Cumulative financing status @ October 2019				Compliance	
				Comm.	Appr.	Disb.	Util.	Fin.	Aud.
HSS	UNICEF & UNICEF SD	2017-Present	2017	5,546,359	3,330,818	1,744,995	85% (\$1,270,372)		
MenA Ops	UNICEF	2017	2017	198,424	198,424	198,424	100%		

¹ Information on the differentiation between full JA and JA update can be found in the Guidelines on reporting and renewal of Gavi support, <https://www.gavi.org/support/process/apply/report-renew/>

² If taking too much space, the list of participants may also be provided as an annex.

³ If the country reporting period deviates from the fiscal period, please provide a short explanation.

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HPV MAC - Op costs	UNICEF	2019	2019	70,286	70,285	70,286	79% (134,000)	Due March 2020 N/A	
HPV VIG	UNICEF	2019	2019	100,000	100,000	100,000			
MR VIG	UNICEF	2017	2017	100,000	100,000	82,658	84% (17,342)		
CCEOP	UNICEF SD	2018	2018	693,289	693,289	528,102	76% (165,187)		
Comments									

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future⁴

Indicative interest to introduce new vaccines or request HSS support from Gavi	Programme	Expected application year	Expected introduction year
		Typhoid Vaccine	May 2020
	MR Campaign	May 2020	2021

Grant Performance Framework – latest reporting, for period 2018

Intermediate results indicator	Target	Actual
IR-C 1.1.2.1 Number of surviving infants in HSS targeted areas/populations who received the third recommended dose of pentavalent vaccine (Penta3)	Not applicable	Not applicable
IR-C 1.1.1 Number of surviving infants who received the first recommended dose of pentavalent vaccine (Penta1)	81,495	77,338
IR-C 1.1.2 Number of surviving infants who received the third recommended dose of pentavalent vaccine (Penta3)	79,865	76,366
IR-C 1.2.1 Number of surviving infants who received the first recommended dose of PCV vaccine (PCV1)	81,496	77,339
IR-C 1.2.2 Number of surviving infants who received the third recommended dose of PCV vaccine (PCV3)	79,815	76,365
IR-C 1.3 Number of surviving infants who received the first recommended dose of IPV	79,865	50,353
IR-C 1.4.1 Number of surviving infants who received the first recommended dose of measles containing vaccine (MCV1)	81,516	74,547
IR-C 1.5.1 Number of surviving infants who received the first recommended dose of rotavirus containing vaccine (Rota 1)	81,496	77,270
IR-C 1.5.2 Number of surviving infants who received the last recommended dose of rotavirus containing vaccine (Rota last)	79,815	76,354
IR-C 1.6.2 Number of girls in the target population who received the second recommended dose of HPV vaccine within a national routine immunisation programme	22,223	Not available
IR-C 1.7.1 Number of children in the target population who received a recommended dose of Men A containing vaccine (routine) (Men A)	81,343	Not available

⁴ Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

Countries are encouraged to highlight in subsequent sections, and particular in the Action Plan in Section 7, key activities and potentially required technical assistance for the preparation of investment cases, applications and vaccine introductions, as applicable.

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Intermediate results indicator	Target	Actual
IR-C 1.7.2 Number of individuals in the target population who received a recommended dose of Meningitis A conjugate vaccine (campaign) (Men A)	305,269	Not available
IR-C 2.0 Occurrence of stock-out at national or district level for any Gavi-supported vaccine	No	Yes - IPV
IR-C 3.0 Effective Vaccine Management Score (composite score)	N/A	Not available
IR-C 4.1 Percentage point difference between Penta 3 national administrative coverage and survey point estimate	5%	1% MICS 6
IR-C 5.0 Timely fulfilment of co-financing commitment for all Gavi-supported vaccines	Yes	Yes
IR-C 6.0.3 CCE expansion in existing equipped sites	100%	N/A
IR-C 6.0.4 Freeze-free to non-freeze-free carrier ratio	67%	N/A
IR-C 6.0.1 CCE replacement/rehabilitation in existing equipped sites	97%	N/A
IR-C 6.0.2 CCE extension in unequipped existing and/or new sites	100%	N/A
IR-C 8.1 Percent of health facilities offering immunisation services	100%	100%
IR-C 8.3 Percent of supervision sessions from province/state to district level conducted	50%	50%
IR-C 8.4 Percent of districts reporting VPD surveillance data	100%	100%
IR-C 8.5 Percent of functional cold chain equipment	95%	98%
Comments		

PEF Targeted Country Assistance: Core and Expanded Partners at mid-2019

Partner	Year	Funding (US\$M)			Staff in-post	Milestones met	Comments
		Appr.	Disb.	Util.			
WHO	2018	70,025	100%	71%	0	12/12	
	2019	112,350	100%	4%	0	6/6	
UNICEF	2018	179,920	100%	100%	1	3/10	
	2019	133,480	100%	0%	1	4/11	
PATH	2018	95,195	95%	95%	0	1/1	The funding is for specific support to Gambia (95,195) (+) multi-country support to HPV (weighted at 64,678 in 2019)
	2019	159,873	46%	46%	0	1/5	
University of Oslo	2018	9,425	n/a	n/a	n/a	n/a	This is a multi-country support. No milestones available for Gambia.
	2019	18,850	n/a	n/a	n/a	n/a	

3. PERFORMANCE OF GAVI SUPPORT

3.1. Performance of Gavi HSS support (if country is receiving Gavi HSS support)

Objective 1	
Objective of the HSS grant (as per the HSS proposal or PSR)	To maintain the high immunization coverage (≥ 95%) and improve the quality and equitable access to RCH service delivery
Priority geographies / population groups or constraints to C&E addressed by the objective	Country-wide
% activities conducted / budget utilisation	Total Budget: 724,017.46 Expenditure: 618,041.82 % Utilisation: 85
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	<p>Four (4) RCH vehicles and eleven (11) motorcycles were procured and distributed. The vehicles were given to NBE, CRR, WR1 and WR2, and the motorcycles to all the 7 health regions. The use of this appropriate outreach trekking vehicles enhance the movement of the RCH trekking team thereby impacting the team's ability to provide the required quality services in a timely manner. The remaining fleet of vehicles are expected to be procured in the next procurement phase.</p> <p>The country also co-financed the CCEOP and procurement of 4 additional units under HSS (due to CCEOP ceiling) to strengthen the cold chain system. The CCEOP items are already in country which are being installed in Q3 2019 by the local agent. Also procured is a 40m3 cold room and 20 sets of TCW 2000 SDD meant for the expansion at central and lowest distribution points respectively for effective vaccine storage. There are plans to construct a structure to house the cold room for installation at the central level to be completed by end of 2020.</p> <p>An assessment was also conducted to map out ideal sites for construction of outreach facilities. At present, five (5) outreach sites are under construction in WR1 and WR2. It was realized that the budget allocated for the construction of the outreach sites was lower than required, as a result this was factored during the reallocation of the HSS budget. The construction and refurbishment of RCH outreach sites will address the issues of equity in the urban areas so as to reduce travel distance, waiting time and improve working environment.</p>
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated changes in technical assistance ⁵)	<p>In the coming year, there is plan for the:</p> <ul style="list-style-type: none"> • Construction of 7 outreach sites in the other 5 regions (CRR, URR, LRR, NBE, NBW) in the country which will help to improve access to service delivery. If UNICEF does not continue, an alternative method can be used to ensure continuity of this activity. • Procurement of 3 RCH vehicles to strengthen outreach services especially at service delivery level • Procurement of 10 motorbikes, which will be used by health workers for routine immunisation and surveillance activities • Procurement of a standby generator for the cold room, which will ensure uninterrupted electricity supply for effective vaccine management • Procurement of a cold chain monitoring vehicle • Procurement of basic furniture for outreach sites <p>The budget for the construction of outreach sites has been significantly increased in the budget because of increase in the cost per unit structure.</p>
Objective 2:	

Objective of the HSS grant (as per the HSS proposal or PSR)	To strengthen the generation and timely use of quality data and information for decision making in RCH services
Priority geographies / population groups or constraints to C&E addressed by the objective	Country-wide
% activities conducted / budget utilisation	Total Budget: 164,795.00 Expenditure: 37,394.65 % Utilisation: 23
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	<p>A total of 20 computers with accessories were procured with the aim of improving data accuracy and efficiency. This will ease the process of data collection and improve quality of data reporting including immunization. A data management training was conducted for 50 participants across the country, looking at ways of strengthening data management issues.</p> <p>Participants included health workers from major health facilities, Regional Data Managers, EPI Regional Operation Officers, Directorate of Planning and Information and other units of the Ministry of Health. The aim was to build capacities of health workers, data managers and stakeholders to enhance quality immunization data generation and management that would be responsive to the needs of the MoH and partners.</p> <p>In-service meetings were conducted at regional and central level. The regions converged at central level to discuss on performance monitoring (coverage, dropout, and surveillance), best practices, main challenges and recommendations.</p>
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated changes in technical assistance ⁵)	<p>Implement and monitor the data quality improvement plan, support in addressing denominator issue and implementation of the DQIP.</p> <p>Continue to expand the VVS and work on the off-line mode.</p> <p>Implement quarterly data quality audit at central, regional and health facility and conduct annual data quality training with health workers.</p> <p>Continue to strengthen the Mychild (Shifo) solution before expansion.</p>
Objective 3:	
Objective of the HSS grant (as per the HSS proposal or PSR)	To enhance the capacities and work environment of health workers for improved RCH services
Priority geographies / population groups or constraints to C&E addressed by the objective	Country-wide
% activities conducted / budget utilisation	Total Budget: 92,640.00 Expenditure: 36,387.00 % Utilisation: 39
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	<p>An incentive scheme is being finalised to guide the identification of staff who will benefit. The incentive scheme will help to attract/motivate staff and retain them in the health work force. The implementation of the incentive scheme is expected to start once it is being finalized by the Senior Management of the Ministry of Health.</p> <p>Training of health workers on data management and disease surveillance.</p>

<p>Major activities planned for upcoming period (mention significant changes / budget reallocations and associated changes in technical assistance⁵)</p>	<ul style="list-style-type: none"> • Immunisation service review meetings at all levels • Support a comprehensive incentive package for RCH service providers • Strengthening the Human Resources Information System • Training of health workers on immunisation services, disease surveillance and data management
<p>Objective 4:</p>	
<p>Objective of the HSS grant (as per the HSS proposal or PSR)</p>	<p>To empower communities, CSOs and other local actors to improve the utilization of RCH services including immunization services by 2019</p>
<p>Priority geographies / population groups or constraints to C&E addressed by the objective</p>	<p>Country-wide</p>
<p>% activities conducted / budget utilisation</p>	<p>Total Budget: 189,266.00 Expenditure: 107.449..00 % Utilisation: 56.77</p>
<p>Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption</p>	<p>EPI Communication strategy has been developed and validated by stakeholders. The overall goal of the strategy is to engage and empower individuals, families and communities, through strategic behavior change communication, to make their children available for immunization and related family health services in accordance with the national schedule.</p> <p>An IPC training manual was developed to enhance the IPC skills of health service providers on communication in RCH including immunization.</p> <p>HePDO as the local CSO has conducted assessment on communities' knowledge, attitude and practice on RCH including immunization (Interviews with communities, FGD and PRA)</p>
<p>Major activities planned for upcoming period (mention significant changes / budget reallocations and associated changes in technical assistance⁶)</p>	<ul style="list-style-type: none"> • Train health workers and Multidisciplinary Facilitation Teams (MDFTs) on inter-personal communication (IPC) skills • Build the capacity of CSOs and organized community groups on RCH services • Promote EPI and RCH Service through communication support materials (print and electronic) • Conduct national immunization consultative forum with stakeholders

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<p>Achievements against agreed targets</p>

⁵ When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should however describe - to the extent known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

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The Gavi HSS objectives are aligned to the overall National Health Strategic Plan objectives of reducing morbidity and mortality in the country. These objectives align adequately with the systemic bottlenecks to achieving and sustaining high immunization coverage.

Due to delay in the start of the HSS (started July 2017), followed by ongoing delays due to slow liquidation of funds, several HSS activities had been delayed such as the implementation of the DQIP, construction of outreach posts, implementation of the EPI Communication Plan, etc.

Immunisation coverage for BCG and Hep B vaccines (given immediately after birth or soon after) has been relatively good over the years with all the seven regions reaching at least ninety percent (90%) of their target. This also includes the OPV birth dose, but none of the regions have achieved the 99% national target.

Similarly, coverage for Penta3 and OPV3 (Surviving Infant) were above the recommended 80% but below the national target in all the regions, consequently resulting in a lower national coverage. There are regional variations in coverage, with the Lower River, Central River, and Upper River Regions recording the lowest coverage. These coverage issues were also linked to the ambitious targets/denominators as being argued by the Regional Health Directorates as being high. This could be a major attributing factor to the low coverage of the administrative reports.

There have been a lot of family planning interventions in the regions especially those implementing the Maternal and Child Nutrition and Health Results Project (MCNHRP). Although there is no research done to support this argument, there is a general believe that these interventions are reducing birth rates, thereby affecting the target projections for immunization. The country has recently implemented a Data Quality Audit (DQA) and developed a Data Quality Improvement Plan (DQIP) using the WHO tool guide. Implementation of the DQIP will go a long way in addressing data issues within the programme.

Nationally, over 90% of children targeted in 2018 were fully immunized (received all the vaccines scheduled from birth to nine months). However, similar to other doses, regional variations were evident in these doses with three regions – Lower River, Central River, and Upper River Regions way below the national target.

Since immunization coverage has a correlation with vaccine supply adequacy, the new vaccine support, if approved will enhance improvement in coverage or at least maintain the performance registered in 2017. The use of the SMT and the implementation of the VVS are measures used to improve stock management. The VVS has an alert system which notifies users when the vaccine threshold is below the recommended level at each of the service delivery level for prompt action. The SMT also has a stock management indicator which guides the programme on how long stocks would last based on the target and number of doses expected to be given

Possible factors for the low immunisation coverage

There has been significant drop in coverage in 2017 compared to the previous years. This could be attributed to several factors as discussed below.

1. **Service Delivery:** Immunisation service delivery points have been inadequate in urban areas as majority of urban health facilities do not conduct or have limited outreach services. This results in low access to immunisation services. Mothers/caregivers usually stay longer at the clinics to receive services and thus discouraged them from returning for subsequent visits.

Inadequate service delivery points leads to congestion or overcrowding. This unfavourable environment may result in overloading health workers consequently leading to missed opportunities. Additionally in 2017, a drop out study conducted in a health facility in LRR by university students revealed that poor screening of Infant Welfare Cards (IWCs) contributes to missed opportunities. Although this was a small scale study, however result may be similar in the other health facilities due to similarities in settings.

The vehicles provided for outreach services are inappropriate as they cannot carry the whole outreach team thus creating inconvenience to the staff, resulting in some service providers not attending the RMNCAH clinic. This can compromise quality of services rendered.

In a bid to address some of these gaps, there is a need for:

- Expansion/extension of more outreach sites especially in the urban areas
- Procurement of appropriate outreach trekking vehicles and motorbikes
- Conduct operational research on MOV, Y2L, KABP, Cold Chain to continuously help guide the programme in improving immunisation services.

2. **Data quality:** Inadequate data verification and supervision at all levels has been a contributing factor to the low immunisation coverage. Data generated at primary level is not adequately verified by facility staff and their supervisors and this may compromise data quality. Absence of functional data quality teams has been much blamed as well. This results in inadequate data analysis and use and health facilities will blindly deliver services without measuring their performances.

The presence of data quality teams would have paved the way for the development of data improvement plans at all levels and would have helped to solve some of the data quality challenges. This would have provided concrete evidences and explanations to the observed inconsistencies in the generated and reported data.

Limited ICT equipment at service delivery points has contributed to data quality issues. Health workers manually collate data on monthly basis and in so doing may likely miscalculate the data thereby compromising the quality of the reported data.

Fragmented reporting of data at regional and national levels has also contributed to the low quality of data. The same data reported by health facilities are not the same in both the DHIS2 and the EPI database.

The denominator issue continue to be blamed for the low coverage. Many of the health facilities and regions have been raising concerns on the accuracy of their target populations. Increase in uptake of family planning services could be a contributing factor affecting the denominator, however, further research need to be conducted to determine the facts.

In order to improve the quality of immunization data, there is need to:

- Conduct data management trainings for regional and health facility service providers to build their capacity on data management, which will further enhance immunisation data quality.
- Procure and distribute computers with accessories to regions and health facilities to improve data collection, collation and reporting.
- Conduct in-service meetings (monthly and quarterly) to create an interface between service providers and their supervisors
- Establish/strengthen functional data quality teams at all levels
- Use new innovations such as the MyChild solution and VVS.
- Strengthen integrated supportive supervision at all level
- Harmonize data reporting into the DHIS2 platform.
- Service of a TA to assist in addressing denominator issue

3. **Human resource:** Inadequate number and capacity of staff to provide child health services has been a key factor contributing to the low immunization coverage. Uncoordinated transfers of health workers and attrition are also impacting negatively on immunization coverage.

In a bid to address the human resources issues, the following have been identified:

- Implementation of the finalised incentive scheme to attract/motivate staff and retain them in the health work force.
- Trainings of staff on immunization service delivery.

4. Community empowerment and CSO engagement

The 2015 Knowledge Attitude Behavior and Practice (KABP) study on the uptake of immunization revealed knowledge gap on importance of immunization among caregivers. Many community members do not know the immunisation schedule, which results in them defaulting to bring their children for immunisation. Furthermore, inadequate communication support materials on immunisation have equally contributed to limited knowledge on the importance of immunization which can lead to low service uptake.

Men are the key decision makers in many families and as such, their support for immunisation services will play a crucial role in coverage. However male involvement in immunisation services is limited. Similarly, there is limited utilization of existing community structures (VHW, CBCs, and VSGs) to promote uptake of immunisation services.

Recently, an EPI communication strategy has been developed and validated, aimed at engaging and empowering individuals, families and communities. Equally, an IPC training manual was developed to enhance the IPC skills of health service providers on communication.

Engagement of civil society organisations has been very limited in the routine immunisation programme. However, Health Promotion and Development Organization (HePDO), a local CSO has been engaged to support the implementation of the communication component of the Gavi HSS Grant. The following has been identified to enhance community empowerment and CSO involvement;

- Support the implementation of the EPI communication strategy
- Conduct IPC training for immunisation service providers

INNOVATIVE SOLUTIONS BEING PILOTED

Currently, two innovative solutions are being piloted in The Gambia; the Vaccine Visibility System by EPI while the other by SHIFO (My Child Solution) through Action Aid the Gambia. These are all geared towards improving immunization data quality, management, and storage. Depending on the efficiency and effectiveness of the innovative solution as may be revealed by their respective planned evaluations, the country will adopt and rollout nationwide.

1. Vaccine Visibility System (VVS):

The Vaccine Visibility System (VVS) is a web based vaccine logistics management tool that utilizes 3D barcodes to improve the stock management of vaccines. The system tracks all routine EPI vaccines from central level through regional stores to health facilities, thereby improving data visibility and enabling better stock management via shipment tracking, expiry notifications, etc. The VVS was piloted at the EPI central store, North Bank West Regional Store and Brikama District Hospital store. After the successful initial pilot, it is now currently being expanded to the five (5) regional stores (JRR, CRR, LRR, NBE, NBW) and 23 health facilities as it has helped in reducing stock outs and also alerts on expiry status.

Challenges

- Limited capacity of store manager and EPI staff on VVS
- Lack of barcodes on all vaccine and the secondary packaging
- Unreliable internet connection
- Sustainability assessment not yet done

2. THE MYCHILD SOLUTION – THE GAMBIA

The system registers every child with a Unique ID as they received their vaccination series which is registered on a “smart paper”. These smart papers are scanned at regional level to aggregate the data into a national PDF report. It provides SMS reminders to parents/guardians to ensure follow-up of children who missed their vaccination visit.

Key Challenges

- Limited printing companies being able to print the MyChild forms.
- Internet connectivity at the Regional Office not strong/adequate enough to support synchronization via the scanners.
- Power supply at the Regional Office is potentially a hindrance as there is no backup power source for when electricity goes off.
- Concerns about the data verification process and required human resources to rectify data
- Costing of printing of smart papers proves more expensive than current paper system
- MyChild is not yet fully aligned with DHIS2 creating parallel systems
- Lack of visibility of data at health facility level

Due to time constraints, the JA did not discuss the Mychild/Shifo project: a 'smart paper' electronic immunisation register currently being piloted in 35 facilities in WR1&2. A recent evaluation concluded that the improvement in data quality and time-savings are minimal when using the Mychild Smart Paper Technology and high-lighted several areas that required follow-up. Moreover, the system turns out to be more expensive despite earlier claims of significant cost-savings. The Mychild still faces several gaps as identified during the 3-year pilot process. As a result, the MOH data quality team met and discussed how to move forward with Mychild solution. The EPI team prefers to be cautious and delay roll-out and fix the system before moving to nation-wide expansion. For the expansion of the MyChild, it was agreed that the capacities of the ICT team should be enhanced to enable them understand the system better. There need to be a sustainability plan so that the government can prepare to take over when the MyChild phases out. The integration of the MyChild with DHIS2 should be accomplished to ensure full compliance with the HMIS objective of having a centralized data management and information system. It is also important to be clear if MOH can sustain the system in the future.

NVS future plans

The programme submitted a HPV proposal which was approved by Gavi for national rollout. The national roll-out was planned for quarter 4 of 2018, but this is not possible due to the shortage of the HPV vaccine in the world market. As a result, the national roll-out is now planned for Q4 of 2019 and the programme has completed and updated the plan of action for HPV introduction.

Measles Rubella Burden

Measles is still a major public health threat and can occasionally cause epidemics. In the Gambia, from 2006 to 2009, there was no confirmed case of measles. However, the measles case-based surveillance data showed two (2) confirmed measles cases in 2010 suggesting the possible accumulation of susceptible cases overtime. There has been a decline in confirmed measles from 2010 to 2014. Due to the delay in implementing the planned MR campaign in 2015, the country experienced an outbreak in late 2015 to early 2016 with 71 and 58 confirmed cases respectively. The index case was detected in the Sabi border of Upper River Region (URR) and travelled to the West Coast Region and caused a protracted localized outbreak in Brikama and part of Kombo north District. Based on the evidence from the national data, the frequently affected regions in the country are URR and Western Region 1 and 2.

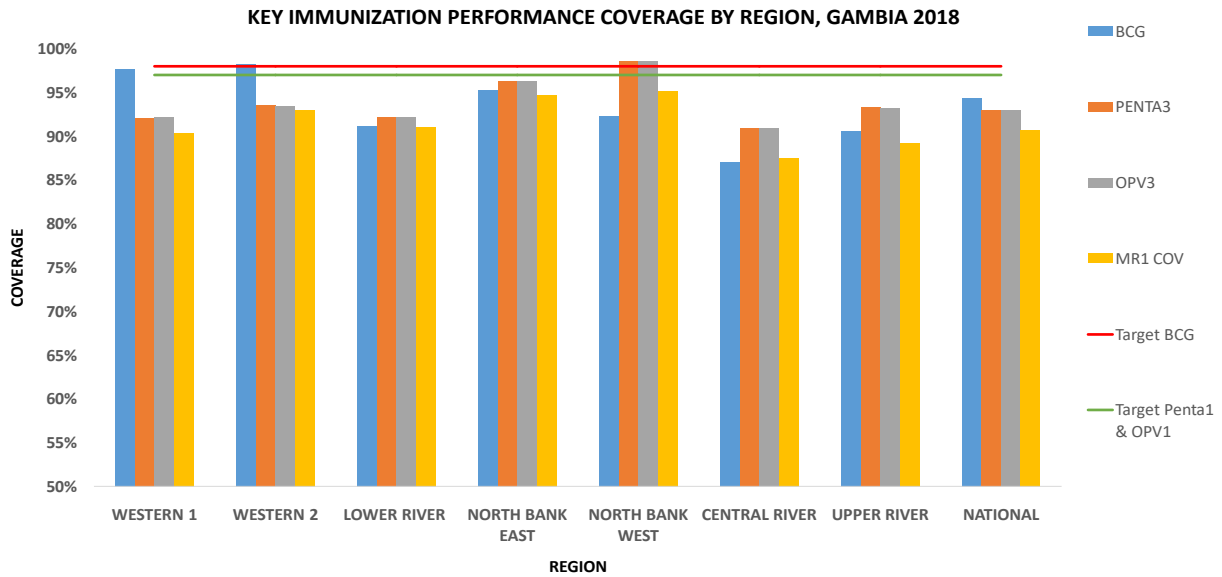
The Gambia has been implementing measles reduction strategies which include strengthening routine immunization, catch-up and follow up SIAs and effective surveillance since the late 2000s. However, with the implementation of surveillance for Measles and Rubella, a total of 114 suspected measles cases of which 37% were IgM positive for rubella and none for measles in 2011. The trend continued to increase in 2012 and 2013 with 42% and 49% respectively of all suspected measles cases were IgM positive for rubella. A study conducted in The Gambia by Medical Research Council (MRC) describe around a 10% Sero-prevalence of Rubella-Specific antibodies in 9 and 10 months old infants; thus, providing evidence of ongoing rubella transmission within The Gambian population. This necessitated the switch from measles vaccine to measles-rubella vaccine in 2017. A national MR campaign was conducted in 2016 and a follow-up is planned for 2021.

3.2. Performance of vaccine support

Table 1: showing indicators, targets and coverage

National Immunisation performance 2014 to 2018					
Indicators	2014 (%)	2015 (%)	2016 (%)	2017 (%)	2018 (%)
Penta 3 coverage	96	97	95	92	93
PCV 3 coverage	96	97	95	91	93
IPV		71	95	20	61
MCV1 coverage	96	97	97	90	91
Rota Vaccine (2) coverage	92	97	95	93	93
Drop-out rate Penta1 and Penta 3	2	2	4	1	1
Drop-out rate PCV1 and PCV 3	2	2	4	1	1
Drop-out rate MCV1 and MCV2	24	21	19	22	22
Drop-out rate RV1 and RV last dose	4	1	4	1	1

There has been an increase in coverage among the NVS as shown in the table above. Following the global shortage of IPV, the country re-introduced the vaccine in May 2018. There has been significant coverage (61%) at end of the year. All efforts are being done to increase coverage of all the antigens in the routine services.



10/14/2019

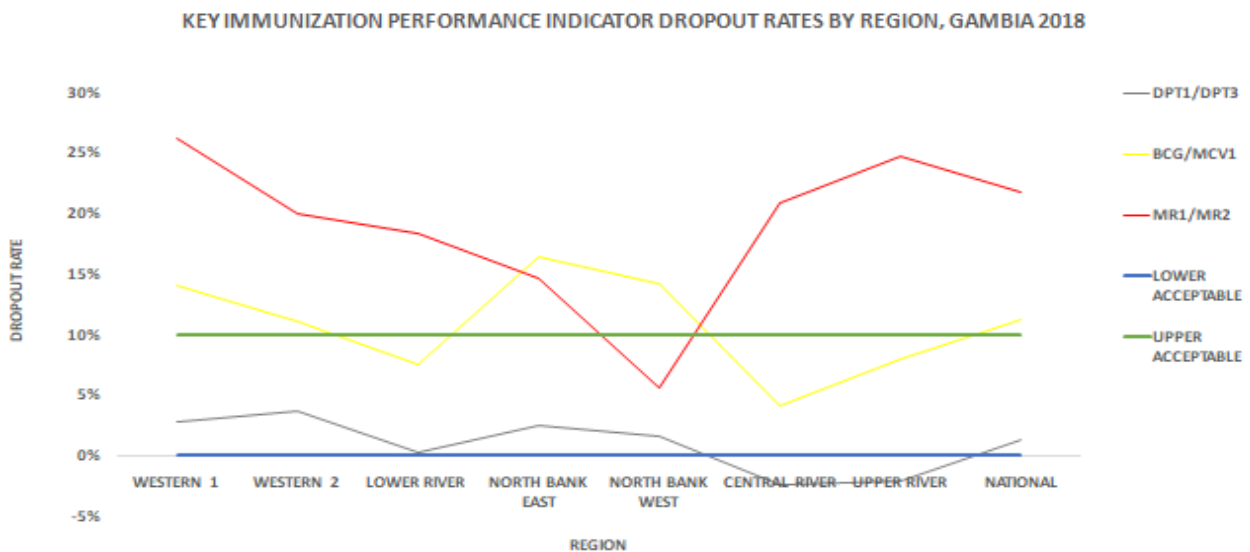
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Figure 1: Routine Immunization Key performance Coverage by Region, Gambia 2018

Coverage for BCG and Hep B vaccines (Live Birth doses) has been relatively good with 6 out of the 7 regions reaching at least ninety percent (90%) of their target.

Similarly, coverage for Penta3 and OPV3 (Surviving Infant Doses) has also increase when compared with the previous year are below the national target in all the regions, consequently resulting in a lower national coverage. There are regional variations in coverage, with the Lower River, Central River, and Upper River Regions recording the lowest coverage.

Dropout rate have been relatively low for DPT1 and DPT3 with the national target at 1%. However, this has been very high above the national target of 10% for Measles-Rubella1 and Measles-Rubella2 doses. Significant dropout differences between regions were recorded, and the national rate remains high at 22% for Measles – Rubella 1 and Measles –Rubella 2. This could be largely attributed to mother’s not coming for immunization services after their children attain their first birth day, due to lack of awareness of both caretakers and health workers. The EPI is looking at new strategies in 2YL guidelines to improve this coverage.



10/14/2019

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Figure 2: Routine Immunization Dropout rates for Key Indicators, Gambia 2018

MenA Campaign

The introduction of Meningitis A vaccine is one of the national priorities included in the Gambia Comprehensive Multi Year Plan for 2017-2021 and an annual work plan for EPI. Following the mass vaccination campaign conducted in the country in November 2013 targeted persons aged 1-29 years, there was the need to conduct a catch-up campaign for the new birth cohort (which will not be part of the routine introduction) in order to sustain the gains made with regards to reducing the cases of Meningitis Type A. As Such, The Government of the Gambia through the Inter-Agency Coordinating Committee (ICC) conducted this campaign in February 2019 to pave the way for the routine introduction completed in April 2019. The main objective of the Catch-up MenA preventive campaign was to vaccinate the new birth cohort (1-5yrs) that did not receive the first dose of MenA vaccine after the 2013 campaign in the country. However, due to the delay in conducting the campaign (which was planned for 2017) some of the vaccines were about to get expired. This prompted the EPI to increase the campaign target to children 1-7yrs. This was an excellent decision as it saved over 100,000 doses from expiring.

The campaign targeted all children aged 1 to 7 years old using a 10 dose LYOPHILISED MenA vaccine (MenAfriVac) as the preferred choice of vaccine presentation. A total of 416,614 children were targeted for vaccination during the 7 days campaign. As shown in the figure 3 below, an administrative coverage of 92% was attained with regional variations. Upper River Region registered the highest coverage of 104%, whilst WHR2 had 86%. These Post Campaign Evaluation results showed little difference in the national coverage of the administrative data (93%) but with significant difference in some regions.

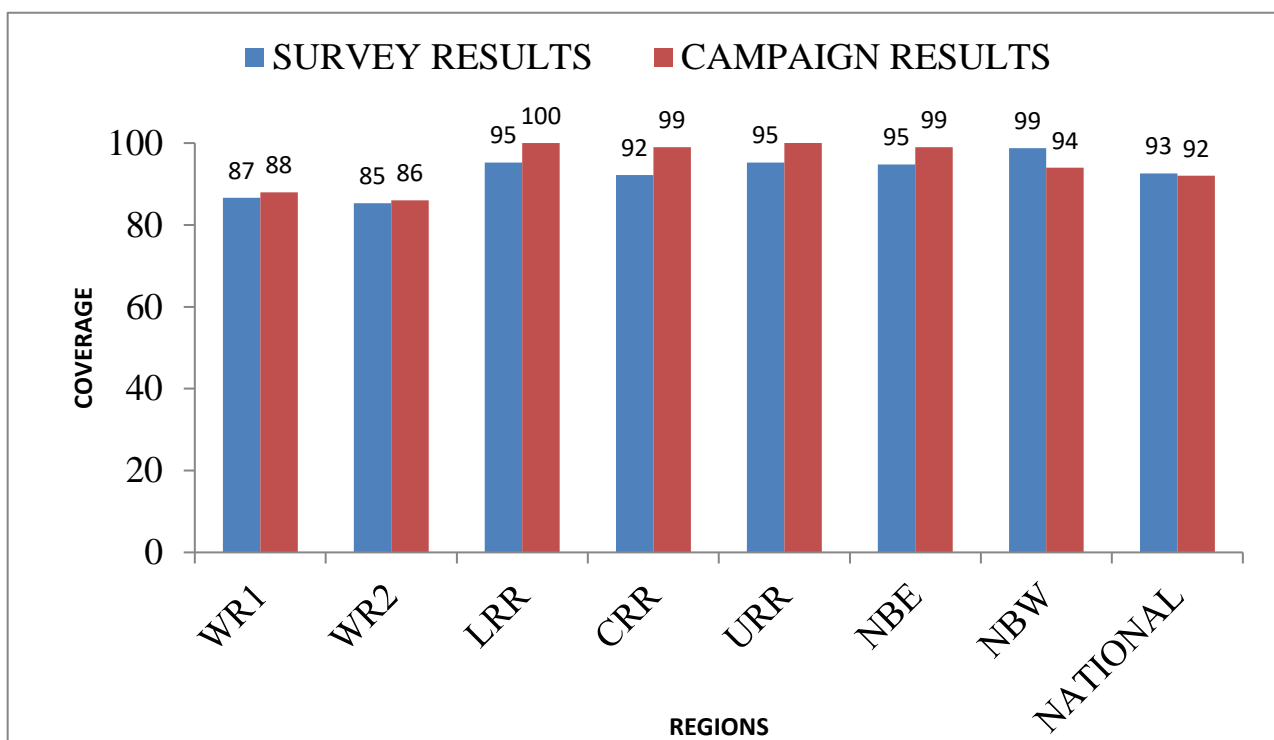


Figure 3: MenA Campaign and Survey Results

Measles and rubella

Measles is still a major public health threat and can occasionally cause epidemics. In the Gambia, from 2006 to 2009, there was no confirmed case of measles. However, the measles case-based surveillance data showed two (2) confirmed measles cases in 2010 suggesting the possible accumulation of susceptible cases overtime. There has been a decline in confirmed measles from 2010 to 2014. Due to the delay in implementing the planned MR campaign in 2015, the country experienced an outbreak in late 2015 to early 2016 with 71 and 58 confirmed cases respectively. The index case was detected in the Sabi border of Upper River Region (URR) and travelled to the West Coast Region and caused a protracted localized outbreak in Brikama and part of Kombo north District.

Based on the evidence from the national data, the frequently affected regions in the country are URR and Western Region 1 and 2. There were four confirmed measles cases in Upper River Region in 2018. One rubella case was confirmed in Lower River Region in 2018 from a child who came from Senegal to attend a religious ceremony with the parents.

The Gambia has been implementing measles reduction strategies which include strengthening routine immunization, catch-up and follow up SIAs and effective surveillance since the late 2000s. However, with the implementation of surveillance for Measles and Rubella, a total of 114 suspected measles cases of which 37% were IgM positive for rubella and none for measles in 2011. The trend continued to increase in 2012 and 2013 with 42% and 49% respectively of all suspected measles cases were IgM positive for rubella. A study conducted in The Gambia by Medical Research Council (MRC) describe around a 10% Sero-prevalence of Rubella-Specific antibodies in 9 and 10 months old infants; thus, providing evidence of ongoing rubella transmission within The Gambian population. This necessitated the switch from measles vaccine to measles-rubella vaccine in 2017.

Table 2 showing Lab Confirmed Measles cases in the Gambia 2012-2018

	2012	2013	2014	2015	2016	2017	2018
WR1	0	0	0	26	45	1	0
WR2	0	0	0	37	4	0	0
LRR	0	0	0	0	0	0	0
NBW	0	0	0	0	0	0	0
NBE	0	0	0	4	1	0	0
CRR	0	0	0	2	0	0	0
URR	0	0	0	2	8	0	4
NATIONAL	0	0	0	71	58	1	4

Table 3: showing Lab Confirmed Rubella cases in the Gambia 2012-2018

	2012	2013	2014	2015	2016	2017	2018
WR1	34	55	20	2	3	0	0
WR2	0	5	10	1	1	0	0
LRR	2	1	0	0	0	0	1
NBW	3	2	1	0	0	0	0
NBE	0	1	0	1	0	0	0
CRR	1	2	0	0	0	0	0
URR	0	0	4	0	0	0	0
National	40	66	35	4	4	0	1

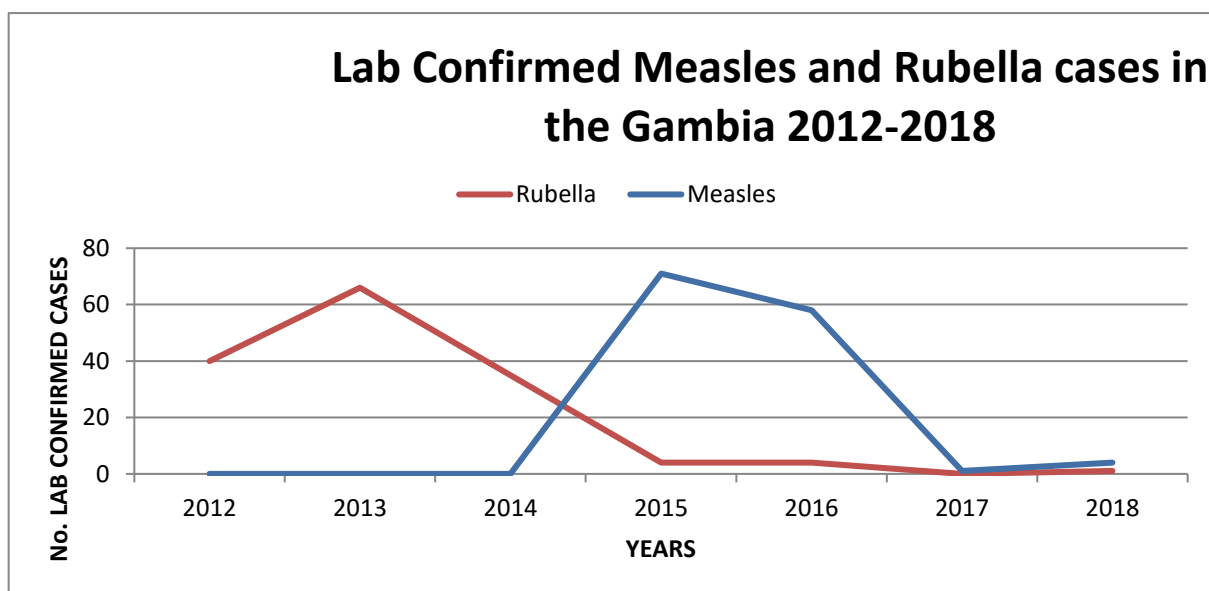


Figure 4: Lab confirmed measles and rubella cases from 2012 to 2018

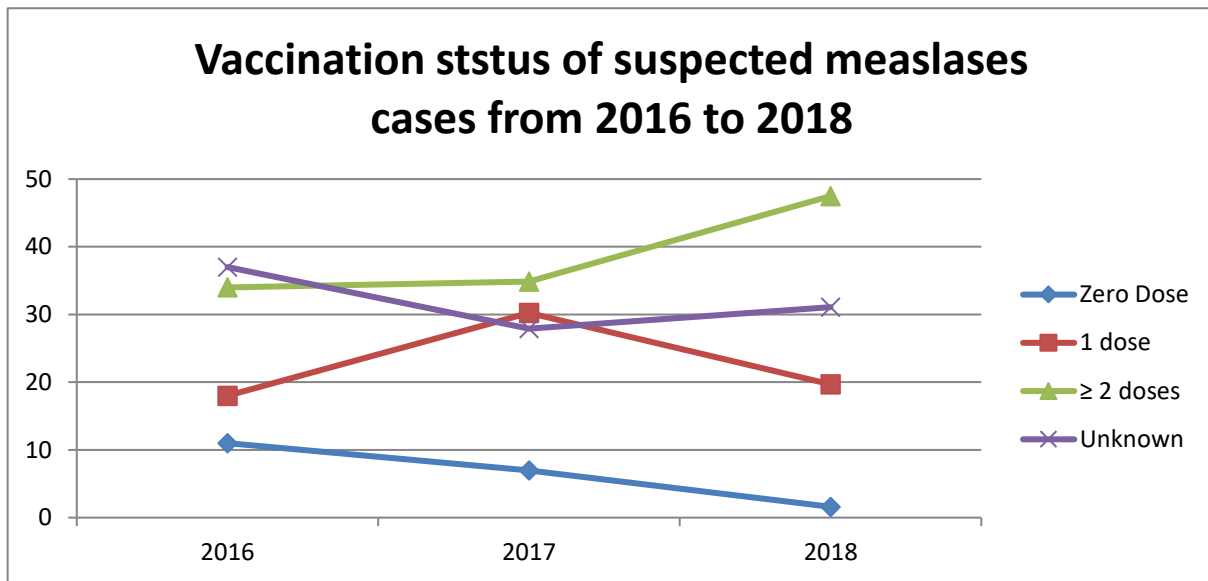


FIGURE 5: vaccination status of measles cases in 2016 to 2018.

3.3. Performance of Gavi CCEOP support (if country is receiving Gavi CCEOP support)

The country has secured \$693,289 in CCEOP funding during 2018 and 2019. The aim is to extend, expand and replace the CCE. Eighty (80) equipment has arrived in country and there was a training of technicians who are to install the equipment. The Project Management Team (PMT) has met the local vendor (SWEGAM) and provided an updated ODP to minimize deviation as much as possible. The PMT conducted series of meetings that consequently led to little or no deviation from the original ODP developed. The PMT has endorsed the installation to start in earnest. As of October 2019, WR1 and WR2 fridges are being installed. An anticipated risk of delay in custom clearance have been successfully mitigated with the support from the MOH. Below is the distribution of the 80 equipment by region that are to be installed in the initial support phase

REGION	CCE TYPE	QTY	CCE TYPE	QTY	CCE TYPE	QTY	CCE TYPE	QTY	TOTAL
CRR	TCW 15 SDD	6	TCW 40SDD	1		0		0	7
LRR	TCW 15 SDD	7	TCW 40SDD	1	TCW3043 SDD	1		0	9
NBER	TCW 15 SDD	5	TCW 40SDD	2	TCW3043 SDD	1		0	8
NBWR	TCW 15 SDD	5	TCW 40SDD	2	TCW3043 SDD	5		0	12
URR	TCW 15 SDD	4	TCW 40SDD	7		0		0	11
WR1	TCW 15 SDD	9	TCW 40SDD	6	TCW2043 SDD	6	TCW2000 AC	2	23
WR2	TCW 15 SDD	5	TCW 40SDD	4	TCW2043 SDD	1			10
TOTAL		41		23		14		2	80

Table 4: CCEOP Distribution by Region

It was recommended by the IRC during the CCEOP review that the country needs to conduct an assessment on the cost-benefits of constructing and equipping a cold store in WR1 and WR2 who gets their supplies directly from the national depot. UNICEF have been supporting this assessment through the TCA 2018 with a preliminary stakeholder workshop conducted in August 2018. The goal of the assessment was to inform decision on the procurement of CCEOP equipment in WR1 and WR. The assessment recommended the 2 regional stores to be equipped.

The second year ODP is being developed in preparation for the procurement of the equipment for the second phase of the platform. The cold store for western 1 and 2 is expected to be constructed through UNICEF before the second year ODP is finalized.

The CCEOP would strengthen the cold chain system is aimed to provide potent and uninterrupted vaccine supplies in order to realize optimal immunization coverages. The 5 mandatory CCEOP indicators would be measured after the installation of the CCE in the country. The installation is expected to be completed latest by December, 2019.

3.4. Financial management performance

Gavi cash grants for the immunisation programme are managed through UNICEF Country Office. This follows the recommendation from the FMA and PCA done in 2015 and 2018 respectively. The 2018 PCA laid down some recommendations (GMRs) which needs to be fulfilled before such cash support can be transferred to the government back.

During the period under review, cash grants for vaccine introduction received were for the MenA VIG and catch-up campaign. The catch-up campaign was meant to be implemented in 2018 and then eventual introduction into the routine. But due to fund liquidation challenges within the ministry, these funds were not utilised in 2018 but rather in 2019.

The country is implementing a five year HSS grant (2017 – 2021). Due to delay in the start of implementation and due ongoing delays in liquidation of funds, only year 1 funds have been disbursed with the following consumption rate.

Grant	Amount Disbursed (\$)	Amount Utilized (\$)	Current Balance (\$)	% Utilization
HSS	1,574,306.00	1,537,047.37	37,258.63	98
HPV	170,286.00	144,491.19	25,794.81	85
MR VIG	99,998.98	81,789.70	18,209.28	82
Men A	298,424.38	298,361.21	63.17	100

It is anticipated that, the fund absorption will increase in the coming year, due the proper planning being taken by the fund holders and the immunisation programme. A plan of action is being developed by UNICEF and the EPI team, which will help to guide and ensure proper planning is taking place to avoid undue delay in activity implementation.

3.5. Transition plan monitoring (applicable if country is in accelerated transition phase)

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Not applicable - initial self-financing

3.6. Technical Assistance (TA) (progress on ongoing TCA plan)

Activity	Status	Proposed plan of Action
Conduct Effective Vaccine Management (EVM) Assessment in 2019 and development of the EVM improvement plan	Delayed due to development of revised EVM tool	To be conducted in early 2020
National construction Engineer to oversee construction activities	Ongoing	4 outreach sites to be completed by March 2020. There is a delay in 1 site
Missed Opportunity for vaccination assesment conducted, particularly for vaccines given in 2YL with high drop out rates	Delayed	To be completed by Decemeber 2019 to feed into EPI 2020 operational plan
TA to support implementation of recommendations of the Gavi PCA related to Management and Coordination	Not done . Challenges inCoordination meetings regarding GMRs	Funds to be re-programmed towards priority activity from JA discussions.
Implementation of DQIP	DQA done, national DQA team formed and meet regulaly, harmonization of national targtes currently being done and expected to be completed this year, Harmonization and integration of imunization data in to DHIS2 has started with support from University OSLO	harmonization of immunization data is being harmonized in to the DHIS2 step by step.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
<p>1. Service delivery and new vaccines/coverage and equity</p> <ul style="list-style-type: none"> • Preparations for HPV introduction: <ul style="list-style-type: none"> ○ Implementation of HPV introduction plan ○ Coverage survey – HPV ○ Mapping of out of school girls • Operational Research on MOV and dropout rates • Institutionalize defaulter tracing mechanism • Construction of new outreach sites 	<p>SERVICE DELIVERY AND NEW VACCINES/ COVERAGE AND EQUITY</p> <p>The EPI continues to be committed to improving immunization coverage through effective and efficient service delivery. Quarterly vaccine delivery to the regions has been maintained to prevent stock-out at the service delivery points.</p> <p>Challenges and how they were overcome:</p> <p>Recently the program had constructed and equipped a cold store in Western Region II to maximize access to vaccine within the region. Following a successful nationwide Meningitis-A vaccination campaign with a 93% coverage, the program had successfully introduced Meningitis-A vaccine into the routine immunization services in April, 2019. To enhance health workers' capacity on the vaccine, a countrywide training of health workers was conducted. Since introduction, the program has achieved an average coverage of 31.4% nationally.</p>

	<p>COVERAGE AND EQUITY</p> <p>There are efforts to improve immunization coverage and this lead to the recent orientation of Traditional Communicators, Village Support Groups, influential leaders and drama groups on the importance of immunization. The EPI program provided mobility for RCH teams to strengthen access to immunization regardless of geographic location. Furthermore, there are plans to expand immunization services to more areas by opening and building new RCH sites to increase access base on geography and population density.</p> <p>A country wide geo-mapping of the service points (SP) (Based and Outreach) was done and followed by the development of a dashboard. The dashboard has three different features namely; the coverage map, stock management and site map and it is fed through the DHIS2 and the SMTs (Central and Regions). The site map show in each base site the CCE, vehicle accessibility, population estimates, pictures and a heat map that shows areas that may need outreaches.</p> <p>Preparation for HPV Introduction:</p> <p>The country plans to introduce HPV vaccine into its routine immunization services in November, 2019. To this effect, the HPV technical working group was revitalized and preparatory weekly meetings commenced towards implementation. The TWG members were group into two main sub- committees (Technical and Social mobilization) based on individual area of expertise and comparative advantage. Each of the sub-committee’s do meets and updates the larger TWG members during weekly meeting.</p> <p>In addition, a school census was conducted in July, 2019 were a template was developed from the national level and shared with the regions. These were equally shared with health facility staff to collect data directly from school registers with the aid of the school authorities. Data was collected from current grade 3 to 7 in the non-demonstration region and grade 3 to 5 in the demo areas including the Arabic schools. The exercise aimed at providing accurate data for the HPV target. A total of 112,688 girls were eligible to receive the vaccine during introduction.</p> <p>Due to delay of the 2019 HPV introduction and MAC (delayed fund flow), the team decided to advance the introduction in the demo region to immunise the in-school girls in order to utilize the 19,200 doses which are to expire by Mid-October. During the official introduction in November, there will be a sweep-up approach in the demo region to reach all Out-of-School girls.</p> <p>Out-of- schools girls: Similarly, the community structures such as Village health workers, Community Birth Companion, and community gatekeepers were used to provide data for out- of-school girls through the health facility staff in their respective catchment areas. Currently, the data collected for out- of- schools girls stands at 890 girls.</p> <p>Communication preparatory activities:</p> <p>As the country prepares for the HPV national Introduction into the routine EPI services, communication activities are ongoing. HPV is incorporated into the training of health workers on immunization services. Also the recently concluded orientation of VSGs, Traditional communicators, and Opinion leaders etc., HPV was integrated.</p> <p>Furthermore, the program received technical assistance from PATH to help develop communication material for HPV introduction.</p>
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	<p>Currently there are available draft in the following documents and this will be finalizing in a workshop with relevant partners.</p> <ul style="list-style-type: none"> • Communication /Social Mobilization Plan • Training Material for health workers • Crisis Communication Plan • Readiness assessment forms <p>Operational Research on MOV & Dropout rates</p> <ul style="list-style-type: none"> • no research was conducted <p>Institutionalize defaulter tracing mechanism</p> <ul style="list-style-type: none"> • Not done • There exist individual or facility level defaulter tracing in some regions but national standardized system <p>EPI adopted combined mobile vaccination & defaulter tracing during the 2019 African Vaccination week celebration.</p>
<p>2. Strengthen Surveillance activities</p> <ul style="list-style-type: none"> • Training of expert committee on AEFI • Develop guidelines and protocols (AEFI) • Orientation of community structures on surveillance • Development communication materials on VPD surveillance • Institute MenA case base surveillance • Institutionalize CRS sentinel surveillance 	<p>Training of expert committee on AEFI</p> <ul style="list-style-type: none"> • This was not done because of lack of funds. Now that it is factored in the HSS, we hope to implement it in the coming year. <p>Develop guidelines and protocols (AEFI)</p> <ul style="list-style-type: none"> • This was not done because of lack of funds. Now that it is factored in the HSS, we hope to implement it in the coming year. <p>Orientation of community structures on surveillance</p> <ul style="list-style-type: none"> • This was not done because of lack of funds. Now that it is factored in the HSS, we hope to implement it in the coming year. • orientation of data managers and surveillance officers on surveillance <p>Development communication materials on VPD surveillance</p> <ul style="list-style-type: none"> • This was not done because of lack of funds. Now that it is factored in the HSS, we hope to implement it in the coming year. <p>Institute MenA case base surveillance</p> <ul style="list-style-type: none"> • Combined enhance & Case based meningitis surveillance system finalised, • Protocol on meningitis surveillance & laboratory surveillance established and training conducted. • TA on meningitis Surveillance GIS & data reporting is being finalised <p>Institutionalize CRS sentinel surveillance</p> <ul style="list-style-type: none"> • Sentinel surveillance not institutionalised • CRS sentinel surveillance protocol & guidelines developed • 600 health care workers trained • Registers and protocol are not produced. <p>Challenges;</p> <ul style="list-style-type: none"> • Protocol & guidelines for CRS, Meningitis and AFP developed but WHO still unable to produce those document as being planned. We will continue to engage WHO to ensure the production of these guidelines • Lack of transport refund for sample transportation. • Change in DHL laboratory specimen transport. Since 2018 DHL no longer allows transportation of blood and stool

	<p>samples now considered a bio-hazard. As such, MOH needs to conduct its own transportation, including to Senegal</p> <ul style="list-style-type: none"> • Shortage in Measles reagents leading to delay in testing <p>Way forward;</p> <ul style="list-style-type: none"> • Print /produce the aforementioned guideline and product. • Conduct refresher training on CRS & lumbar puncture orientation for doctors and hospital admins • Support surveillance samples transportation within and outside the country. We hope to include this in the HSS when we do a reprogramming in 2019 • Support AEFI expert committee & protocol development and train all health care workers by October 2020 • Develop VPD communication material & support quarterly feedback community informants by October 2020 • Support Neonatal Tetanus Surveillance strengthening. • Conduct step down training on meningitis data system and reporting
<p>3. Immunization Data Quality and Data Systems</p> <ul style="list-style-type: none"> • Continued integration of immunization data into DHIS2 <ul style="list-style-type: none"> ○ Developing EPI dashboard ○ Implement DQIP with regional and facility level. ○ Deployment and training on the EPI data quality module in DHIS2 ○ Conduct quarterly data audit 	<p>Continued integration of immunization data into DHIS2</p> <p>Integration of immunization data into DHIS2 has been ongoing with support from University of Oslo. However, full integration has not yet taken place as regions continue to send in the tailored Immunization Summary Excel Sheet database. The reason for this is that we still could not address the long standing denominator issue due to lack of access funds.</p> <p>The country developed a DIP in 2019, and in it was recommended that the MoH have a common denominator for all programs for similar target age group. This would be the target programmed in DHIS2 for programs to use in their data analysis and use. The National Data Team of MoH has developed activities to address denominator issues as per the DIP recommendations. The Team conducted a consultation tour of all the programs and units, as well as the senior management of the Ministry to sensitize them on their resolve to generating a common set of denominators for used by all programs. The aim was to seek appreciation and maximize use of the generated denominator.</p> <p>To support implementation of the DQ team's data quality activities on denominator issues, The EPI Manager have approved transfer of the \$6000 2018 TCA funds balance at WHO to the National Data Quality. However, these funds could not be accessed, and got expired. Notwithstanding, the WHO continued processing the request with the 2019 TCA funds; The DQ team was informed of the disbursement of the requested monies on September 17th, 2019.</p> <p>Developing EPI dashboard</p> <p>A consultant was sent by the University of Oslo in August 2019 to among other this with other programs as well:</p> <ol style="list-style-type: none"> <i>Configure EPI data into the DHIS2, and create a dashboard for immunization data</i> <i>Configure the WHO immunization App into DHIS2</i> <p>The consultant met with the EPI team on August 16 to complete such task, which the doable portions including reviewing and updating of key EPI indicators were completed.</p> <p>After configuration of WHO Immunization App in DHIS2, the team was introduced to App. However, the training component of the consultant's mandate was not done as the head of IT Unit was said</p>

	<p>to have travelled. The consultant promised to come back later to accomplish that task.</p> <p>Implement DQIP with regional and facility level</p> <p>The country sought TA through WHO to develop a DIP. The plan was successfully done in March 2019, and covers the period 2019 – 2021. Some of the activities therein were already in the Gavi HSS, hence their implementation is ongoing.</p>
<p>4. Logistics and Supply chain management</p> <ul style="list-style-type: none"> • Conduct EVM assessment in 2019 • Deployment of year 1 CCEOP • Conduct quarterly preventive maintenance 	<p>The country has secured CCEOP from Gavi with the aim of extending, expanding and replacing of the CCE. Eighty (80) equipment have arrived in country and there was a training of technicians who are to install the equipment. The PMT has met the local vendor (SWEGAM) and provided an updated ODP to minimize deviation as much as possible. The PM is to sign some documents with the local vendor for installation to start in WR1 and WR2. The ODP for year 2 is currently being developed.</p> <p>The country has the Stock Management tool (SMT) at central level to monitor the stock levels. It is being updated once vaccines are supplied to either regional stores or Service points collecting their vaccines directly from the nation depot. It is currently used at the regional stores but not regularly reported in by all the regions. A consultant is helping the country to create a dashboard for the SMT to visualize an in-depth analysis.</p> <p>There also exist a Vaccine Visibility System (VVS) that is web based vaccine logistics management tool that utilizes 3D barcodes to improve the stock management of vaccines. The system tracks all routine EPI vaccines from central level through regional stores to health facilities, thereby improving data visibility and enabling better stock management via shipment tracking, expiry notifications, etc. The VVS is an online data base currently on pilot phase and deployed at the EPI central store, in all the regional vaccine stores and 23 service points. A ToT was conducted at the central level in 2019 followed by a cascade training for health service providers in all the regions. The developers also trained MOH ICT personnel to learn some skills in Tanzania to be able to support the country after the pilot phase of the VVS. A great improvement has been realized as most vaccines sent to the Gambia are with 3D barcodes to enable the smooth implementation of the VVS.</p> <p>An evaluation is currently going on way to map out a way for possible expansion to more service points. It is also being tried to be integrated in to the DHIS2 and to possibly work on offline internet mode as internet is a major challenge in VVS implementation.</p> <p>An assessment was conducted by consultants hired by UNICEF to look at the redesigning of the immunization supply chain in the country. This came about as a result of a recommendation from the IRC to see the cost benefit analysis of equipping a cold store at WR1 and WR2. The country has secured some funding from UNICEF to implement some of the immunization supply chain redesigning scenario in CRR and WR2.</p>
<p>5. Leadership, Management and coordination</p> <ul style="list-style-type: none"> • Quarterly review meetings to monitor the progress of EPI annual work plan including the JA action plans • Engage dialogue with MOH on HR training plan to sustain capacity investments 	<p>The programme over the period under-review conducted quarterly review meetings will the aimed of discussing immunisation services across all the service delivery level. These meetings were an avenue where immunisation service issues were discussed and strategies put in place to ensure continuity and maintenance of the high immunisation coverage.</p>

<ul style="list-style-type: none"> Implementation of incentive scheme Establishing the NITAG 	The incentive scheme geared towards improving HR morale has been developed and validated is awaiting signature by the Ministry of Health. Thereafter, this can be implemented across the board.
Additional significant IRC / HLRP recommendations (if applicable)	Current status
Not applicable	

5. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND RESOURCE/SUPPORT NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for the next year and requested modifications to Gavi support:
Based on the bottlenecks described in above section, the following actions have been prioritised

Key finding / Action 1	To improve service delivery			
Current response	<ul style="list-style-type: none"> High dropout rates on vaccines given during 2YL No standardised defaulter tracing system Inadequate outreach sites especially in urban areas High staff attrition rate MoH staff incentive scheme not endorsed by MoH management Inadequate capacity in the training school 			
Agreed country actions	<ul style="list-style-type: none"> Use local capacities to conduct operational research on MOV and Dropout rate Develop SOPs and data collection tools on defaulter tracing Scale up construction of new outreach sites If UNICEF does not continue, an alternative method can be used to ensure continuity of this activity. MoH management to endorse staff incentive scheme for implementation Support the capacity building of training schools 			
Expected outputs / results	<ul style="list-style-type: none"> Improved coverage in the 2YL vaccines 12 outreach posts completed Standardized defaulter tracing mechanism implemented across the country Improved access to immunization services in urban areas Improve capacity of graduates from the training institutions 			
Associated timeline	2020-2021			
Required resources / support and TA	Adequate financial resources and TA for the development of the SOPs and defaulter tracing mechanism.			
Key finding / Action 2	Maintain high coverage and address inequities			
Current response	High national coverage (93%) which varies across the regions. Some regions (W1, W2, CRR and URR) have relatively low coverage, below the recommended RED approach.			
	The highest number of unvaccinated children are in these regions and there is need to develop targeted strategies for these regions and within each region.			
	REGION	DTP 3 unimmunized	MR 2 unimmunized	Access
	W1	2370	10025	1 – population
	W2	867	3420	4
CRR	1123	3806	2 – distance	
URR	846	4137	3 – distance and population	
Transport (outreach vehicles)	4			
Agreed country actions	<ul style="list-style-type: none"> MR campaign application To have a targeted strategy for urban immunization Investing in outreach sites in priority areas identified to increase access Allocating additional vehicles and motorcycles based on areas identified with highest transport limitations / needs 			

	<ul style="list-style-type: none"> • Institutionalize defaulter tracing in low performing regions (facilities) – • Institutionalize the use of the GIS tools across the different levels. • Conduct MOV assessment • Develop guidelines for HepB birth dose delivery and reporting.
Expected outputs / results	<ul style="list-style-type: none"> • MR Application submitted by May 2020 • Increased coverage especially in low coverage regions • 7 New outreach sites identified in the other 5 health regions and built / Increase in coverage in these areas • Defaulter tracer integrated in routine immunization • GIS tool finalized and made available to all regions. Capacity building provided and tool is used routinely / Better prioritization of activities to improve equity and coverage • MOV assessment conducted and recommendations integrated into existing strategies to improve coverage and equity • Guidelines developed for HepB delivery and disseminated
Associated timeline	2020-2022
Required resources / support and TA	<ul style="list-style-type: none"> • Construction Engineer to supervise outreach construction • Further development, rollout and capacity building on GIS tool (UNICEF)
Key finding / Action 3	Continued improvement of data quality
Current response	<ul style="list-style-type: none"> • A DQA was conducted and DIP developed. • Outdate EPI policy; • Inadequate utilization of data at all levels. • Uncoordinated staff movement (transfer) • Lack of agreed/common national denominators • Weak coordination on data management at national level • Inadequate computers and accessories on data management. • Inadequate coordination of quarterly data verification
Agreed country actions	<ul style="list-style-type: none"> • Review and update the draft EPI policy (finalise draft) • Participate in DQIP led exercise to harmonise denominator across MOH program. • Enhance data availability and utilisation by: <ul style="list-style-type: none"> A) development/finalisation, harmonisation and improvement of data collection tools (eg UNICEF GIS platform and DHIS2 app + offline mode) B) improve skills development through data trainings C) enhance supportive supervision and mentorship on data usage D) Strengthen and institutionalise data verification reviews (at facility, regional and nat. levels). • Tackling drop-out rates, by 1st identify key causes, 2nd improved data trainings, 3rd linked to denominator challenge • Align and improve M&E framework with renewed national health strategic plan. • Identify incentive approach to enhance data quality (TBC – no agreement on the how) • Quarterly integrated supportive supervision by the national level and monthly supportive supervision by the regional and facility staff
Expected outputs / results	<ul style="list-style-type: none"> • Distribution and training on updated EPI policy • Agreed and revised denominator across MoH • Functional data verification committees (facility and regional level) • DHIS2 app integrated in DHIS2 • GIS platform finalised and integrated within HMIS/MOH and staff trained on new tools • Streamlined data reporting achieved and data usage enhanced thanks to improved tools and skills (trainings). • Regular facility, regional and national data reviews institutionalised to rectify data challenges.
Associated timeline	2020-2022
Required resources / support and TA	<ul style="list-style-type: none"> • Update and finalise epi policy (WHO consultant?) • GIS platform roll-out and integration within MOH (UNICEF) • DHIS2 app & offline mode completed (UNI Oslo) • Support in data trainings

Key finding / Action 4	Strengthening of logistics and supply chain
Current response	<ul style="list-style-type: none"> • The country has secured CCEOP from Gavi with the aim of extending, expanding and replacing of the CCE. Eighty (80) equipment have arrived in country and there was a training of technicians who are to install the equipment. • The PMT is to sign some documents with the local vendor for installation to start in WR1 and WR2. The ODP for year 2 is currently being developed. • The country has the Stock Management tool (SMT) at central level to monitor the stock levels. It is being updated once vaccines are supplied to either regional stores or Service points collecting their vaccines directly from the nation depot. It is currently used at the regional stores but not regularly reported in by all the regions • There also exist a Vaccine Visibility System (VVS) that is web based vaccine logistics management tool that utilizes 3D barcodes to improve the stock management of vaccines. The system tracks all routine EPI vaccines from central level through regional stores to health facilities, thereby improving data visibility and enabling better stock management via shipment tracking, expiry notifications, etc. • The VVS is an online data base currently on pilot phase and deployed at the EPI central store, in all the regional vaccine stores and 23 service points. • A ToT was conducted at the central level in 2019 followed by a cascade training for health service providers in all the regions. • The developers also trained MOH ICT personnel to learn some skills in Tanzania to be able to support the country after the pilot phase of the VVS. A great improvement has been realized as most vaccines sent to the Gambia are with 3D barcodes to enable the smooth implementation of the VVS.
Agreed country actions	<ul style="list-style-type: none"> • Train health staff on the SMT and other logistics tool for regular reporting • Train health service providers on the VVS • The PMT to update SMT and health staff on the CCEOP implementation • Develop ODP for the CCEOP year 2
Expected outputs / results	<ul style="list-style-type: none"> • CCE equipment installed and functional • Staff trained on logistic tools and report regularly • SMT and health staff updated with the CCEOP implementation • Year 2 ODP developed with the regional staff
Associated timeline	2020-2022
Required resources / support and TA	TA Supply Chain, CCEOP, Y2L
Key finding / Action 5	Engagement of Relevant stakeholders on communication activities
Current response	<ul style="list-style-type: none"> • Poor state of RCH structures • Areas without RCH sites • Overcrowding of RCH sites • Increase access to services • Inadequate communication support materials
Agreed country actions	<ul style="list-style-type: none"> • Engagement of LGAs on the identification, construction and maintenance of service delivery points in their local government areas • Development of advocacy materials to reinforce communication activities • Training and engagement of VSGs on defaulter tracing • Train and Retrain service providers on IPC in Immunization • Bi-monthly in-service meetings at the regional level • Mapping of community informants on surveillance at health facility, regional and national level • Engagement of community informants (Traditional healers, bone setters, VHWs) • Development of communication aid materials on VPDs (flip charts, posters, leaflets, audios, booklets, brochures, discussion cards) • Data review and validation at district level
Expected outputs / results	<ul style="list-style-type: none"> • High immunization coverage <ul style="list-style-type: none"> ○ LGAs engaged on the identification, construction and maintenance of service delivery points in their local government areas

	<ul style="list-style-type: none"> ○ Advocacy materials developed ○ VSGs trained and engaged on defaulter tracing ○ Service providers trained on IPC ○ Bi-monthly in-service meetings conducted ○ Community informants mapped out at all levels ○ Community informants (Traditional healers, bone setters, VHWs) engaged ○ Communication support materials developed ○ Data reviewed and validated at district level
Associated timeline	2020-2022
Required resources / support and TA	<ul style="list-style-type: none"> ● Support in communication training (WHO Consultant) ● design of Communication aid materials on VPDs (flip charts, posters, leaflets, audios, booklets, brochures, discussion cards) (UNICEF) ● Development of the communication materials?

Based on the above action plan, please outline any specific technology or innovation demand that can be fulfilled by private sector entities or new innovative entrepreneurs.

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

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The JA was presented and discussed at the 16th November 2019 ICC, chaired by the Hon. Minister of Health and was unanimously endorsed by the members.

7. ANNEX: Compliance with Gavi reporting requirements

	Yes	No	Not applicable
End of year stock level report (due 31 March) *	X		
Grant Performance Framework (GPF) * reporting against all due indicators	X		
Financial Reports *			
Periodic financial reports	X		
Annual financial statement	X		
Annual financial audit report			X
Campaign reports *			
Supplementary Immunisation Activity technical report	X		
Campaign coverage survey report	X		
Immunisation financing and expenditure information			
Data quality and survey reporting			
Annual data quality desk review		X	
Data improvement plan (DIP)		X	
Progress report on data improvement plan implementation		X	
In-depth data assessment (conducted in the last five years)			
Nationally representative coverage survey (conducted in the last five years)			
Annual progress update on the Effective Vaccine Management (EVM) improvement plan			
CCEOP: updated CCE inventory	X		
Post Introduction Evaluation (PIE) (specify vaccines):	X		
Measles & rubella situation analysis and 5 year plan			X
Operational plan for the immunisation programme		X	
HSS end of grant evaluation report			X
HPV demonstration programme evaluations			X
Coverage Survey			X
Costing analysis			X
Adolescent Health Assessment report			X
Reporting by partners on TCA	X		

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

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