Joint Appraisal report 2017

Country	Rwanda
Full Joint Appraisal or Joint Appraisal update	Full Joint Appraisal
Date and location of Joint Appraisal meeting	14-17 November 2017, Sport view Hotel, Kigali
Participants / affiliation[1]	MoH/RBC (SPIU, MCCH/VPDP, ESR), WHO CO, WHO IST, UNICEF, Gavi
Reporting period	1 July 2016 – 30 June 2017
Fiscal period[2]	1 July 2016 – 30 June 2017
Comprehensive Multi Year Plan (cMYP) duration	2017 - 2021

1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

1.1. New and Underused Vaccines Support (NVS) renewal request(s)

Type of support (routine or campaign)	Vaccine	End year of support	Year of requested support	Target (population to be vaccinated)	Indicative amount to be paid by country	Indicative amount to be paid by Gavi
Routine	Inactivated Polio Vaccine (IPV)	2018	2018	354 244	US$ 0	US$ 306,000

1.2. New and Underused Vaccines Support (NVS) extension request(s)

Type of Support	Vaccine	Starting year	Ending year
Routine	Human Papillomavirus (HPV)	2018	2018
Routine	Rotavirus (ROTA)	2018	2018
Routine	Pneumococcal Conjugated Vaccine (PCV)	2018	2018
Routine	PENTAVALENT (DTP-HepB-Hib – PENTA)	2018	2018
Routine	Measles (2nd dose)	2018	2018

1.3. Health System Strengthening (HSS) renewal request

Total amount of HSS grant	US$ 10,339,970
Duration of HSS grant (from…to…)	Nov 2013 – Dec 2018
Year / period for which the HSS renewal (next tranche) is requested	2018
Amount of HSS renewal request (next tranche)	US$ 1,968,345 (4th tranche) and US$ 1,970,785 (5th tranche)

[1] If taking too much space, the list of participants may also be provided as an annex.
[2] If the country reporting period deviates from the fiscal period, please provide a short explanation.

1.4. Cold Chain Equipment Optimisation Platform (CCEOP) renewal request – NOT APPLICABLE

Total amount of CCEOP grant	US$	
Duration of CCEOP grant (from…to…)		
Year / period for which the CCEOP renewal (next tranche) is requested		
Amount of Gavi CCEOP renewal request	US$	
Country joint investment	**Country resources**	US$
	Partner resources	US$
	Gavi HSS resources[3]	US$

1.5. Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[4]

Indicative interest to introduce new vaccines or request HSS support from Gavi	**Programme**	**Expected application year**	**Expected introduction year**
	HSS	2018	2019

[3] This amount must be included either in an earlier HSS approval or else in the current HSS renewal request in section 1.4 above.
[4] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

2. CHANGES IN COUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

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/km^2). 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 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, 503 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 1,200 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. 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 100% all traditional vaccines.

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 the Government and the 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.

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). A functional Inter-Agency Coordination Committee for Immunization (ICC) contributes to the achievements of vaccination program through advocacy, funds mobilization and provide technical support. From 2007 up to date, Rwanda has benefitted from the 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. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

3.1. Coverage and equity of immunisation

Coverage

Rwanda DHS2014-15 showed that the immunization coverage was maintained high compared to the previous DHS conducted in 2010. While Measles coverage remained 95%, Penta 1 and Penta 3 coverage

was 99% and 97% in 2010 and reached, in 2015, 99% and 98% respectively. Fully Immunized Children increased from 90% to 93%.

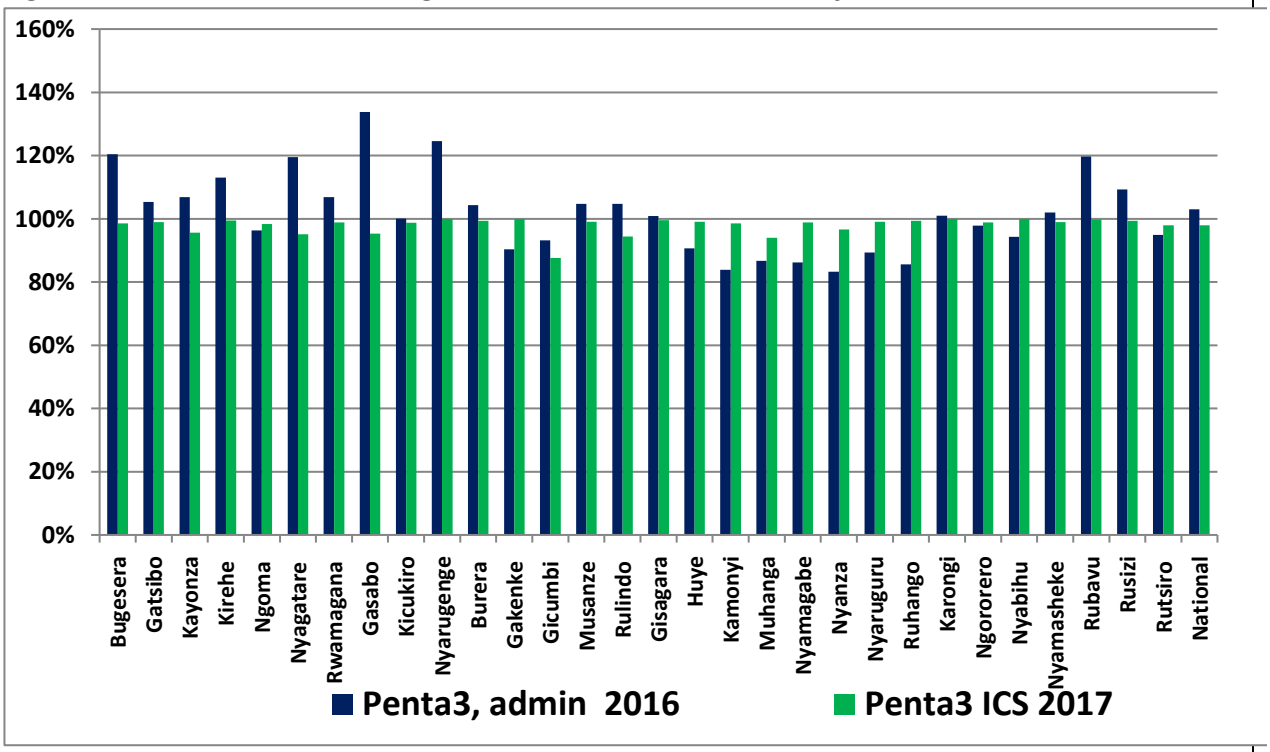
A recent Immunization Coverage Survey (ICS) indicates that 94.9% of the children aged 12-35 months are fully vaccinated with a slightly low performance in urban areas. The proportion of fully immunized children with crude coverage was the lowest in Southern province (94.1%) and Northern province (94.2%), and Gicumbi district (88.4%). The districts of Muhanga, Nyagatare and Kayoza have a performance below 90%.

Equity

The Rwanda GPF target set for vaccination coverage is <5% for the difference between the highest and lowest wealth quintile.

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 ICS (2017) shows that PENTA 3 crude coverage is slightly lower among children who are not covered with a health insurance (96.9%), among Ubudehe category 1 (96.1%), among those living in a distance of 60-90 minutes to the nearest health facility (96.3%), and among children from no schooled mothers (96.4%). This proportion was the smallest in Gicumbi district (87.6%) followed by Rulindo district (94.4%) what made Northern Province the least covered for PENTA3 (95.9%).

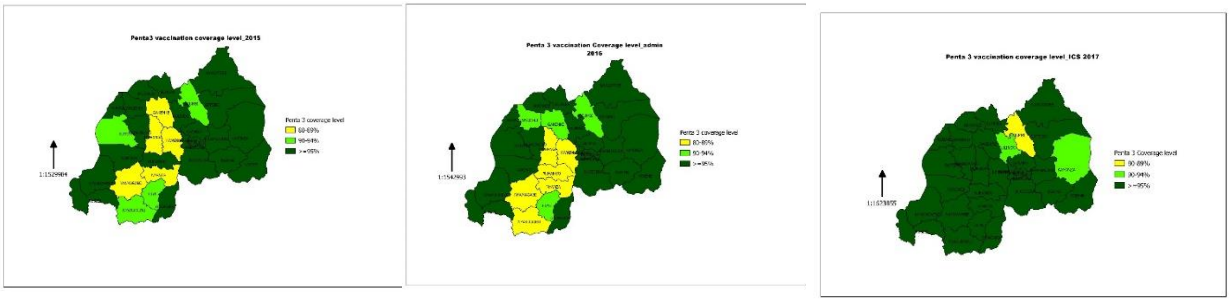
Fig.1: Penta3 Vaccination coverage, administrative data Vs Survey



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; Penta 3 coverage in male has reached 98.5% against 97.8% in female (DHS2014-15) while the ICS (2017) gives a crude coverage of 97.7% and 98.2% in males and females respectively, the rural area being more performant (98.2%) than urban area (95.7%) with national average of 97.9%.

Further analysis of equity by geography using routine immunization data shows that all districts have reached Penta 3 coverage above 80%. According to Rwanda JRF 2015, 5 district have a coverage ranging between 80-89%, 5 districts with a coverage between 90-94% and the majority of districts (20) with coverage >= 95%. A slight change of this pattern is observed in 2016 where 6 districts have a coverage ranging between 80-89% and 4 districts with coverage between 90-94% (Rwanda JRF 2016).

Penta 3 Coverage comparing JRF Data (2015 & 2016) and ICS (2017)



These maps show the lowest coverage rates with JRF data are observed mainly in southern province and this pattern disappears with ICS (2017) data and DHS (2014-15); the JA appraisal discussed and noted these changes in data patterns and suggests an underlying factor may be a denominator issue and recommended conducting regular surveys as a practical solution.

Good performance is also observed in the area of VPDs Surveillance which is routinely conducted countrywide. Since 2014, more than 85% of districts have met key performance indicators for AFP and Measles surveillance. In 2015, only 1 case of measles was confirmed by lab in 429 suspected cases. However, a sharp increase of cases was observed in 2016 and 2017. The following table shows the trend of measles and rubella suspected and confirmed cases in the last 3 years.

Table 1: Number of specimens tested and measles and rubella-positive results reported, Rwanda 2014-2017

	2014	2015	2016	2017 (Jan-June)
Specimens tested	462	429	910	420
Measles +	10	1	57	33
Rubella +	15	1	15	12

Source: Case-based surveillance database

3.2. Key drivers of low coverage/ equity

In general, equity analyses show no socioeconomic, geographic, gender or other barriers to access, utilization and delivery of vaccination services and no big issues of equity are observed. A number of factors allow the country to perform well in this area of equity:

Health Work Force: There is at least one HC in all administrative sectors with qualified nurses to offer standard vaccination services allowing availability and even distribution of vaccination services countrywide.

Supply chain: No health facilities has recorded issues of stock out of vaccines for years and the country has improved vaccine storage capacity according to the EVM improvement plan. A strengthened distribution system is in place.

Demand generation / demand for vaccination: A strong CHWs network helps community in increasing/keeping demand for vaccination and outreach sites are funded and strategically distributed in all HCs catchment areas. Sensitization messages for vaccination reach out communities through different communication channels including mass media and campaigns. Retention rate of vaccination cards is high.

Capacity building: The programme has gaps in staffing and structure. For staffing and capabilities, one staff is taking now a Masters course in Supply Chain Management what is going to be an additional capacity to the programme. There is a high staff turnover compromising the number of staff trained (EPI review 2014). A new restructuring which is taking place at peripheral level needs to be followed up by the programme to define actions to take to keep the records of good performance against the changes.

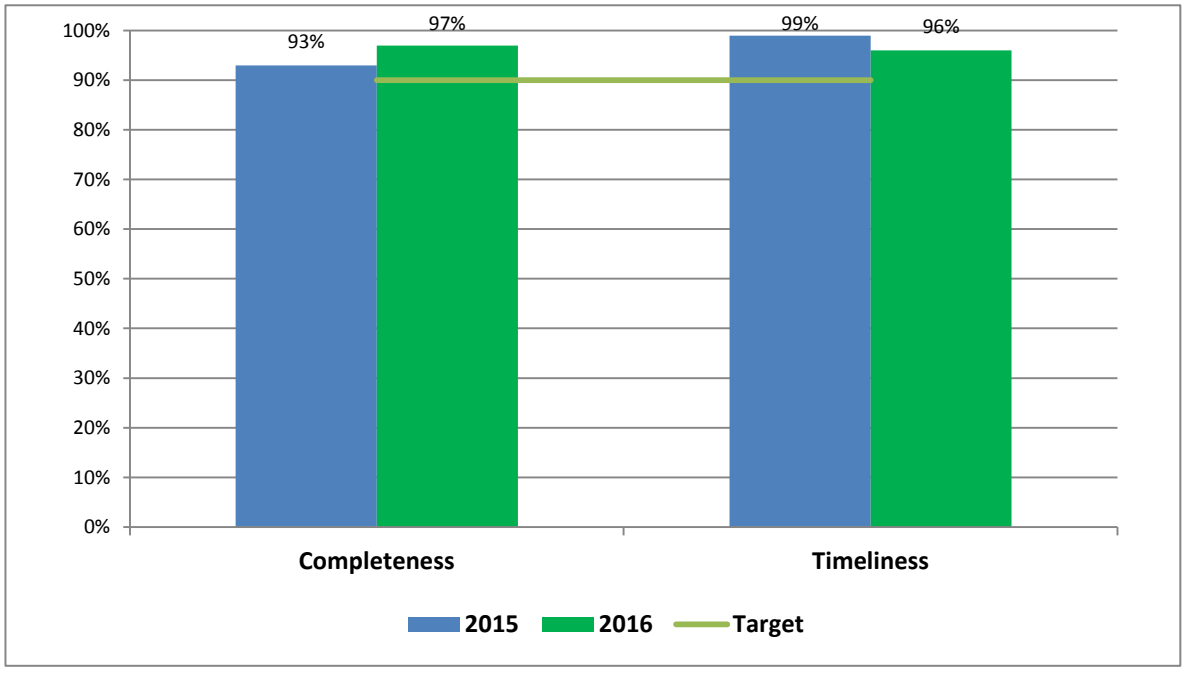
For the public financial management: Rwanda Biomedical Centre continues to timely disburse funds to district hospitals despite delays in reporting from some hospitals which also leads to delays in transfer of funds to them. The disbursement rate could be further improved with coordination meetings where all issues are identified and discussed for timely remedial solutions".

Other critical aspects: The PIE MSD (2017) gives areas for continuous improvement for the EPI in general and include exploiting well and improving the defaulter's tracking among target children for immunization and strengthening monitoring and reporting AEFIs for all vaccines.

3.3. Data

Rwanda has a robust data reporting and recording system. Regarding reports of health facilities offering routine immunization services, the JA observed a good performance in areas of timeliness and completeness of the reports. The following figure shows the performance in 2015 and 2016 against a GPF target of 90%.

Fig. 2: Reporting timeliness and completeness (2015 and 2016)

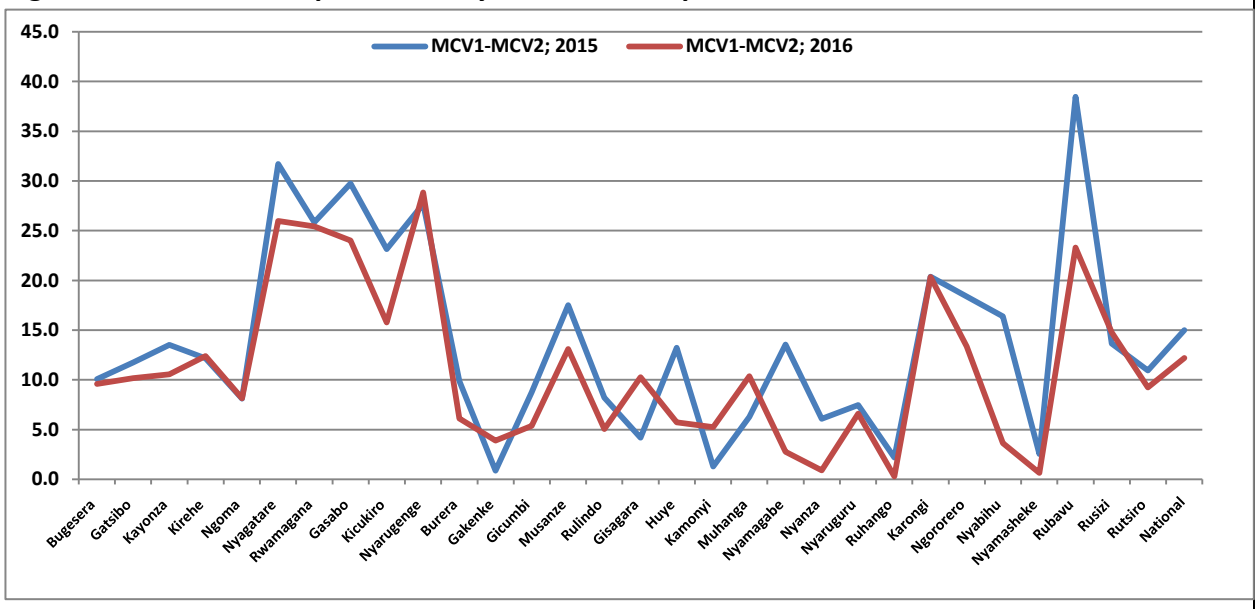


Source: HMIS

The key limitations / weaknesses related to the quality of the data and data analyses used in this Joint Appraisal are discrepancies observed in coverage rates from JRF Data and ICS Data especially in Southern province and these discrepancies are believed to stem from a denominator issue. Other limitations include negative dropout rates (penta 3-MCV1) observed in 3 districts and coverage records above 100% in 16 districts.

Main efforts / innovations / good practices focused on improving data system strengthening and addressing key issues include an effective use of defaulter tracking system, commonly known as "échéancier" to ensure each child who missed a vaccine is tracked and brought to health facility to get immunized. The following figure gives MCV1-MCV2 dropout rates by district in the period 2015-2016.

Fig. 3: MCV1-MCV2 dropout rates by district in the period 2015-2016



Drop out between MCV1 and MCV2 decreased in most of the districts from 15% (in 2015) to 12.2% (in 2016).

3.4. Role and engagement of different stakeholders in the immunisation system

Since 1996, EPI has had a functioning Interagency Coordinating Committee (ICC) which includes senior officials from the Ministry of Health, representatives from different local and international partners. The ICC for immunization is active and, above all, plays a technical and advocacy role in support of the program. ICC meetings are regularly held and their proceedings are approved through formal written minutes.

The EPI works in close collaboration with other divisions and programs of RBC/Ministry of Health, as well as with districts. The program also maintains partnerships with different ministries, seeking their engagement in social mobilization, especially for national or local vaccination campaigns. Local NGOs also partner with the programme in the area of social mobilization.

The National Polio Eradication Committee (NPEC) supports the immunization program in keeping a polio free status that Rwanda documented in 2004. The last case of polio was recorded back in 1993. The same committee is actively helping the country in implementing Polio end game strategic plan.

Regarding involvement of private sector, some private HFs especially in Kigali City, offer vaccination services. Cross-sectoral collaboration plays a pivotal role in the success of many undertakings of the vaccination programme (eg: schools playing a role in organization of HPV vaccination sessions; the MR Follow up campaign was launched alongside Governance campaign).

4. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

4.1. Programmatic performance

Rwanda is managing HSS grant which contributes to improvement and maintenance of coverage and equity in access to immunization. During the last five years, coverage of all vaccines has increased and equity in access to immunization is still one of the successes of the program.

During the reporting period (January-December 2016); Rwanda managed HSS funds and this support contributed in achieving the current immunization performance resulting from some activities implemented through HSS funds:

- 100% of health facilities (42 district hospitals and 504 health centres) received HSS funds for vaccines and vaccine devices supply.100% of District hospitals financially supported to perform supervision of health centers;
- Funding of 100% of outreach vaccination sessions organized countrywide in order to reach remote areas and to facilitate equity in vaccination;
- VPD surveillance were financed by availing at district level funds related to sample transportation (samples of suspected measles and polio);
- 100% of Health Centres organized coordination meetings with CHWs. For each semester, each health center organized meeting with CHWs to increase demand generation and to perform VPD surveillance and minimize defaulters in vaccination
- HSS funds contributed a lot in keeping vaccines in recommended condition to maintain vaccine potency and to reduce wastage.
- Maintenance of vaccine refrigerators; (cold chain spare parts procurement, mission and transport fees for biomedical technicians who performed the maintenance was funded.

Concerning the achievements against agreed targets; as specified in the grant performance framework (GPF), HSS activities were performed as following:

- 100% of health facilities had functional cold chain equipment: spare parts were available at both central level and peripheral level;
- 75% (3 out of 4 meetings) of quarterly coordination of central level and districts were organized using HSS funds. During these meetings, many topics were discussed including immunization performance by district. For districts with low immunization, the meeting identified the reasons behind low performance and put in place appropriate strategies/recommendation for improvement.
- 84 integrated supportive supervisions were conducted in health facilities (each district hospital was visited 2 times during this reporting period) to strengthen the performance and capacity of health care providers and maintain quality of data;

Regarding CSO involvement, one civil society organization (*Urunana* development Communication) which is a local CSO member of ICC playing a big role in raising awareness on the Importance of Immunization in Rwanda. Main activities implemented by *Urunana* DC during the period covered by the JA include:

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 every month.

These activities have been instrumental to increase the immunization coverage.

HSS fund reallocation:

Although HSS has made remarkable achievements, the JA observed a moderate budget execution rate and the JA processes recommended to speed-up the submission of reallocation proposal to achieve the remaining priorities.

The final reallocation proposal after validation will be annexed to this JA report and submitted by 1 December.

HSS planning from 2019 onwards:

The JA meeting was informed that Rwanda is expected to consider country engagement framework (CEF) to plan for next HSS funding. The CEF provides an opportunity for comprehensive long term planning for HSS and vaccine support. The CEF processes will start in January 2018 and is expected to be coompleted before the end of the current HSS grant.

PBF:

PBF funding for 2014 and 2015 awards will be used for construction of vaccine warehouse which will accommodate 12 cold rooms for vaccine storage at central level and vaccine devices. After the warehouse construction, the MOH/RBC will no longer have to hire a warehouse and associated savings will be allocated to other priorities. This state-of-the art standard warehouse will help also to maintain high quality storage conditions of vaccine and vaccine devices and reduce wastage.

NVS

During the last JA, it was decided that Rwanda immunization program should have some changes in vaccine presentation (PCV 1 dose to 4 doses per vial and Rotavirus vaccine (3 to 2 doses schedule). This JA observed that in April, 2017, Rwanda switched from PCV 1 dose to 4 dose per vial and Rotavirus vaccine 3 doses to 2 doses schedule.

The following are updates on priorities related to NVS highlighted during the last JA:

1. The integrated Maternal and Child Health week and MR follow-up campaign was conducted in October, 9th-13th, 2017 and the post campaign evaluation is ongoing (a training of data collectors has been conducted and remaining data collection, data analysis and report production). The MCH week and MR campaign was cofounded by GAVI and END fund and these funds focused in the different health interventions (MR vaccination, Vitamin A provision, de-worming, Family planning Methods provision and sensitisation on health issues. GAVI funds covered 22 District hospitals while END funds covered 18 district hospitals.
2. Introduction of IPV: Rwanda had to introduce IPV in 2015 but due to global shortage of IPV supply, JA meeting was informed that IPV is being introduced in March 2018 in routine immunization and a catch campaign will be conducted in 2019 and targeted children will be discussed with GAVI.
3. Meningitis A risk assessment: There is no intention to introduce Meningitis A Vaccine as Meningitis A risk assessment conducted in 2016 showed no risks for Rwanda. . The country needs to reinforce meningitis surveillance.

Cold Chain Equipment Optimisation Platform (CCEOP)

CCEOP application is one of the priorities highlighted in the last JA. Rwanda developed and submitted its application to the Gavi in September 2017. Prior to developing the application, cold chain equipment inventory was conducted countrywide to determine the quantity of refrigerators to be replaced. The JA meeting reminded the country of CCEOP joint investment stating that the final HSS reallocation should take into consideration the 20% of the total CCEOP budget and add 8.5% of the calculated amount as handling fees.

These were the objectives of CCEOP:

- Improve efficiency and safety of vaccines by increasing the CCE's operating time
- Reduce running cost and improving temperature control
- Introduction of new technologies in Cold Chain Equipment.

The impact of CCEOP is to enable remote HFs with no access to electricity grid to store vaccines appropriately and increase sustainability of immunization coverage and equity.

Concerning performance for measles and rubella and progress against the country's measles-rubella 5 year plan; the JA meeting observed that Rwanda has made significant progress towards measles and rubella elimination. High coverage with MCV1 has been maintained (99% in 2016) and MCV2 has progressively increased from 77% in 2014 to 90% in 2016. Intensive efforts were conducted in 2016, including use of radio/ media to put emphasis on increase of awareness on the immunization schedule, especially measles second dose. .

An EPI coverage survey was conducted in 2017, with the exception of 1 district, all districts had high coverage (>95%) for MCV1 and in comparison only 5 districts has ≥95% coverage for MCV2. There is need for continuous effort to increase MCV2 coverage, especially with focus in sub-national level to meet the elimination targets.

Surveillance

In Rwanda vaccine preventable diseases (VPDs) surveillance focuses on measles/ rubella, polio and maternal and neonatal tetanus. In 2015, the VPD surveillance was transferred from EPI to Epidemic Surveillance and Response Division (ESR) which is another RBC Division.

In 2016, surveillance indicators were maintained for both measles and polio surveillance systems at the national level. Key activities undertaken in 2016 to maintain performance included sensitization meeting with health facilities, formative supervision of peripheral level and training of trainers of on VPD surveillance. During the JA exercise, it was observed that at the sub-national level not all districts met the surveillance indicators, and had low sensitivity to detect cases. Emphasis should be put to strengthen surveillance, including at the community level to increase detection and reporting of cases.

Increased number of measles cases were reported in 2016 (55) and 2017 (58). Cases were mainly associated with outbreaks in both years. In 2016, 3 outbreaks were reported from 3 districts in Western Province. These districts are close to the border with DRC and have a risk of importation of measles cases. In 2017, 1 outbreak was reported from Nyanza district in Southern Province, most cases reported were <15 years of age indicating accumulation of susceptible since last SIA conducted in 2013. A nationwide MR campaign targeting children 9-59 months of age was conducted in October 2017 to close immunity gap.

4.2. Financial management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

Considering the remaining period for HSS project to its end, the JA observed a moderate budget execution (44% expenditure of total budget up to 30 June 2017). This is due to delay in first disbursement and in country process including administrative procedures related to signing of memorandum of agreement, opening of GAVI account by each sub-recipient and procurement process. It is in that framework that a reallocation not exceeding 25% of total budget was allowed by GAVI with window of including new activities in alignment with objectives of the project.

For the compliance with financial reporting and requirements; during the JA, some reporting deadlines were reminded to the audience. Financial reports were submitted. The JA considered the period of disbursement of grant related to PCV Product switch grant which due in August 2017, therefore its financial statement will be submitted at the end of December 2017.

The JA meeting recommended a presentation to ICC of status of implementation of audit recommendations from cash programme audits conducted in 2016. For the financial management systems, some changes were reported. In fact, previously all different grants from GAVI (HSS, VIG,) were managed from one bank account and it was difficult to provide bank statements by grant category as the used IFMS provides a comprehensive cashbook;. Today, in collaboration with GAVI, the country has opened a new bank account for VIG grants and the initial bank account is currently used for HSS fund only.

4.3. Sustainability and (if applicable) transition planning

Rwanda does not rank among high priority countries as the last polio case was reported back to 1993. As part of Global Polio Transition plan, Rwanda has conducted inventory of funded polio assets. Polio funds are used to support the following activities:

- Suspected polio sample transportation (Shipment to UVRI).
- Sensitization meetings to the public and private health care providers on surveillance of polio through AFP.
- Supportive supervision of vaccine preventable diseases (VPDs) including suspected polio through AFP.
- Hold meetings of NPEC on quarterly basis.

Given the inventory of Rwanda polio assets, the country will consider a funding source when polio programme funding has come to an end, and look for other sustainable funding source/international mechanism to support the highlighted activities.

4.4. Technical Assistance (TA)

For Gavi supported Targeted Country Assistance (TCA) activities and milestones, this JA has defined priorities (activities and milestones) from discussions. The activities as defined are detailed in section 6 of this report.

Amendments to the currently planned and ongoing Technical Assistance activities and milestones are envisaged (short term) in the area of data Quality improvement as this JA has observed that there are more gaps to fill in the area of data quality.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
1. EPI Warehouse construction and consider provincial vaccine stores	Progress
2. Update CCE inventory and submit application to Gavi CCEOP	Submitted (Achieved)
3. Follow up Measles SIAs	MR follow up implemented, Post campaign Evaluation ongoing.
4. National immunization coverage survey combined with MCV2 PIE	Survey conducted
5. Revision and production of routine immunization tools and SOPs for effective vaccine management at all levels inclining updating the EPI Guidelines	In progress
6. Computerization of routine immunization services	In progress
7. Strengthening REC strategies in all districts including provision of transport mean	In progress
8. Conduct RI mentorship & integrated support supervision (of MCH, EPI/VPD and other programs) to health facilities in the 30 districts	In progress
9. Reinforce VPDs surveillance by working closely with Epidemic Surveillance and Response (ESR) Division	Different joint meeting organized
10. Strengthening the AEFIs Surveillance including establishment of the national AEFIs committee	Documentation for official establishment of the committee in pipeline
11. Strengthen data - conduct DQA	
12. Develop strategies to increase MR2 and HPV coverage	In progress
13. Document EPI achievements	Work in progress
Additional significant IRC / HLRP recommendations (if applicable)	**Current status**
Not applicable	***Not applicable***

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being priorities in the new action plan (section 6 below).

4. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for the next year:

Key finding 1	**Conduct cEVMA & develop 3 years IP**

Agreed country actions	1. Training on cEVMA 2. Assessment 3. Report writing
Associated timeline	cEVMA report and 3 years IP available to implement recommendation
Technical assistance needs	Yes
Key finding 2	**CCEOP implementation activities:**
Agreed country actions	1. Develop CCEOP deployment plan 2. system design 3.Capacity building on CCE maintenance
Associated timeline	CCEOP deployment plan available and System design developed and training on Maintenance conducted
Technical assistance needs	Yes
Key finding 3	**Sustain public demand for quality immunization services to maintain high coverage and reduce drop out rate:**
Agreed country actions	1. Story lining through *Itetero* group 2. Develop messages and share for *Itetero* radio program
Associated timeline	Children radio magazine promote immunization activities
Technical assistance needs	Yes
Key finding 4	**REC strategy implementation and monitoring to improve coverage and Equity**
Agreed country actions	1. Training of vaccinators at health centers levels 2. Monitoring of implementation at Health facility level
Associated timeline	EPI staff at Health center level are skilled in new REC guideline
Technical assistance needs	Yes
Key finding 5	**SMT training**
Agreed country actions	
Associated timeline	Training organized
Technical assistance needs	Yes
Key finding 6	**Strengthening REC strategy in all districts**
Agreed country actions	1. Training of new staff at district levels on Immunization as the new structure will require capacity building 2. Sensitization meeting of CHWs supervisors on cards retention and defaulter tracing especially in the second year of life
Associated timeline	Sensitization meeting on vaccination cards retention and defaulters tracing conducted

Technical assistance needs	Yes
Key finding 7	**Support computerization of vaccination data**
Agreed country actions	1. Support the development SOPs and training tools 2. Training of data managers and EPI supervisors
Associated timeline	Data managers and EPI supervisors trained
Technical assistance needs	Yes
Key finding 8	**Monitor the implementation of immunization data quality improvement plan**
Agreed country actions	1.Conduct field visits to monitor and supervise the quality of immunization and VPDs surveillance data 2.Conduct quarterly meeting to review and harmonize vaccination and VPDs surveillance data
Associated timeline	Monitoring, supervision and quarterly review meeting conducted
Technical assistance needs	Yes
Key finding 9	**Support the introduction of IPV in routine immunization and conduct post introduction evaluation**
Agreed country actions	
Associated timeline	IPV PIE completed
Technical assistance needs	Yes
Key finding 10	**Support provinces in Polio eradication and measles elimination in the context of accountability framework**
Agreed country actions	1. Support measles risk assessment 2. Conduct quarterly field visits to monitor VPDs performances indicators 3. Initiate mentorship on vaccination services delivery at health center level
Associated timeline	-Measles risk assessment conducted -Mentors trained at national and district level
Technical assistance needs	Yes
Key finding 10	**Support the establishment and operationalization of NITAG, AEFIs and MEV committees**
Agreed country actions	1.Conduct orientation workshop for NITAG, AEFIs and MEV committees members 2.Support bi-annually meeting of NITAG, AEFIs and MEV committees
Associated timeline	NITAG, AEFIs and MEV committees fully operational
Technical assistance needs	Yes
Key finding 11	**Support the development of CEF strategy**
Agreed country actions	1. Provide technical support to MOH to conduct situation analysis, technical development of PSR, operational budget/work plan and performance framework 2. Support in country review and planning workshop

Associated timeline	Documents finalized and submitted for review
Technical assistance needs	Yes

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

The JA is "an annual in-country, multi-stakeholder review of the implementation progress and performance of Gavi's vaccine and cash grant support to the country, and of its contribution to improved immunisation outcome". The 2017 Rwanda Joint Appraisal was reviewed in a meeting held from 14-17 November 2017, Sport view Hotel, Kigali. The meeting was conducted in form of active discussions based on different documentations engaging participants from different stakeholders including MoH/RBC (SPIU, MCCH/VPDP, ESR), WHO CO, WHO IST, UNICEF and Gavi.

The implementation progress and performance of Gavi's vaccine and cash grant support to Rwanda, and its contribution to improved immunisation outcome were discussed and the summary of findings from the JA meeting was presented by EPI and Gavi secretariat to the ICC meeting which convened on 17 November 2017 with aim of considering the Rwanda JA report for the year 2017.

The ICC meeting which was chaired by Hon. Minister of State in charge of Public Health and Primary Health Care took note of the report, discussed key issues raised by the participants from the presentations made on the report before it was endorsed by ICC. The key discussion points were about achievements from the last year's JA and next year priorities which were defined from recommendations from JA discussions and ICC meeting deliberations. Among ICC meeting decision was to add CEF among the needs for Technical Assistance.

The turnout of the ICC meeting was high and, therefore, its quorum was met.

6. ANNEX

Compliance with Gavi reporting requirements

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal.

It is important to note that delayed reporting may impact the decision by Gavi to renew its support.

	Yes	No	Not applicable
Grant Performance Framework (GPF) reporting against all due indicators	yes		
Financial Reports			
Periodic financial reports	yes		
Annual financial statement	yes		
Annual financial audit report	yes		
End of year stock level report	yes		
Campaign reports	yes		
Immunisation financing and expenditure information	yes		
Data quality and survey reporting	yes		

Annual desk review		No	
Data quality improvement plan (DQIP)	yes		
If yes to DQIP, reporting on progress against it	yes		
In-depth data assessment (conducted in the last five years)		No	
Nationally representative coverage survey (conducted in the last five years)	yes		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	yes		
Post Introduction Evaluation (PIE)	yes		
Measles-rubella 5 year plan		No	
Operational plan for the immunisation program	yes		
HSS end of grant evaluation report		No	
HPV specific reports			NA
Transition Plan		No	

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.
