Joint appraisal report

Country	**Rwanda**
Reporting period	***Jan 2014 – December 2014 (also covering Jan-Jun 2015)***
cMYP period	***2013 - 2017***
Fiscal period	***July 2014 –June 2015***
Graduation date	*Only relevant for graduating countries*

1. EXECUTIVE SUMMARY

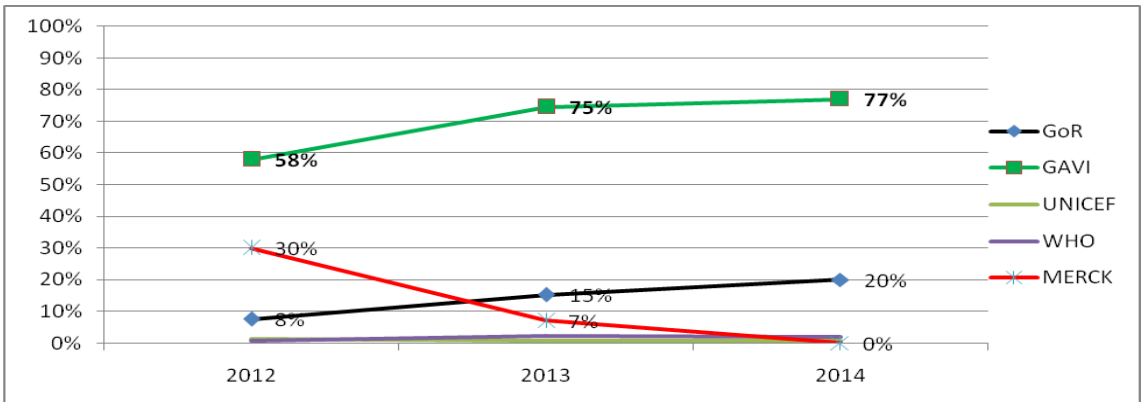
1.1. Gavi grant portfolio overview

Five out of 12 antigens currently available in Rwanda immunization program are new and co-financed by both Government of Rwanda and GAVI, while all traditional vaccines are procured 100% by government. Introduction of new vaccines and high immunization coverage have tremendously contributed to the reduction of infant and child morbidity and mortality in Rwanda.

GAVI did not only support Rwanda in NVS but also in Cash support through HSS and VIG. HSS has contributed to overcome immunization program bottlenecks and it has revitalized vaccination activities at all levels. GAVI/HSS has helped Rwanda to overcome health system constraints on the delivery of immunization and related services, it has helped Rwanda in health work force mobilization, distribution and motivation at district level and below. It has improved a lot the quality of services at both Districts level and below through cold chain equipment maintenance, organization, monitoring, and management of health services especially immunization. Predominently Rwanda was able to cover training, It did strengthen immunization program through training, supervision, procuring supplies and equipments and it has improved aspects of the HMIS using results based decisions. In Rwanda HSS is mostly consistent with REC (Reach Every Child) strategy which increase immunization coverage and equity among Rwandan population.

All GAVI grants (Vaccines and HSS funds) are reflected in National Health sector budget.

The following graph shows the trends of vaccination program funding by source over the past 3 years:



Source: APR 2012-2014

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)

Achievements.

All activities implemented through HSS have been designed in integrated manner as to duly achieve desired outcome.

- A dry storage capacity volume was increased of the EPI/VPD consumables and other non-EPI/VPD consumables from other programs of MOH,
- 2 vehicles were procured for transportation of EPI/VPD and other essential medical commodities; supervision of EPI/VPD and other priority health services.
- 84 biomedical technicians trained in basic maintenance of sound cold chain integrity as well as maintenance of other medical equipment helped in addressing trouble shooting timely and effectively at Central, district and health facility levels.
- Several types of spare parts were procured (335 Thermostats, 44 compressors, 45 starting relays, 410 heaters for 50 RCW, 200 gaskets), sensor 250, capacitor 45, Relay 45, Wick 1000, Burner 100, Glass flue 400, Sealing ring 50, for maintenance of cold chain equipment by the trained biomedical technicians.
- 2000 health professionals at all levels trained in production and utilization of quality of data (HMIS, EPI/VPD & general EIDS data) and strategic information.
  Strengthening the skills of personnel in data analysis, interpretation & reporting, data utilization for evidence based decision making (EBDM), and understanding, formulation and use of performance indicators. Planning, coordination and inadequate supportive supervision, especially at district level. Annual planning at national level, and annual micro-planning of the Central level of the MOH.

Rwanda has achieved a lot in terms of immunization coverage in 2014:

- ✓ BCG 101%
- ✓ Pent 1: 103%, Pent 3: 102%
- ✓ PCV 1: 103%, PCV 3: 102%
- ✓ Rota 1: 103%, Rota 3: 102%
- ✓ MCV1: 97%, MCV 2: 77%
- ✓ HPV 1: 103.3% , HPV 3: 103.2%

- VPDs surveillance indicators were maintained high
- No stock out of any vaccine was reported at all levels
- 4 new vaccines were introduced in last 6 years; In 2014 particularly, Measles &Rubella combined vaccine at 9 months was introduced into the routine system in January 2014 (through Gavi support), and Measles second dose in July 2014 (funded by Rwanda).
- Infant and child mortality dropped from 50/1000 to 32/1000 and from 76/1000 to 50/1000 in 2010 and 2014 respectively (DHS2014-15)
- Outreach vaccination sessions were revitalized in all health facilities
- According to DHS 2014-15, the proportion of fully immunized children has increased from 90% in 2010 to 93% in 2014-15.

Challenges

- Funds transfer procedures delays (From GAVI to country and within the country)
- Vaccination program records not yet computerized
- Population movement in the region wich impacts the vaccination program with high risk of having imported VPD outbreaks (Burundian Refugees movement)
- Unplanned quantity of vaccines being given to refugees
- Financial sustainability of the program (Around 80% is external funds)

Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)
• Integration of vaccination activities with other health interventions like deworming at 15 months together with Vit A • Operationalization of Reaching Every Child (REC) strategies in all health facilities, • Public & Private partnership with all Private clinics. • Vaccine forecasting and shipment plans are developed ahead of time to avoid stock out of vaccine

1.3. Requests to Gavi's High Level Review Panel

Grant Renewals
New and underused vaccine support • Rwanda has requested in APR 2014 the programme extension of routine new vaccine support (HPV, PCV13, Rotavirus vaccine, DPT-HepB-Hib and measles second dose (MR, with Rwanda paying the full amount of the Rubella component) up to 2021 in line with its new cMYP which is currently pending finalisation) However due to the current cMYP timeline, Rwanda is requesting HLRP to renew up to 2017. • Rwanda requested the switch from Rotavirus vaccine 3 to 2 doses/schedule understanding that this will not be available in 2016, but Rwanda is requesting for consideration as soon as it does become available **Health systems strengthening support** • Rwanda requests the HSS GAVI funds for the third year (July 2015-June 2016) $1,960,833 considering 74% of the budget implementation and commitment for year 1 and year 2. • Rwanda requests HLRP to disburse 2014 HSS PBF reward funding

1.4. Brief description of joint appraisal process

As recommended by GAVI on grant renewals, each Country has to conduct in-country Joint Appraisal and submit the report of findings to GAVI. Rwanda has conducted the joint appraisal from 10th to 14th August 2015 to complement the 2014 Annual Progress Report (APR) submitted to GAVI in May 2015. All key immunization partners were involved in plenary discussion and field visit.

The Joint Appraisal was initiated in July 2015 with three preparatory meetings conducted in July and August 2015. The objectives of the meetings were (i) to have a common understanding of the Joint Appraisal process, (ii) review documents to be used for this exercise, (iii) select hospitals for field visits and assign corresponding team,(iv) review of tools to be used during the field visits. Participants of Joint Appraisal were from the Ministry of Health (RBC/MCCH/VPDP, Planning unit and M&E in RBC, RBC/SPIU, development partners (WHO, UNICEF, USAID), Civil society organizations (Rotary club, Polio Eradication Committees, BUFMAR, URUNANA Development Communication and GAVI alliance Secretariat was represented by Antonia Pannell who gave a series of presentations: Update from Gavi and Introduction to Joint Appraisal, HSS reporting, financial reporting and wrap up.

This report has been prepared taking into account inputs from immunization partners in the country including WHO and UNICEF country offices. The findings were presented to the MoH/ICC on 8th September 2015.

This is the first time the country has undertaken in-country Joint appraisal and it has been an opportunity to relook closely at the program performance, discuss and propose solutions to some of identified challenges; and the program Managers have benefitted also from inputs provided by the appraisal team.

2. COUNTRY CONTEXT

2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants.

With 26,338 square kilometers, Rwanda is a landlocked country in central and eastern Africa with a population of 10,515,973 (Census, 2012). The population is young with the mean age of 22.7 and predominantly rural with 83% of the population living in rural areas; and a density of 415 inhabitants per square km one of the highest in Africa. Rwanda is at high altitude, with a hilly terrain in the West and North, savanna in the east, and numerous lakes throughout the country. The climate is temperate, with two rainy seasons and two dry seasons.

The health system in Rwanda is organized as a three-level pyramid. The central level includes the Ministry of Health (MoH), Rwanda Biomedical Center (RBC) which is the implementing agency of the Ministry of Health (MoH) and the national referral hospitals.

The intermediate level includes district hospitals while the peripheral level includes health centers and health posts providing primary health care in collaboration with the community through Community health workers (CHWs). Rwanda currently has 42 district hospitals, 481 health centers, 380 health posts and 14,837 villages. On the health workforce side, Rwanda has one doctor per 15,428 inhabitants and one nurse per 1200 inhabitants. There are 3 CHWs at village level totalizing 44,511 CHWs countrywide.

Vaccination services in Rwanda began in 1973 offering BCG and smallpox vaccines. In 1976, smallpox vaccination campaign was organized countrywide and was followed by the first measles vaccination campaign in 1978.The vaccination program became operational in 1980 by offering 6 traditional antigens (BCG, DPT, OPV and MCV) and has grown since to offer 12 antigens by 2015. EPI activities are fully integrated into the routine health services as part of the minimum package of health interventions within each health facility.

As a result of health services integration, 90% of Rwandan infants are immunized at fixed sites and outreach immunization services have been revitalized to reach the remaining unimmunized with support from Government and GAVI. Effective IMCI interventions; prompt medical attention, good community case management through CHWs, high immunization coverage and introduction of new vaccines as well as the performance based financing (in all Districts there is an indicator on DPT 3 coverage and Measles; MCV 1, and Ministry of health is paying this indicator on quarterly basis) have contributed to registered commendable progress in child health indicators and MDG 4 was achieved: both infant and Under five mortality rates remarkably decreased, respectively from 86/1,000 in 2005 to 32/ 1000 live births in 2014-15 and from 152/1,000 in 2005 to 50/1,000 live births in 2014-15.

Immunization coverage has been higher than 90% for all antigens over the last 8 years, due to Government commitment to support immunization program by procuring at 100% all traditional vaccines and GAVI co-financing requirements is above the minimum at 0.35 USD per dose and has been for sometime up to now.

Since 2002, GAVI has played a big role in new vaccines introduction and 6 new antigens have been added to Rwanda routine immunization schedule (Hepatitis B, Hemophilus influanzae type B, PCV, Rotavirus vaccine, HPV and MR combined vaccine).

ICC composed of in country immunization partners has contributed to the achievement of vacination program through advocacy, funds mobilization and provide technical support.

From 2007 up to date, Rwanda has benefitted from GAVI HSS support which has contributed to overcoming immunization program bottlenecks.

Despite the achievements, there are uncontrolled external factors such as financial sustainability and movement of the population in the region (Refugees) which can hinder the performance of the program, particularly the challenge on Rwanda to pay co-financing for these doses. As of now vaccine buffer stocks have been used to provide for the refugees.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

3.1. New and underused vaccine support

3.1.1. Grant performance and challenges

GAVI is supporting Rwanda for underused vaccine and new vaccines: Pneumococcal conjugated vaccine (PCV13), Human Papilloma Virus vaccine (HPV), Pentavalent vaccine, Rotavirus vaccine and MR vaccine.

In 2002, Hepatitis B and Hib vaccines (components of Pentavalent vaccine) were the first introduced vaccines supported by GAVI.

Rwanda is the first country in sub-Saharan Africa to introduce the Measles Rubella (MR) vaccine into RI schedule nationwide (in January 2014). The MR Vaccine currently used is given at 9 months replacing MCV that was being used. MR was first used in a nationwide campaign supported by GAVI in March 2013, targeting 4,278,528 children aged between 9 months and 15 years. The National MR Coverage for the campaign was 97.5%, which was a good indicator to introduce MR into Routine Immunisation schedule. The country also introduced Measles Vaccine second dose to the Routine Immunisation schedule at 15 months (July 2014) adding another health worker contact with the caregiver. Rwanda introduced MCV2 in routine immunization program independently in 2014 (without GAVI support), and going forwards GAVI will be supporting the 'M' component of MR2.

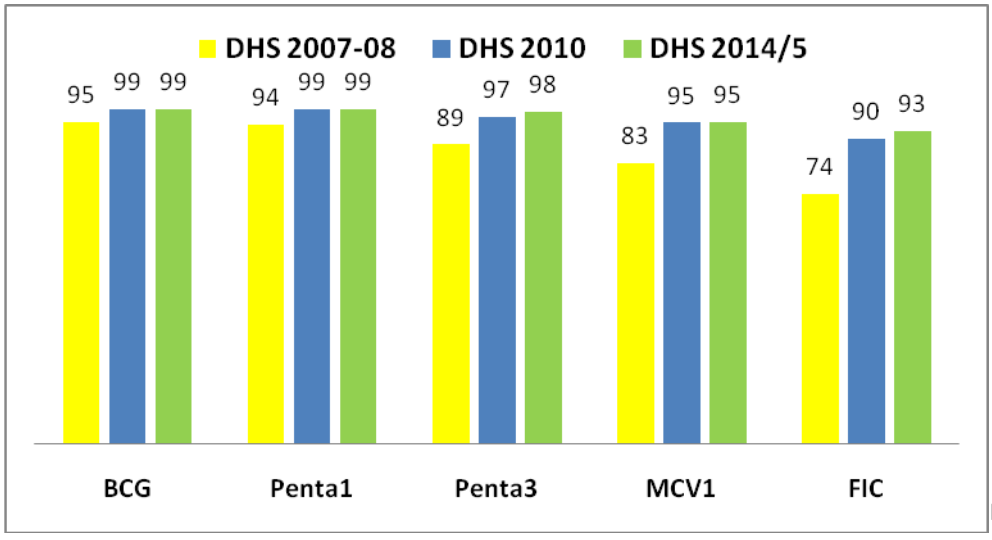
Figure 1: Summary of the received support in kind since 2002 to 2014.

The vaccination coverage has been maintained high over the last 8 years for traditional vaccines procured 100% by Government of Rwanda and for underused and new vaccines co-financed by both GAVI and Government of Rwanda.

2014 coverage of each Gavi-supported vaccine (according to admin data was as follows):

- ✓ PCV 3= 102%
- ✓ Pentavalent 3= 102%
- ✓ Rotavirus 3 = 102%
- ✓ HPV = 98%
- ✓ Measles & Rubella first dose = 97%, and MR2 :77%

Figure 2: The following chart shows the trends of vaccination coverage according to different DHS (2007/08; 2010; 2014/15)



The administrative coverage in 2014 APR reached 100% for most of antigens, Rwanda vaccination program is committed to maintaining high immunization coverage and the drop out will be minimized (less than 1%).The immunization coverage above 100% should be explained with some factors; people coming from neighboring countries to look for immunization services, denominator issues with movement of refugees creating additional vaccine demand.

The immunization coverage for MR 2 is low in 2014 (77%) because care givers were acquainted with ending all vaccinations at 9 months and there were no IEC material that had been used for the introduction of Measles vaccine second dose.

The proportion of the infants to be vaccinated in routine immunization is estimated at 3% of the total population (source: RPHC4_Population projections 2013-2032). According to the Population projections from 2012 Census, the proportion of adolescents girls aged 12 to get HPV vaccine is estimated at 1.3% of the total population.

The most common reference surveys for vaccination data are Demographic and Health survey (DHS) and DHS is conducted every 5 years, the latest was conducted in 2014/2015. Immunization coverage from routine data are not different from DHS. Vaccination program plans to conduct a comprehensive immunization coverage survey in 2016 including new vaccines (HPV and MSD). Routine immunization coverage in 2014 is not significantly different from the coverage from surveys (Discrepancies <5%).

Most of EPI activities are implemented with the participation of development partners, In fiscal year 2014/15, WHO and UNICEF participated in EPI Review, post introduction evaluation (PIE) for measles and rubella (MR) in routine immunization. The most recommendations/results were:

- ✓ Pre-introduction training conducted at all levels vaccine successfully introduced in all the districts in January 2014; it was well-received by the community and health workers.
- ✓ Data collection tools updated and available before introduction of MR vaccine
- ✓ No resistance recorded in the implementation of new vaccines, cooperative
- ✓ Adequate cold chain capacity for the new vaccine
- ✓ No stock outs of the MR vaccine was reported in any of the sites reviewed
- ✓ Majority of care givers interviewed did not know about the rubella component of the MR vaccine
- ✓ There is high wastage when MCV2 and MR are used concurrently for the different age groups
- ✓ Low uptake of measles second dose because care givers were acquainted with ending all vaccinations at 9 months
- ✓ The country should consider using MR to replace MCV2 for ease of administration and storage
- ✓ Intensified sensitization of Communities on MR & MCV 2; Benefits, Schedule, to motivate them to come back at 15 months
- ✓ More IEC materials on MR should be available and displayed in the HCs to remind caregivers of the vaccine

3.1.2. NVS renewal request / Future plans and priorities

Rwanda is requesting the extension of the following vaccines up to 2017 (the end of current cMYP):

- ✓ PCV-13
- ✓ Pentavalent
- ✓ HPV vaccine (Quadrivalent)
- ✓ Rotavirus Vaccine
- ✓ MR 2 (Rwanda to co-pay for R component)

In 2014 APR, the request was made up to end of 2021 (the end of revised cMYP however this cMYP is not yet ready for submission, so vaccines are requested to end of current cMYP, 2017).

To save both storage capacity and cost of rotavirus vaccine, Rwanda has requested to change Rotavirus vaccine presentation in 2013 and 2014 APR (From 3 to 2 doses/schedule).This change of rotavirus Vaccine was discussed with GAVI Senior Country Manager during the Joint Appraisal, and agreed that, although it is the preference to change to 2-dose presentation, this is not possible currently due to lack of supply. Suggested that Rwanda request again for 2-dose schedule in 2016 when supplies may be clearer. Until then, GAVI has supported Rwanda to pay lower co-financing per dose of Rotavirus, recognizing that it is paying co-financing for a third dose which the country does not want.

In January 2016, Rwanda will introduce one dose of Inactivated Polio Vaccine (IPV) in routine immunization, all requirements to ensure the soooth introduction have been put in place; (cold chain storage capacity has increased, training of stafff, acceptability study of IPV has been conducted) and switch from t-OPV to b-OPV is planned in April 2016.

Rwanda would like to conduct a prior Meningitis A diseases burden assessment before the introduction of Meningitis A vaccine in Routine immunization. However Men A is might not necessarily be Rwanda priority for introduction, and malaria might be more of a priority for Rwanda's finances for immunization. The discussion still ongoing at programmatic level, and final decision will be shared with partners.

In 2017, measles and rubella combined vaccine follow up campaign is expected to be done for 12 to 23 months children and Rubella vaccination campaign for women in child cearing age (WCBA, Rwanda is looking the way to work closely with immunization partners to support.

The main objectives and priority actions for EPI programme in 2015 and 2016 are:

- To improve and sustain higher coverage objectives for all current vaccines (>95%)
- To introduce Inactivated Polio Vaccine (IPV) as one of the strategies of polio endgame
- Switch from tOPV to bOPV in 2016
- Implementation of elimination mode of measles surveillance and congenital rubella syndrome surveillance (CRS)
- Strengthening REC strategies in all districts
- Introduce performing vaccine management system (SMT)
- To increase cold chain storage capacity and quality at central level and expand storage capacity at peripheral level
- To develop SOPs for effective vaccine management at all levels.

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

The ongoing Rwanda five year GAVI HSS grant started in July 2013. This JA report includes the contribution of HSS grant in terms of EPI performance by achieving different indicators initially defined in the HSS proposal.

To monitor the achievement of HSS grant the M&E framework has been developed for tracking the progessive achievement, So far, most indicators are being achieved

Twenty seven activities were planned during the second year of the project, the implementation status of second year activities is detailed in PBF reporting form.

The ICC composed of key immunization partners including WHO, UNICEF and USAID and CSO, is the overall committee to coordinate and make advocacy for all immunization activities including endorsement of the HSS workplan, new vaccines introduction proposal and validation of reports. it meets on quarterly basis. There are many stakeholders in implementation of HSS grant; Vaccine Preventable Diseases Program, Maternal, Child and community Health Division, CSO and health facilities. .

The delay in the first disbursement of funds (first tranche of funds were disbursed by Gavi in November 2013, when start date of programme was July 2013) impacted the implementation of first and second year activities; as a result some of the activities will be carried forward in the third year.

HSS funds have been used to monitor and improve the quality of data in all health facilities, currently all health facilities have trained staff in Data Quality and general program management. Supervision and mentorship are being conducted from central level to district and health center level to improve the quality of service delivery therefore the quality of data is enhanced. Vaccination program meets at quarterly basis with all District Hospital for vaccination activities coordination and district hospitals meet with health centers on monthly basis for the same purpose. RED strategies are being implemented in all health facilities since 2005, and have been revitalized to Reach Every Child (REC) in 2012.

The total HSS budget of the second year is USD 1,977,144; plus the carry-over of the previous year was 1,606,009 USD. The total expenditure up to June 2015 is equivalent to 2,268,448 USD and commitment totalizing USD 170,198.53 for item and services order during the year but not yet paid). Total budget execution is 63.3% up to june 2015, taking into consideration commitments the execution rate increases to 68.1% (USD 2,438,647).

The main challenge encounted in last year is related to the delay of funds release from GAVI for the first tranche (7 months delay according to the request), the second year tranche of HSS project was received in country in April 2015 on time according to the request made. , The delay for the first year disbursement impacted the implementation of activities up to now. Another challenge was related to procurement process which took long time. *During JA, it has been decided to report by Semester July-December and January-June; This ensures that reporting works both for Rwanda (by July-June fiscal year) and for GAVI (by calendar year).*

3.2.2. Strategic focus of HSS grant

Before the current HSS grant, there were gaps in access and coverage of immunization services connoting equity challenges in the population. Therefore, HSS grant in past two years has improved the situtaion and health facilities were supported in terms of implementation of vaccination activities. Outreach activities have been revitalised with HSS funds by providing funds to facilitate them to cover the hard to reach areas, vaccines and vaccine devices transportation have been improved from central to peripheral level, cold chain equipments have been maintained and health facilities personnel are trained in core program management.

The percentage of District with DPT 3 coverage increased from 60% in 2010 to 100% in 2014 (JRF 2010 and 2014). DTP3 coverage in the lowest wealth quintile was maintained at 96% from 2010 to 2014-2015 (DHS 2010, 2014/15).

In Rwanda there is no gender barrier to immunization and other health services. Vaccination program in Rwanda is integrated with other health services such as follow up of children born from mother living with HIV, Growth Monitoring Progam (GMP) and Prevention of Malaria.

3.2.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

Rwanda has received the first two tranches of HSS funds ($2,462,813 disbursed in Nov 2013 and $1,977,144 disbursed in May 2015). In the third year (July 2015–June 2016) of the HSS project, Rwanda will continue to focus on improvement of immunization coverage and access to vaccination services. Activities to be implemented in third year are listed in the annual work plan. The approved budget for the third year is 1,960,883 USD, and Rwanda is requesting HLPR to approve its disbursement to Rwanda. The total budget of the current fiscal year will include the balance of the previous year (1,314,703.88 USD) and the total amount will be 3,275,586.88 USD.

3.3. Graduation plan implementation*(if relevant)*

Not relevant

3.4. Financial management of all cash grants

Gavi cash grants utilized by Rwanda in 2014 were:

1. HSS first tranche: $2,462,813 (disbursed Nov 2013, but utilized in 2014)
2. VIG for MR 1 introduction: $299,500 (disbursed Nov 2013, but utilized in 2014).

The Ministry of Health is the principal recipient and implementer of GAVI support in the country. The Principal project bank account in USD is managed by SPIU/RBC (Single Project Implementation Unit/Rwanda Biomedical Center) approved by the Cabinet of GoR. The SPIU/RBC provides technical support and oversight to all donor projects in the country. The SPIU/RBC in collaboration with the Directorate of MCH and the Directorate of Planning oversees implementation of activities funded by GAVI.

For HSS funds, the sub-recipients are the Vaccine Preventable Disease Program (VPDP) and MCH division. Since January 2015, there was a change in management of all cash grant whereby SPIU/RBC has been shifted from Ministry of Health to Rwanda Biomedical Center (RBC) which is implementing agency of Ministry of Health,.Following those changes, the Chief budget manager of SPIU funds is no longer the Permanent Sectretary in the ministry of health, he has been replaced by the Deputy Director General of RBC.

4. TECHNICAL ASSISTANCE

4.1 Current areas of activities and agency responsibilities

In 2014, vaccination program received diffferent technical support:

1. EPI review and MR post introduction evaluation

The review teams consisted of ten national staff members, six external reviewers, and local representatives from partners (WHO and UNICEF). The overall objective was to conduct comprehensive EPI, PIE for MR and in depth surveillance system review in Rwanda from 10th to 21st November 2014.

2. IPV application and introduction plan

To develop IPV application and introduction plan Rwanda requested TA from WHO.
Two consultants worked together with EPI team to develop all required documents and the IPV application and introduction plan were submitted to GAVI secretariat. Rwanda request was approved and IPV introduction is planned in January 2016.

3. TA for Effective Vaccine Management Assessment

Every three years,effective vaccine management is conducted. Last year the EVM at the third time was carried out and there was exteranl team from UNICEF. Vaccination program has satrted to implement therecommendations from EVM.

4.2 Future needs

Standard immunization coverage survey:
The ICS support is for short term and potential funder would be WHO.
Rwanda has been facing a problem of denominator for the last 5 years, routine data have shown good immunzation coverage but some times exceding 100% at National level and some districts exceed 100% while others the coverage remain low (around 80%). The recent reference of immunization coverage is DHS 2014-2015 and it is not showing the coverage by district. and new antigens are not included in the DHS (HPV, MSD)
The following are expected outcomes from the TA:

1. Immunization coverage survey protocol
2. Tools development, data analysis and interpretation
3. Immunization Coverage Survey report
4. Immunization Coverage sustainability/improvement plan

IPV Post Introduction evaluation (PIE): IPV Post Introduction Evaluation (PIE) will require a short term support from WHO. IPV has its own specificity as an Injectable vaccine to be added in routine immunization. The introduction of one dose of IPV in routine immunization which will be given at 3½ months in addition to other injectable vaccines (PCV13 and Pentavalent vaccine) requires the post introduction evaluation to document its impact on routine vaccination in general and the perception of the population.
Lessons will be drown from the IPV introduction to inform further introduction of new vaccines, to document and share best practices.

To update RIM3 and capacity building on use the tools: RIM 3 is utilized to report number of vaccinated children to WHO. New vaccines are not included in database and Vaccination program will need a technical support to update the database and provide analysis using the RIM 3 database. The potential support is WHO. The introduction of new vaccines in routine immunization requires including all of them in immunization database to allow EPI to share with stakeholders the number of vaccinated children.

Expertise on Financial Costing tools: Rwanda is developing new cMYP, the Country has to cost activities during annual action plan and strategic plan elaboration. Institutional capacity will be strengthened to better plan, implement, monitor and evaluate health sector strategies. Rwanda did not identify potential funder up to now. This wil be short term support.

Expertise in Financial sustainability and institutional income generation: As the external fund is decreasing, there is need to sustain gained achievements by mobilising internal/domestic resources: eg Diversify partners and looking for other internal support. Institution financial stability improved to sustain already achieved gains. This is a long term support and Rwanda does not have expected funder.

Measles second dose PIE: MSD was introduced in July 2014. Once the vaccine is introduced it is a requirement to carry out post introduction evaluation within 6 to 12 months after the introduction. It is very important as a new vaccine and at the same time the new contact added on the immunization schedule. This is a short term support from WHO.

1. **ENDORSEMENT BY ICC, HSCC OR EQUIVALENT& ADDITIONAL COMMENTS**
(Section to be completed after the ICC meeting)

Brief description of how the joint appraisal was endorsed by the relevant nationalcoordination mechanism:
Issues raised during debrief of joint appraisal findings to national coordination mechanism. The main issue discussed during Joint appraisal report presentation to ICC members is related to the Population movement in the region and it was captured in the ICC meeting report attached to this JA report.
Any additional comments from • Ministry of Health: • Partners: • Gavi Senior Country Manager:

2. **ANNEXES**

[Please include the following Annexes when submitting the report, and any others as necessary]

- **Annex A. Key data** (this will be provided by the Gavi Secretariat)
- **Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
Vaccine antigen targets need to be adapted based on population targets. The country needs to evaluate its new targets precisely.	The current population target is based on 2012 census Population projections .
Fast track installation of additional 5 cold rooms with 40m3 each in 2014/15 with support from UNICEF, and GAVI/HSS Implement the recommendations from the Cold Chain Inventory from 2013 & EVM 2014 to augment the cold chain capacity, management and monitoring	In 2014/15, three additional cold roms of 40 m3 for each were installed. In 2015/16, it is planned to purchase 2 more cold rooms under HSS grant.
Country should consider coverage survey on HPV vaccination to shed light on the quality coverage data and integrate HPV vaccine into to the routine immunization program (static and outreach)	HPV vaccine has been introduced in routine immunization since 2014 and the target population of HPV is 12 years old girls. In 2016, it is planned to conduct immunization covergae survey

	and HPV will be included.
Shift to measuring PAB rather than TT2+ coverage	Measuring of PAB will start to be collected in 2016. It requires the revision of data collection tools and the introduction of IPV and switch from t-OPV to b-OPV will be an opportunity to consider this new indicator in all data collection tools.
Secure MINECOFIN representation on the ICC to ensure that they understand and secure the resource needed to fund new vaccines and operational costs.	**Discussion is on going**
Establish a schedule for regular ICC meetings that are led by the MoH and discuss program performance on regular basis and not just Gavi related business.	**Done**
MoH will discuss merits of creating a NITAG and take a decision accordingly	**Ministry of Health is exploring among existing committees**
Improve financial disbursement and accountability systems to facilitate funds flow Improve and streamline the government procurement systems; Request for procurement to be transitioned to UNICEF to mitigate delays.	Some procurement have been transferred in UNICEF. E.g: Cold Rooms
Improve planning, implementation and monitoring of the RED/REC Strategy to support efforts to reach 100% coverage	All health facilities now have micro planning and RED/REC strategies are discussed in quarterly coordination meetings
Vaccine and logistics management needs to be streamlined to avoid overstocking and under stocking at all levels through training and regular monitoring of stocks at all levels	To improve the program management, all district hospitals have been trained in DVD-MT and at National level SMT is being used
Strengthen capacity of EPI staff in data analysis and use	All health facilities have trained staff in data management.
Establish periodic EPI specific M&E and supervision visits and review meetings at all levels of health system	It is done and it is a continuous process.
Review Gavi HSS funding to determine whether it can be aligned to the country's planning cycle	- It has been discussed and reporting will be January-June and July-December
Determine baselines for the remaining years of HSS support to ensure that the impact of the support can be adequately measured	- Done
Ensure that programme and financial reports provide an update on the status of activities and also funds spent on activity implementation along with identification of other funding agencies	Done
Develop an asset register for procurements undertaken with Gavi support and promote culture of keeping assets in	-

good-condition.	
Rwanda needs to submit to Gavi by Oct 2014 a note outlining the change in implementation management and transition process need to be monitored closely by MoH	Done
NRA including AEFI surveillance systems needs to be strengthened	Ongoing
Increase government contribution to the immunization program, specially operational costs	Ongoing discussion
Technical support with the development of success stories from the health sector; Technical support with an external evaluation on the national immunisation programme; Technical support to develop an operational research agenda including a data quality assessment and EVM, the development of an Elimination Plan for Measles/Rubella and a Readiness Assessment for SARA. Technical assistance to enhance durable financial sustainability strategies and to update the costing tool for cMYP.	Done in collaboration with WHO, the country is waiting the feedback on SARA

- **Annex C. Description of joint appraisal process** (e.g. team composition, how information was gathered, how discussions were held)

From 10th to 14th August 2015, The Joint Appraisal was conducted in Rwanda for the second time. The first Joint appraisal was held with support from external team including GAVI secretariat, WHO and UNICEF. The main purpose of the JA was to complement the 2014 Annual Progress Report (APR) submitted to GAVI in May 2015. All in country key immunization partners were involved in plenary discussion and field visit.

Different meetings were held with following objectives:

(i) to have a common understanding of the Joint Appraisal process,

(ii) (ii) review documents to be used for this exercise,

(iii) (iii) select hospitals for field visits and assign corresponding team,

(iv) (iv) review of tools to be used during the field visits.

Participants of Joint Appraisal were from the Ministry of Health (RBC/MCCH/VPDP, Planning unit and M&E in RBC, RBC/SPIU, development partners (WHO, UNICEF, USAID), Civil society organizations (Rotary club, Polio Eradication Committees, BUFMAR, URUNANA Development Communication and GAVI alliance Secretariat was represented by Mrs Antonia who gave a series of presentations: Update from Gavi and Introduction to Joint Appraisal, HSS reporting, financial reporting and wrap up.

Discussions arround the implementation of immunization activities were held with key immunization partners for two days. All components of immunization were discussed,

performances, chall

- **Annex D. HSS grant overview**

General information on the HSS grant							
1.1 HSS grant approval date			6 June 2013				
1.2 Date of reprogramming approved by IRC, if any			-				
1.3 Total grant amount (US$)			10,339,970				
1.4 Grant duration			- July 2013 – Jun 2018 (5 years)				
1.5 Implementation year			July 2013 – Jun 2018				
(US$ in million)	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	
1.6 Grant approved as per Decision Letter	2,462,813	1,977,144	1,960,883	1,968,345	1,970,785		
1.7 Disbursement of tranches	2,462,813 (Nov 13)		1,977,144 (May 15)				
1.8 Annual expenditure	0	1,949,432	1,175,820 (up to Jun 15)				
1.9 Delays in implementation (yes/no), with reasons			Yes, Delay in funds transfers both GAVI to Rwanda and also from central to district level in Rwanda				
1.10 Previous HSS grants (duration and amount approved)			USD 5,605,000 (2007-2009)				
1.11 List HSS grant objectives - To improve and sustain higher coverage objectives for all current vaccines (>95%) - To introduce Inactivated Polio Vaccine (IPV) as one of the strategies of polio endgame - Switch from tOPV to bOPV in 2016 - Implementation of elimination mode of measles surveillance and congenital rubella syndrome surveillance (CRS) - Strengthening REC strategies in all districts - Introduce performing vaccine management system (SMT) - To increase cold chain storage capacity and quality at central level and expand storage capacity at peripheral level - To develop SOPs for effective vaccine management at all levels.							

1.12 Amount and scope of reprogramming (if relevant)

- **Annex E. Best practices (OPTIONAL)**