

Joint appraisal report

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

Country	Rwanda
Reporting period	<i>July 2015 – June 2016</i>
Fiscal period	<i>July 2015 – June 2016</i>
If the country reporting period deviates from the fiscal period, please provide a short explanation	<i>The Rwanda fiscal year starts from July to June of the following year</i>
Comprehensive Multi Year Plan (cMYP) duration	<i>2013 – 2017</i>
National Health Strategic Plan (NHSP) duration	<i>2012-2018</i>

1. SUMMARY OF RENEWAL REQUESTS

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

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by GAVI
Pentavalent in existing presentation	<i>Renewal</i>	2017	350,803	US\$ 221,500	US\$ 1,102,500
PCV in new presentation (PCV13 4ds)	<i>Renewal</i>	2017	350,803	US\$ 250,000	US\$ 4,416,000
Rota in new presentation (Rota 2ds sch)	<i>Renewal</i>	2017	350,803	US\$ 134,000	US\$ 1,370,500
HPV in existing presentation (Quad)	<i>Renewal</i>	2017	121,029	US\$ 61,500	US\$ 1,342,500
IPV (IPV 5ds)	<i>Introduction</i>	2017	85,000 (3 months)	N/A	US\$191,000
Measles 2nd dose in existing presentation (MR10ds 1yo)	<i>Renewal</i>	2017	347,295	\$140,844	US\$119,501
HSS – 4rd Tranche	<i>Renewal</i>	2017	N/A	N/A	US\$1,968,345
HSS Performance based reward for 2015 performance	<i>Approval</i>	2016	N/A	N/A	US\$ 984,000

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	<i>MR campaign</i>	<i>2017 (Jan)</i>	<i>2017</i>
	<i>CCEOP</i>	<i>2017</i>	<i>2018</i>

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

2. COUNTRY CONTEXT (maximum 1 page)

[If relevant, comment only on any changes since the previous joint appraisal to key contextual factors that directly affect the performance of Gavi grants – see guidance document for more details]

Rwanda, fondly known as the land of a thousand hills, is small landlocked country located in the Great Lakes region of east-central Africa and lying just south of the equator with an average elevation of 1,700 meters. Approximately 35 percent of the land is fit for cultivation.

Its population was 10,515,973 inhabitants (census 2012), with a surface area of 26,338 square kilometers and one of the most densely populated in Sub-Saharan Africa (average density 416 inhabitants/km²).

The population is predominantly rural (with 83%) and essentially young, with 52 percent of all Rwandans under the age of 20. In terms of gender, the 2012 census shows females to be in the majority (52 percent) while males make up 48 percent of the population (NISR, 2012). 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 provincial and 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 5 Referral Hospitals, 4 Provincial hospitals and 35 district hospitals, 498 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 have 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.

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 influenzae type B, PCV, Rotavirus vaccine, HPV and MR combined vaccine). ICC composed of in country immunization partners has contributed to the achievement of vaccination 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.

3. GRANT PERFORMANCE AND CHALLENGES

3.1. New and underused vaccine (NVS) support

3.1.1. Grant performance, lessons and challenges

Programmatic performance and challenges:

During the reporting year (2015), Rwanda conducted routine immunization activities as no campaign nor demonstration project were organized.

In general, the joint appraisal found that the Rwanda performance in routine immunization for GAVI supported vaccines is satisfactory. Wastage rate was kept low for all vaccines, drop out remained in globally acceptable limits with exception of MCV1 and MCV2. No stock out was observed for all vaccines and vaccine devices. The antigens for which the coverage did not reach the targets are MCV2 and HPV 2nd dose with coverage of 87% and 90% respectively.

The coverage achieved for each antigen run as follows :

Vaccine	Target	Coverage	Wastage	Drop out	Stock level (# doses)
Penta3	97%	101%	2%	2%	Pentavalent: 420,380 doses
Rota3	97%	101%	2%	2%	Rotateq: 322,025 doses
PCV-3	97%	101%	2%	2%	PCV-13: 424,000 doses
MCV1	95%	101%	20%	2% (Between Penta1 and MCV1)	MCV: 587,000 doses
MCV2	NA	87%		16.7% (between MCV1 and MCV2)	
HPV 2 nd dose	95%	93%	2%		HPV: 114,760 doses

Source: JRF 2015

Reasons for deviations include:

- The introduction of MCV2; in routine vaccination has increased the number of visits/contacts from 5 to 6 in the vaccination schedule. As parents were used to having their children fully vaccinated at 9 months. The added visit at 15 months is getting more familiar with mothers or child caregivers.
- For HPV; the second dose was given when a number of schools had finished exam and their students had returned at home. Subsequently, not all the students have got the second dose as it was planned. Next year, the program will start vaccination earlier for girls to receive the two HPV doses before they take exams.

In 2015, results of DHS2014-15 were published and immunization coverage was maintained high compared to the previous DHS conducted in 2010. Penta 1 and Penta 3 coverage was 99% and 97% in 2010 and reached 99% and 98% respectively in 2015 while Measles coverage remained 95%. Fully Immunized Children increased from 90% in 2010 to 93% in 2015.

Equity

The joint appraisal considered equity analyses and found that the country has a target of less than 5% for the difference between the highest and lowest wealth quintile as far as vaccination coverage is concerned. The DHS 2014-15 shows that the coverage of DPT 3 is 95.7% in the lowest wealth quintile against 98.9% in the highest wealth quintile marking a difference of only 3.2% between the lowest and highest wealth quintile.

The coverage of DPT 3 in the rural and urban population is 98.7% and 98 respectively. The difference among provinces according to the DHS2014-15 are also small with Kigali City reaching coverage of 99.1%, Southern Province 98.6%, Western Province 96.3%, Northern Province 100% and the Eastern Province with 98.0%.

Considering mother's education, the coverage of DPT 3 among children whose mothers have no education is 95.4% against 99.1% among children whose mothers have a secondary education or highest.

Vaccination in Rwanda is not gendered. The DHS2014-15 shows that Penta 3 coverage in male reached 98.5% against 97.8% in female.

Equity analyses show no socioeconomic, geographic, gender or other barriers to access, utilization and delivery of vaccination services. Further analysis of equity by geography using routine immunization data shows that all districts reached Penta 3 coverage above 80%. 5 district with coverage ranging between 80-89%, 5 districts with coverage between 90-94% and the majority of districts (20) with coverage $\geq 95\%$.

Challenges

Rwanda should have introduced IPV in 2015 and preparatory activities were smoothly carried out until the introduction stopped due to supply constraints for Inactivated Polio Vaccine (IPV). The country took stock of tOPV inventory by in 2015 and developed National Plan for Switch to bOPV approved by ICC in September 2015. The country switched from trivalent OPV to bivalent OPV on 4th April, 2016 with a subsequent introduction of bivalent OPV in routine immunization countrywide. The introduction of IPV is still pending subject to the

vaccine availability probably in the last quarter of 2017.

During the Joint appraisal exercise, the measles outbreak occurred in September 2016 in Nyabihu District in western province was also subject of discussion and it was noticed that even though the immunization coverage is high for routine vaccination, there is still a number of susceptible cases of measles and it has been observed that there is a need of conducting MR follow up campaign in 2017. The last Measles mass vaccination campaign (catch-up campaign) was conducted in March 2013 targeting children aged from 9 months to 15 years.

Governance/oversight

The degree of participation of key stakeholders is considerable in the implementation of the HSS proposal. 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 relevant related to immunization services in Rwanda. Concerning decisions related to immunization, Rwanda has a very effective Inter-Agency Coordinating Committee (ICC) for immunization chaired by Hon. Minister of health which meets regularly to review and amend key decisions related to immunization

Surveillance

Some efforts are being made to strengthen surveillance systems (for AEFIs and diseases surveillance). A draft of National Manual for Surveillance of Adverse Events Following Immunization (AEFI) has been developed and now available for inputs from relevant stakeholders. The document is going to be validated and disseminated after it has been reviewed by stakeholders. In addition, AEFI committee is expected to be established and functional by June 2017 as one of the priorities stated in this joint appraisal. Also, trainings are planned to be conducted for health facilities in 2017.

For diseases surveillance, the programme maintained surveillance performance indicators in the reporting year (2015), the surveillance of VPDs has been transferred to Epidemic Surveillance and Response Division which is another RBC Division. However both divisions are under Institute of HIV, diseases Prevention and Control department (IHDPC/RBC) which is assuring coordination functions.

The country is implementing elimination mode of measles surveillance and congenital rubella syndrome surveillance (CRS) is now operational in one sentinel site (Muhima District Hospital). VPDs surveillance indicators were maintained high and polio risk assessment was done and shared with stakeholders on regular basis.

For Surveillance of Invasive Bacterial-Vaccine Preventable Diseases (IB-VPD) Cerebro-Spinal Fluid (CSF) specimens testing are routinely send to Regional Reference Laboratory (RRL) and the results database is updated.

Rotavirus surveillance is also being conducted as part of study aiming at assessing the impact of Rotavirus vaccine In Rwanda. The data associated with this surveillance are updated and shared on monthly basis.

Data quality

In order to improve the immunization data quality, RBC organizes two integrated supporting

supervisions and DQA each year where the DQA includes vaccination indicators. 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.

Every 5 years, a DHS is conducted and the last one is DHS2014-15 and program has started using the data from the survey in 2015 for all reports and plans from health centers to central level.

Denominator issue is reported in some districts where the immunization coverage is exceeding 100% (underestimation of the denominator), in some districts negative drop out between Penta 1 and Penta 3 has been reported and RED/REC is not fully implemented in health facilities. The JA recommends to conduct a DQA for immunization data in 2017.

EVMA review

This JA considered the level of implementation of recommendations/tasks from the last Effective Vaccine Management assessment. For 33 tasks recommended, 28 representing 85% were completed, 2 representing 6% are on track, 2 tasks representing 6% delayed and will be implemented once the cold chain maintenance engineer is recruited and 1 activity which represents 3% was cancelled. A notable progress in implementation of these recommendations has been made.

The following are some EVM recommendations implemented:

- Temperature mapping and temperature monitoring study was conducted
- Using Freeze tag during vaccine transportation was introduced.
- The storage capacity was expanded at Central Vaccine Store with 5 new cold rooms and 129 refrigerators were purchased
- Continuous temperature recording device was installed
- 4 refrigeration units for the Cold Rooms back-up at CVS were purchased
- 9 solar direct drives (SDDs) refrigerators were purchased for the purpose of storage capacity expansion
- SoPs for the vaccine management and contingency plan were developed

About the availability of trained supply chain managers; the programme has got sufficient number of staff trained on supply chain management:

- 2 staff benefited a course on general health supply chain management organized by the Regional Centre of Excellence Health Supply Chain Management
- 2 staff received a Short course on strategic training executive program (leadership) organized by the Regional Centre of Excellence Health Supply Chain Management.
- 2 staff were trained on Access Medicine Supply Chain redesign. A training organized by the Regional Centre of Excellence Health Supply Chain Management
- 1 staff attended a training on Supply chain capacity development organized by PSA Oxford UK
- 1 staff participated in the Regional immunization Supply Chain Management workshop Organized by UNICEF Eastern and Southern African Regional Officer.

Staffing issues include inadequacy of staff at grassroots level putting pressure on the few available staff coping with challenges associated with high workload and issues of high staff

turnover.

Logistics:

The program faces vaccine supply constraints challenges resulting from the fact that

- A number of health facilities do not have enough means for vaccine transportation.
- Insufficient categorization of vaccine wastage reporting and follow-up, this issue will continue to be one of the priorities to be focused on during supervisions
- Some Health facilities do not have enough and regular vaccine transportation facilities.
- The preventive maintenance of cold chain equipment is not properly done due to insufficient of technicians ,
- No stock register for dry materials in some health facilities,

Most of these challenges will be addressed by regular monitoring and supervision and exchange meetings.

Communication

Communication activities are not highlighted in operational plan at all levels and Lack of education/Communication materials on Immunization. In general, Rwanda does not have issues of public perception. The only concern was the acceptability of multiple injections when the country was preparing for IPV introduction which would increase the number of injections. To respond to that concern, a study on EPI Programme and multiple injections in preparation for co-administration of IPV & OPV and OPV2 withdrawal conducted in 2015 by the Drexel University School of Public health and showed that no significant issues.

Rwanda did not default on its co-financing payment in 2015. The 2016 co-financing payment for Rwanda is \$ 968,000 to be paid by 31 Dec 2016 plus \$126,150 co-payment for second dose of Rubella. Rwanda has elected to reduce its co-financing payments (\$0.20 per dose compared to \$0.35 per dose to date) the reason behind this reduction was lack of getting documentation on how the co-financing was increased and it was clearly highlighted in GAVI co-financing Policy that should co-finance \$ 0,20. Rwanda is committed to meet the co-financing requirements and co-financing line budget will continue to be secured in the government budget.

Vaccines for refugees

Government of Rwanda does not include vaccines for refugees in its projections UNICEF procures these vaccines for the refugee populations. UNICEF is requesting Gavi's support in procuring these vaccines going forwards.

3.1.2. NVS future plans and priorities

During this fiscal year 2016/17, Rwanda immunization program will have some changes in vaccine presentation and the switch is scheduled in March 2017.

- Change in presentation type for PCV (1 to 4 dose vial) and
- Rotavirus (3 to 2 dose schedule)

NVS priorities are related to:

- IPV introduction: Rwanda will introduce IPV during Q4 2017. GAVI will officially confirm to Rwanda when this vaccine will be provided and UNICEF will organize shipment.
- MR follow up campaign
- Meningitis A risk assessment (Q1 2017) and WHO will support the country with TA.
- Rwanda will also develop and submit the CCEOP application by May 2017

For the MR follow up campaign, the application due 18 January 2017 (for review in March IRC) and an epidemiological analysis will be carried out prior to application (to support age groups, frequency/timing, geographical scope) and Rwanda must pay 2% of co-financing of campaign vaccines (around \$20,500 if target population is <5 years). The Gavi will provide funding for operational costs of campaign = \$0.65 per target population. Support for MR routine immunization remains same after the campaign Gavi procures the M component of MR second dose until the 5 years support ends (mid 2020).

Finally, in order to be in compliance with data quality and survey requirements; the joint appraisal requested the country to organize a survey or deep immunization data quality audit.

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

The HSS grant contributes to improve and maintain coverage and equity in access to immunization as the coverage which has been maintained high for all vaccines and equity in access to immunization is still one of the success of the program. HSS grant has played an important role in those achievements as it is used to support vaccination activities which include vaccines supply from central level to district hospitals and from district hospitals to health centers, supportive supervisions of health centers by district hospitals and supervision for maintenance of cold chain equipment are financed. Also, this grant finances vaccination outreach sessions countrywide and sample transportation from peripheral level to central level. The same grant is

used to pay salaries for some staff in vaccination programme and storage capacity of vaccine and vaccine devices has expanded through the grant.

GAVI HSS funds are also used to finance data quality monitoring and improvement in various ways.

- The programme has equipped all EPI supervisors at district hospital level with laptops computers for monitoring and improvement of immunization data quality and reporting. 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. In these meetings, data are presented and discussed for improvement.
- Training on the use of DVD-MT was conducted and 82 participants from all District Hospitals and 10 staff members from central level were trained. Each DHs was represented by the EPI Supervisor and M&E Officer.
- In the furtherance of immunization data quality, the program envisions computerizing vaccination services and a national immunization coverage survey combined with MCV2 PIE is going to be carried out.

3.2.2. Grant performance and challenges

During the appraised period (January-December 2015), the HSS support helped in achieving most of targets and intermediate results. Supply chain of vaccines and vaccine devices from central level to operational level has been funded through the Gavi HSS grant. Therefore, no vaccine stock-outs of vaccines and vaccine devices was reported in health facilities.

- 100% of district hospitals benefited from 2 integrated supportive supervisions,
- The 17 planned incinerators have been built using HSS grant
- 100% of health facilities offering immunization services have tracer items for delivery of immunization (cold box/vaccine carrier with ice packs, functioning refrigerator and thermometer/fridge tag),
- 97% of Health Facilities submitted their reports on time
- 93% of HF submitted complete reports covering immunisation indicators.

Concerning the implementation of planned activities versus financial expenditure; the joint appraisal noted that some HSS activities were completed, a number of activities which are planned annually are continuing.

CSO involvement ICC is overseeing all decision related to EPI and endorse relevant document such as the HSS work plan, 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, and there is a full involvement of CSO.

Urunana Development communication is local CSO member of ICC and is playing a big role in Raising Awareness on the Importance of Immunization in Rwanda.

Following were main activities of *Urunana* DC during the period covered by the JA:

1. Produce and broadcast *Urunana* episodes with key messages on the importance of Immunization in at least **4** out of **8** episodes per month
2. Produce and present one radio magazine program focusing on immunization 2 every month;
3. Conduct an assessment on the effect of the key messages among the target population toward the end of the 3rd year of the project;

The existing Gavi HSS support alongside other source like ordinary budget, WHO and UNICEF is being used to meet a number of programmatic interventions and issues. The Gavi HSS is ending in December 2018 and most of the challenges highlighted above will have been addressed by the end of the project. There is no problem pertaining to the overall programmatic capacity to manage NVS grants as the programme has successfully introduced a number of new vaccines over years

HSS fund reallocation:

Due to different reasons, the joint appraisal noted that funds allocated to some activities will not be used: Conduct external Evaluation on the National immunization program every 2 years, conduct two (2) operational researches (HMIS/EPI Data Quality Assessment & EVM) for monitoring and evaluation of EPI performance by the end of December 2018 and conduct external financial audit on the GAVI HSS project every year. On this point, the joint appraisal authorized the country to prepare reallocation for funds from activities which will not be implemented, up to a total reallocation of 25%. This reallocation will be oriented to existing HSS activities or new activities in relation with project's objectives.

PBF:

About the use of PBF, the country was informed on the second PBF award equivalent to USD 984,000 for good performance during 2015. The joint appraisal proposed to orient the two PBF on building of warehouse but ICC meeting of 27 April 2017 approved the use of PBF of 2014 performance for warehouse construction and reallocated funds from HSS were planned to top up the 2014 PBF for warehouse construction. The design of this warehouse was presented during joint appraisal workshop and appreciated and a recommendation to speed up the costing of the warehouse and to fasten a subsequent of the request the two PBF to GAVI in order to start its construction. Gavi will be in a position to transfer both PBF award to Rwanda once they receive the full budget from VPDP.

Even if with HSS grant the country achieves a lot, some challenges regarding financial management of HSS grant were observed and key challenges are the delay of project implementation and low budget execution. As solution, the joint appraisal recommended the following:

- To identify funds which will not be used and reallocate (up 25%) to other activities,
- VPDP to submit financial statement up to 30 June 2016 and 2015/16 audit report to GAVI to enable the transfer the 3rd tranche in order to avoid the delay of activity implementation due the shortage of funds in country.

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

Due to low budget execution for some activities and delay of fund disbursement of the current HSS project, the joint appraisal allowed a reallocation not exceeding 25% of the total budget to fund existing HSS activities or new activities in relation with the HSS objectives.

The ideas were oriented on:

- Increasing the number of incinerators to be built in health facilities,
- Computerization of vaccination services,
- Equip some health centers with motorcycles in order to facilitate access to vaccination outreach sessions,
- Procuring a generator with enough capacity to run all the cold rooms.
- Decentralization of cold rooms by constructing 2 provincial cold room.

3.3. Transition planning *(if relevant)*

Not relevant

3.4. Financial management of all cash grants *(e.g. HSS, VIG, campaign operational cost grant, transition grant)*

The budget execution of HSS grant is low considering the period implementation (36% expenditure of total budget between January 2014 and June 2016 – the half-way point of the project). As presented in previous sections; this is due to delay in first disbursement and in country processes like administrative procedures related to signing of memorandum of agreement and opening of GAVI accounts by sub recipients and procurement process.

About VIG; during the period of the appraisal the country managed vaccine introduction grant for IPV. The use of this grant stopped following the notice from immunization partners about the postponement of introduction of IPV; the grant will be fully used for the introduction of IPV in Q4/2017.

During the joint appraisal exercise, the audit conducted by OAG had not finished for the joint appraisal to have a say on it (The audit report will be shared).

Financial performance and challenges:

Currently, Rwanda is managing the GAVI HSS project with a total budget of \$ 10,339,970 for 5 years starting from January 2014 – December 2018 and Vaccine introduction grant (IPV) of \$338,000.

HSS

The HSS project meets some challenges related to low budget execution. In the fiscal year 1 July 2015 – 30 June 2016, expenditure was \$1,227,827. As on 30 June 2016 the total expenditures were \$3,770,712 (36%) with a 2.5-year project implementation remaining period.

The main causes of low budget include:

- Administrative procedures where the management of HSS grant required a specific

account. The procedures of opening these accounts by sub recipients started when the first tranche was in country.

- Procurement process which took more time and delayed the use of funds.

IPV

For IPV vaccine introduction grant, by June 2016 the total expenditures were \$179,072 (53%). This is due to the fact that the introduction of IPV which was postponed due supply constraints for Inactivated Polio Vaccine, however the Rwanda team was not aware of this postponement at the time of making the expenses.

According to activities already implemented there are:

- Meeting with district hospitals staff to explain the introduction of IPV and its rationale,
- Training of EPI supervisors from all district hospitals on Inactivated Polio Vaccine,
- Production of child immunization cards and other vaccination tools which include IPV,
- Payment of communication fees to central level staff,
- Development of spot radio,
- Distribution of syringes to district hospitals.

PBF funds

Also, Rwanda has been so far awarded with Performance based funding (PBF) equivalent to \$984,000 in 2015 (for 2014 performance) and \$984,000 awarded in 2016 (for 2015 performance). The disbursement of these PBF is still pending awaiting Rwanda’s submission of the final budget for these funds to Gavi.

To overcome all these challenges, the joint appraisal decided the following:

- reallocation not exceeding 25% was accepted. Reallocated funds will be oriented to existing activities or new activities (as per newly identified needs) in relation with project’s objectives.
- For IPV grant, the outstanding funds will be used during introduction of IPV expected in the last quarter of 2017.

For the PBF grants, the award for 2014 and 2015 performances will be oriented on construction of the EPI warehouse whose plan was presented during the joint appraisal with a subsequent visit of the site by the joint appraisal team.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised strategic actions from previous joint appraisal	Current status
1. Procurement and instalment of 2 Cold Rooms, each of 40 M3 (at VPDP)	Done
2. 42 Biomedical Technicians trained in basic maintenance of sound cold chain integrity and other medical equipment	Done
3. 17 incinerators constructed in health centers	Done
4. 959 staff from health centers in all districts received comprehensive immunisation training	Done
5. Integrated Supportive supervisions (2 per district hospital) and 2 x Coordination meetings with DHs were organized.	Done

Recommendations from previous HLRP	Current status
1. Noted that the country expressed a desire to switch from Rotateq to Rotarix but could not do so because of a locked-in agreement with the manufacturer; this would be reviewed by Gavi once this agreement ends.	Switch planned in March 2017,

5. PRIORITISED COUNTRY NEEDS¹

Prioritized needs and strategic actions	Associated timeline for completing the actions	Does this require technical assistance?*(yes/no) If yes, indicate type of assistance needed
EPI Warehouse construction and consider provincial vaccine stores	June 2018	No
Update CCE inventory and submit application to Gavi CCEOP	May 2017	Yes
Follow up Measles SIAs	September 2017	Yes
National immunization coverage survey combined with MCV2 PIE	June 2017	Yes, but covered under 2016 Gavi TCA funds
Revision and production of routine immunization tools and SOPs for effective vaccine management at all levels inclining updating the EPI Guidelines	March 2017	Yes
Computerization of routine immunization services	June 2018	Yes
Strengthening REC strategies in all districts including provision of transport means	June 2018	Yes
Conduct RI mentorship & integrated support supervision (of MCH, EPI/VPD and other programs) to health facilities in the 30 districts	Continuous activity	No
Reinforce VPDs surveillance by working closely with Epidemic Surveillance and Response (ESR) Division	June 2018	No
Strengthening the AEFIs Surveillance	June 2017	No

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

including establishment of the national AEFIs committee		
Strengthen data - conduct DQA	December 2017	Yes
Develop strategies to increase MR2 and HPV coverage	December 2017	No
Document EPI achievements	December 2017	Yes

**Technical assistance not applicable for countries in final year of Gavi support*

6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	
Issues raised during debrief of joint appraisal findings to national coordination mechanism	
Any additional comments from:	
<ul style="list-style-type: none"> • Ministry of Health • Gavi Alliance partners • Gavi Senior Country Manager 	

7. ANNEXES

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

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

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Annex B: Changes to transition plan (if relevant)

Changes proposed	Rationale for changes	Related cost (US\$)	Source of funding for amended activities	Implementation agency	Expected result

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