Joint Appraisal report 2019

Country	Rwanda
Full JA or JA update[1]	☑ **full JA** ☐ JA update
Date and location of Joint Appraisal meeting	16 – 20 September 2019; Ubumwe Hotel, Kigali
Participants / affiliation[2]	MoH/RBC (SPIU, MCCH/VPDP, ESR), WHO CO, WHO IST, UNICEF(CO and Supply division), Gavi Secretariat, CHAI, USAID and Girl Effect
Reporting period	1 July 2018 – 30 June 2019
Fiscal period[3]	1 July 2018 – 30 June 2019
Comprehensive Multi Year Plan (cMYP) duration	2017 - 2021
Gavi transition / co-financing group	Low income group

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes ☐ ✓	No ☐	
Does the vaccine renewal request include a switch request?	Yes ☐	No ☐✓	N/A ☐
HSS renewal request	Yes ☐ ✓	No ☐	N/A ☐
CCEOP renewal request	Yes ☐✓	No ☐	N/A ☐

2. GAVI GRANT PORTFOLIO

Existing vaccine support *(to be pre-filled by Gavi Secretariat)*

Introduced / Campaign	Date	2017 Coverage (WUENIC) by dose	2018 Target %	2018 Target Children	Approx. Value $	Comment
Insert						
Insert						

Existing financial support *(to be pre-filled by Gavi Secretariat)*

Grant	Channel	Period	First disb-ursement	Cumulative financing status @ June 2018 Comm.	Appr.	Disb.	Util.	Compliance Fin.	Audit
Insert									
Insert									
Comments									

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	Programme	Expected application year	Expected introduction year
	Hep birth dose	2021	2020 - 2021

[1] Information on the differentiation between full JA and JA update can be found in the Guidelines on reporting and renewal of Gavi support, https://www.gavi.org/support/process/apply/report-renew/
[2] If taking too much space, the list of participants may also be provided as an annex.
[3] If the country reporting period deviates from the fiscal period, please provide a short explanation.
[4] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.
Countries are encouraged to highlight in subsequent sections, and particular in the Action Plan in Section 7, key activities and potentially required technical assistance for the preparation of investment cases, applications and vaccine introductions, as applicable.

Gavi			

Grant Performance Framework – latest reporting, for period 2018 *(to be pre-filled by Gavi Secretariat)*

Intermediate results indicator	Target	Actual
Insert		
Insert		
Comments		

PEF Targeted Country Assistance: Core and Expanded Partners at [insert date] *(to be pre-filled by Gavi Secretariat)*

Year	Funding (US$m)			Staff in-post	Milestones met	Comments
	Appr.	Disb.	Util.			
Insert						
Insert						
Insert						
Insert						

3. RECENT CHANGES IN COUNTRY CONTEXT AND POTENTIAL RISKS FOR NEXT YEAR

The following are key changes from the last JA

- From 2018, in Rwanda, there are 3 to 4 CHWs at village level forming a network of 58,443 CHWs in 14,837 villages countrywide a move from around 45,511 CHWs.
- Introduction of IPV in routine vaccination.
- A number of measles outbreaks to which vaccinations has been effective response and has been an opportunity to close immunity gaps in the affected areas.
- The risk of imported VPD cases from neighbouring countries posing challenges of active measles outbreaks and EVD.
- The country has operationalized various EPI committees (NITAG, AEFI, MEV) and the committees support the programme in areas of vaccines safety, introduction Etc.).
- Construction of vaccine warehouse which will accommodate 12 cold rooms for vaccine storage at central level and vaccine devices. The MOH/RBC will no longer have to hire a warehouse and associated savings will be allocated to other priorities.
- Increased workload associated with the new roles and responsibilities for EPI Supervisors (new structure of health sector employees).
- Polio funds are used to support the following activities including polio sample transportation (Shipment to UVRI) and hold meetings of NPEC on quarterly basis. 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.

Potential future issues (risks)

1. The risk of EVD and ongoing preventive activities is taking significant time of immunization staff.
2. The risk of importation of VPD cases from neighbouring countries posing challenges of measles outbreaks and risk of EVD remains high.
3. Sustenance of management of EPI Committees and coordinated and synergetic performances

4. PERFORMANCE OF THE IMMUNISATION PROGRAMME

4.1. Coverage and equity of immunisation

Coverage: DTP3, MCV1, etc.	Year 2016 6 of 30 districts have DTP3 coverage between 80-89% and all these 6 districts are in Southern P • Nyanza: DTP3 coverage ~83% • Kamonyi: DTP3 coverage ~84% • Ruhango: DTP3 coverage ~86% • Nyamagabe: DTP3 coverage ~86% • Muhanga: DTP3 coverage ~87% • Nyaruguru: : DTP3 coverage ~89% 7 of 30 districts have MCV1 coverage between 80-89% all these 7 districts are in Southern Prov • Nyanza: MCV1 coverage ~81% • Nyamagabe: MCV1 coverage ~82% • Kamonyi: MCV1 coverage ~83% • Huye: MCV1 coverage ~88% • Muhanga: MCV1 coverage ~88% • Nyaruguru: MCV1 coverage ~88% • Ruhango: MCV1 coverage ~88% Surce: JRF 2016 Year 2017 6 of 30 districts have DTP3 coverage between 80-89% and all 5 districts are in Southern Provinc • Kamonyi: DTP3 coverage 83% • Nyamagabe: DTP3 coverage 85% • Huye: DTP3 coverage 86% • Muhanga: DTP3 coverage 87% • Ruhango: DTP coverage 85% • Gakenke: DTP3 coverage 88% 6 of 30 districts have MCV1 coverage between 80-89% among for these 5 districts are in Southe • Nyamagabe: MCV1 coverage 83% • Kamonyi: MCV1 coverage 84% • Ruhango: MCV1 coverage 84% • Muhanga: MCV1 coverage 86% • Huye: MCV1 coverage 87% • Nyabihu MCV1 Coverage 89% Other districts with coverage between 80-89% are Gakenke (DTP3_88%), in Northern Province Source: JRF 2017 Year 2018 2 of 30 districts have DTP3 coverage <80% • Nyamagabe: DTP3 coverage 75% • Huye: DTP3 coverage 77% 11 of 30 between 80-89% with a Southern Province prominence. • Nyanza: DTP3 coverage ~81% • Kamonyi: DTP3 coverage ~82% • Ruhango: DTP3 coverage ~81% • Muhanga: DTP3 coverage ~80% • Nyaruguru: : DTP3 coverage ~81% • Gisagara: DTP3 coverage 89% • Nyabihu: DTP3 coverage 86% • Ngororero: DTP3 coverage 89% • Gakenke: DTP3 coverage 82% • Gicumbi: DTP3 coverage 85% • Ngoma: DTP3 coverage 83% 1 of 30 districts have MCV1 coverage <80% Nyamagabe : MCV1 Coverage 76% 10 of 30 districts have MCV1 coverage between 80-89% all these 7 districts are in Southern Provinc

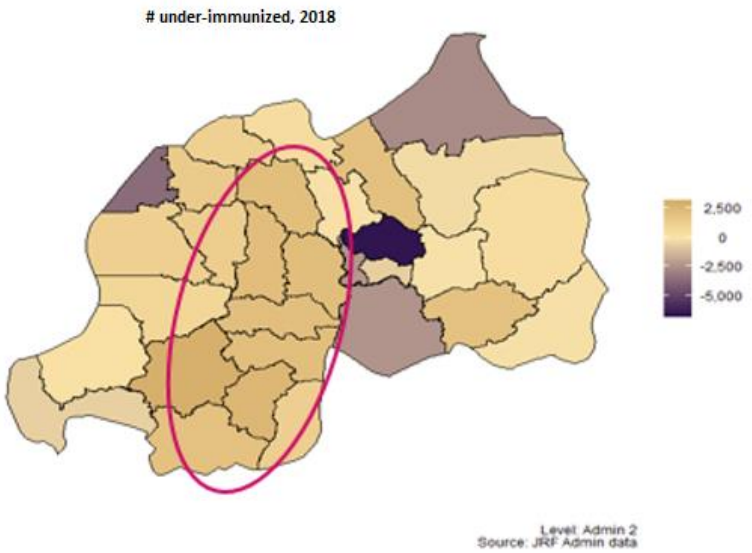
- Nyanza: ~85%
- Kamonyi: MCV1 coverage ~84%
- Ruhango: MCV1 coverage ~87%
- Muhanga: MCV1 coverage ~81%
- Nyaruguru: MCV1 coverage ~81%
- Nyabihu: MCV1 coverage 87%
- Ngororero: MCV1 coverage 89%
- Gakenke: MCV1 coverage 82%
- Gicumbi: MCV1 coverage 86%
- Ngoma: MCV1 coverage 86%

Source: JRF 2018

Coverage:

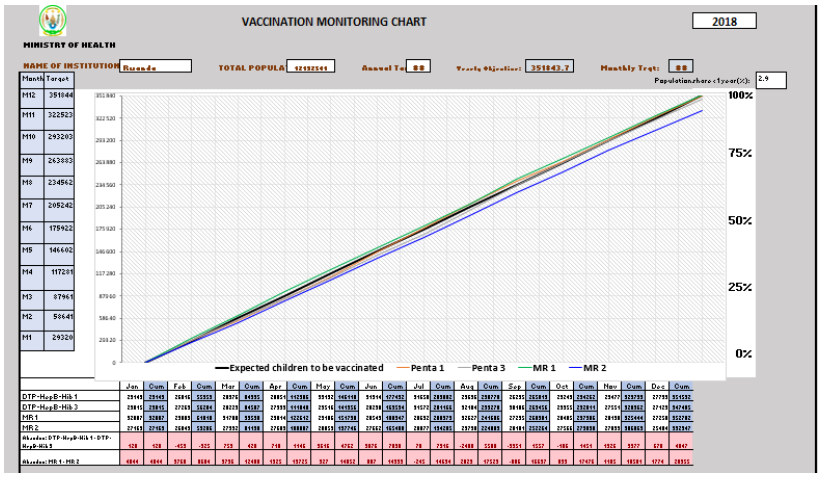
Absolute numbers of un- or under-immunised children

Numbers of under-immunized children by district



- Relatively high numbers of under-immunized children can be found in the districts that reported low DTP3 coverage and low number of vaccinated kids.
- These districts also have relatively lower concentration of target population (surviving infants).

Fig. XXX Trends of vaccination of DPT and MCV by the monitoring chart, 2018



Coverage:

DTP3, MCV2, etc.

Antigen	Immunisation Coverage (%) & Source of Data		
	RDHS	Immunization	Administrative

	2014- 2015	Coverage Survey 2017	2018
DPT3	98	98	97
MCV1	95	98	99
MCV2	NA	89	96

Equity:

- Wealth (e.g. high/low quintiles)
- Education (e.g. un/educated)
- Gender
- Urban-rural
- Cultural, other systematically marginalised groups or communities e.g. from ethnic religious minorities, children of female caretakers with low socioeconomic status, etc.

Rwanda being a very highly performing country in immunisation coverage, 'all, basic vaccinations' were taken for comparison of the various population groups- as tabulated below

Background Characteristic	Coverage: All Basic Vaccinations (Fully Immunised children)		
	DHS 2010	DHS 2014-15	ICS 2017
Residence			
Urban	93.3	93.4	94.9
Rural	89.7	92.5	94.1
Geographical Province			
City of Kigali	96.3	96.1	95.6
South	92.8	94.5	94.1
West	80.9	89.8	97.0
North	93.6	94.8	94.2
East	92.8	91.0	93.9
Mother's Education			
No education	87.0	85.9	91.8
Primary	90.1	93.0	95.7
Secondary and higher	96.8	97.9	95.9
Wealth Quintile			
Lowest	86.6	86.7	91.6
second	87.2	93.4	95.2
Middle	91.7	93.0	
Fourth	92.1	97.0	95.7
Highest	95.5	95.2	
National Average (Rwanda)	90.1	92.6	94.6

Although there is stagnation in urban immunisation coverage including the City of Kigali, there is generally modest improvement in immunization coverage except slight decline in the households in Eastern province, with mothers who had no formal education and those in the lowest wealth quintile.

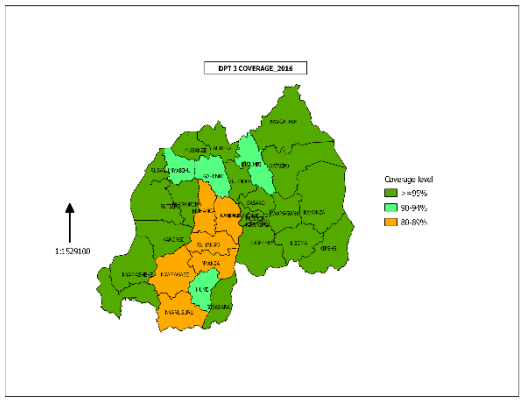
While the gaps between urban and rural residences have remained minimal and even narrowed further in the DHS 2014-15, the gap between households with mothers who had no education and those with secondary education and above increased from 10% in 2010 to 12% in 2017. A similar trend is observed between the wealth quintile with the highest coverage and that with the lowest coverage. Immunisation Coverage Survey (2017) found similar variation by education and wealth status.

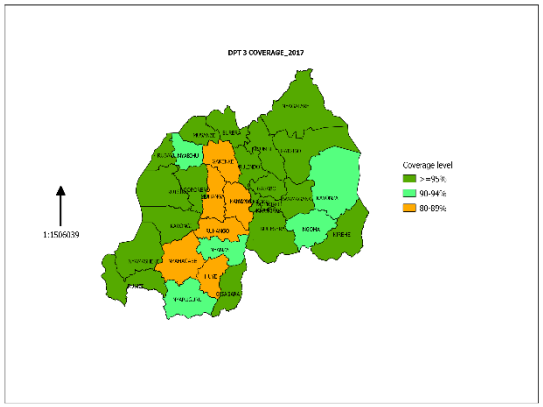
Populations to target for improvement of coverage are those in districts with low coverage.

Close examination of Immunization Coverage Trends

Heat maps showing variation of DPT3 and MCV1 Coverage between 2016 and 2018

Figure 1: DPT 3 from 2016 to 2018





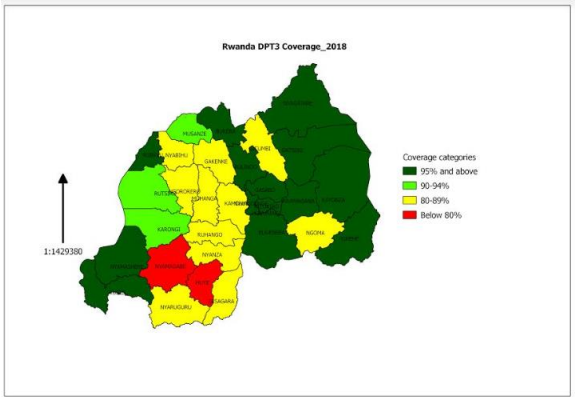
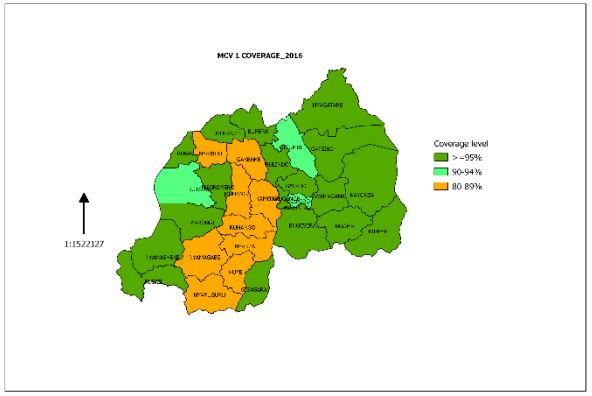
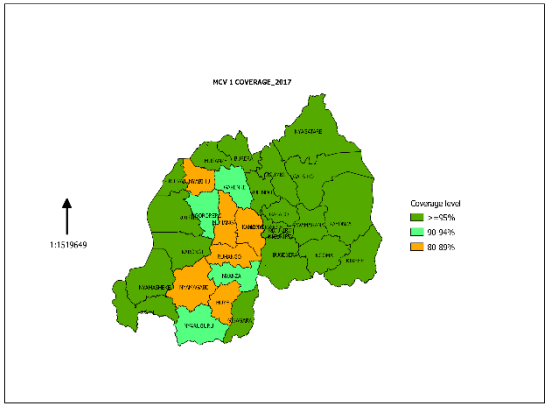
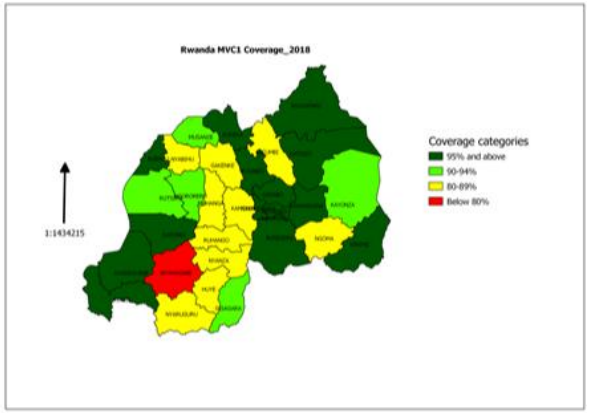


Figure 2: MCV 1 from 2016 to 2018 (Administrative Data)



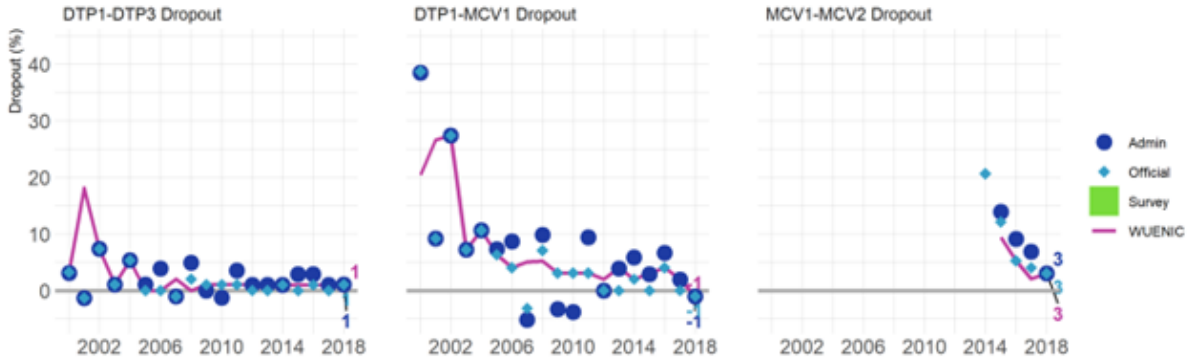




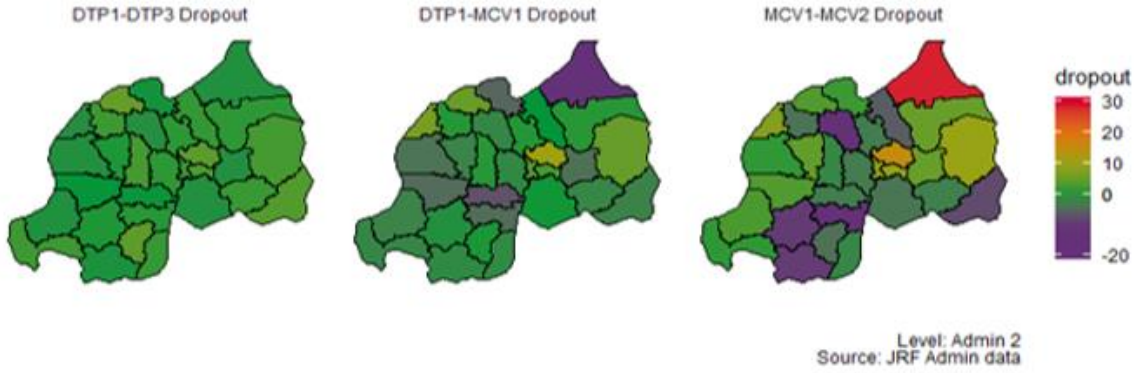
The coverage trend of Penta3 (JA Report 2017) shows persistent pockets of moderate coverage in the Northern and Western provinces. The lowest coverage rates with JRF data are observed mainly in southern province contrasting with the provinces's good performance in surveys suggesting that an underlying factor may be a denominator issue and recommended conducting regular surveys as a practical solution. Since 2012, all districts had maintained a DTP3 coverage of 80% and above. In 2018, the first time in 7 years, 2 districts fell below the 80% threshold resulting in 93% of districts having a coverage above the threshold.

Dropout rates

Fig. … Dropout Rates by Source and Vaccine



Fig….. Pockets of relatively high drop-out rates at sub national level, 2018



- *Good national drop-out rates trends for DTP and MCV.*
- *However, negative drop-out rates for DTP1 and MCV1*

Key Observation in 2018 Programme performance:

- Coverage data aligned across different data sources.
- Slight dip in coverage in 2018 except MCV1.
- About 350,000 children each vaccinated with these 3 vaccines in 2018.
- Nyamagabe and Huye districts have the largest number of under-immunised kids.
- 11 out of 30 districts have coverage above 100%.
- Difficulties to determine real coverage for planning and projections with >100% coverage reported in so many districts.
- Good national drop-out rates trends for DTP and MCV.
- However, negative drop-out rates for DTP1 and MCV1.

4.2. Key drivers of sustainable coverage and equity

- **Health Work Force**

Though there is general understaffing at all levels of the health system, there is at least one Health Centre in all administrative sectors with qualified nurses to offer standard vaccination services allowing availability and even distribution of vaccination services countrywide. Related to capacity building; two nurses at each health center have been trained on Reaching every child strategy in order to improve and maintain the high coverage.

- **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. Development of a 5 years EVM 2018 cIP. Basing on the five supply chain strategy fundamentals, there has been a move from fridge tag 1 to fridge 2 to increase the quality of vaccine management, a training on biomedical preventive maintenance, training on SMT and development of operational deployment plan (CCEOP) and reinforcement of cold chain capacity. For a more quality assurance and safety of vaccine, there has been of change in distribution model currently supplying by push system, 76% of hospitals.

- **Service delivery and demand generation**[5]

Fore service quality improvement, a data quality review was conducted in southern province what led to improved coverages is some districts where the review was conducted. The immunization e tracker system is currently in use and this system is expected to be linked to the CHWs' phones for better tracking the defaulters. A strong CHWs network helps community in increasing/keeping demand for vaccination making immunisation services available for all communities. Immunisation schedules are respected and outreach sites are funded and strategically distributed in all HCs catchment areas. Districts and ECD have been formally mobilized for retention of vaccination cards among children is enrolling in schools and ECDs. From the last JA, the country increased the capacity to ensure effective and timely responses to AEFI, vaccine related events and vaccine hesitancy as AEFI reports requiring causality assessment by the National AEFI Committee were conduct to keep the population confidence in vaccines and prevent potential drop in vaccine uptake. Itetero children radio programme is airing immunization demand generation messages.Through a partnership with Girl Effect, we have leveraged the Ni Nyampinga youth media brand to create content which greatly contributed in shifting negative attitudes, perception and behaviours that prevent girls from accessing the HPV vaccine.

- **Gender-related barriers faced by caregivers**[6]

There is practically no variation by sex the 2017 ICS suggest a coverage of 93% for male children against 92 % for female children. However, complete vaccination coverage increases steadily with mother's level of education, from 86 percent among children whose mothers have no education to 98 percent among children whose mothers have a secondary education or higher. The proportion of children fully vaccinated generally increases with increasing wealth but falls slightly at the highest quintile. Overall, over the last 10 years, the vaccination coverage among children age 12-23 months has continued to improve steadily.

- **Data / Information system**

Data inconsistencies are attributable to the use of different indices (NISR supplied) by the national and district levels to calculate the number of under one year olds in the districts and inadequate monitoring and supervision.

- Inconsistencies in the coverage rates reported at the national level and those computed from the HMIS system at the district level;
- High population projections and indices resulting in low performance coverage, for instance in Southern Province;

[5] Programmatic guidance on demand generation https://www.gavi.org/library/gavi-documents/guidelines-and-forms/programming-guidance---demand-generation/

[6] For additional programmatic guidance refer to http://www.gavi.org/support/process/apply/additional-guidance/#gender. Gender-related barriers are obstacles (for access and use of health services) that are related to social and cultural norms about men's and women's roles. Women often have limited access to health services and are unable to take their children to get vaccinated. Barriers include lack of education, lack of decision-making power, low socio-economic status, women unable to move freely outside their homes, inaccessibility of health facilities, negative interaction with health workers, lack of father's involvement in healthcare etc.

- Data inaccuracy in source documents (variances between registers, tally sheets and monthly reports) as a result of summation and transcription errors;
- Data inaccuracies between HMIS and monthly reports as a result of transcription errors; and
- Errors noted under the vaccines management section in the quarterly vaccines stock/reports compared to service delivery data.

- ***Leadership, management and coordination***

As per the ICC terms of reference, meetings are held on a quarterly basis. In 2018, the ICC meetings were held three times.

NITAG, AEFIs and MEV committees were established in 2017 and the JA 2017 set a priority of operationalizing them. The Rwanda Programme Capacity Assessment (PCA, November 2018) observed that the NITAG had a low participation of core members. In 2018, more additional core members were added to widen the composition of NITAG. The committee's orientation meetings were held in 2018 with support of WHO/IST.

The programme organised a Mid-Level Managers training for EPI Supervisors and Data Managers and PBF Supervisors in all district.

- ***Other critical aspects****:*

4.3. Immunisation financing[7]

Availability of national health financing framework and medium-term and annual immunization operational plans and budgets

Immunization financing is well defined through different documentations. In fact, the national health financing framework and medium-term and annual immunization operation plans and budget are available and all these documents define the way in which immunization program gets funds. There is transfer from the central government to RBC and local governments and peripheral health facilities on the basis of needs and performance.

Allocation of sufficient resources in national health budgets for the immunization programme/services

Immunization program is one of the health programs that need more funding to cover all the targeted beneficiary population (in this regard for vaccines, vaccine devices, vaccination materials, running cost and payment of salaries of staff who run the program). During the three last years, the GoR has been meeting its obligations related to co-financing of all new vaccines; this is in addition to purchasing 100% of traditional vaccines, supporting the EPI program by availing funds for essential materials to be used by health facilities for integrated service delivery as well as paying salaries of the larger proportion of staff at central level and all (100%) of the staff working at sub-national / health facility level. In addition, Government is solely responsible for health infrastructure development including provision of electricity power and maintenance of buildings and plants of health facilities. Beyond the government financing considerable funds are provided by different partners including the Global Alliance for Vaccine and Immunization (GAVI), which contributes significantly in different aspects. GAVI also co-finances new vaccines and provides cash through the Health System Strengthening grant, vaccine introduction and campaign grants, performance based financing and switch grants. All these different grants contribute to achieving the current outcomes of the VPD / EPI program. One of the strategies of Health Sector Strategic Plan 4 (HSSP4) pertaining to EPI is to Increase the domestic budget allocated to the immunization program. In the same HSSP4, the driver for the high program cost is the cost of Immunization (vaccine preventable diseases) program. This accounts for about 50% of the costs of the national programs.

Timely disbursement and execution of resources:

For timely disbursement and execution of resources; the GoR is doing all necessary to avail fund for vaccines, salary of staff paid by GoR, and committed fund for non-vaccine costs.Additionally, in the

[7] Additional information and guidance on immunisation financing is available on the Gavi website https://www.gavi.org/support/process/apply/additional-guidance/#financing

country, there were delays in disbursement of funds to districts due to delays in accountabilities (for previously disbursed funds back in 2014/2015- but today these issues are being tackled and solved)

Adequate reporting

The immunization financial reporting is done according the predefined periods. Reports are prepared by each level and submitted to the corresponding high level. Sometimes some health facilities delay in providing financing information thereby negatively affecting timely reporting, including financial accountability. However, the central level is trying to encourage health facilities to report on time and high leaders of Ministry of health and RBC are involved where issues are persistent. This will be much improved in the next strategic period (five years) through the planned quality improvements of data management and supportive supervision of the sub-national level by the central VPD management.

5. PERFORMANCE OF GAVI SUPPORT

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

Objective 1	
Objective of the HSS grant (as per the HSS proposal or PSR)	**Strengthening the logistics and supply chain management capacity of the national health system including EPI/VPD commodities, at all levels of the health system**
Priority geographies / population groups or constraints to C&E addressed by the objective	- The acquisition of five cold rooms in order to increase the storage capacity at central level, - Improving the vaccine supply chain from central level to district stores using refrigerated vehicles and financing the vaccine supply from district to health centres - Building the capacity of bio technicians at district level maintenance of cold chain equipment and supply of cold chain spare parts to ensure continuous integrity of refrigerators at all levels
% activities conducted / budget utilisation	- 100% of planned cold rooms were procured - 100% of health facilities timely received required vaccines and there was no any stock out reported - 100% of district staff were trained in vaccine management - 100% of district bio technicians were trained on maintenance of cold chain equipment
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	- Procurement of five Cold Rooms to upgrade the cold chain vaccine storage capacity at central level - Procurement of two refrigerated vehicles - Train middle level health managers (MLM) in efficient management of vaccines and other medical supplies - Train 84 Biomedical Technicians in basic maintenance of sound cold chain integrity and other medical equipment in the 42 district Hospitals - Provide cold chain maintenance spare parts to all the 500 health facilities
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[Error! Bookmark not defined.]	- System design for vaccines supply - Implementation of CCEOP Operational Development Plan - Establish eLMIS system in management of vaccines at HC level
Objective 2:	
Objective of the HSS grant (as per the HSS proposal or PSR)	**Strengthening generation and utilization of strategic information for responsive management of health services at all levels of the health system**
Priority geographies / population groups or constraints to C&E addressed by the objective	In order to strengthening generation and utilization of strategic information for responsive management of health services at all levels of the health system, during the course of this reporting period, we conducted different activities to achieve this objective and these include; - Quarterly evaluation meetings with district staff (Hospital

	Director General, EPI supervisors, M&E …) - Conduct integrated support supervision to health facilities in the 30 districts - Initiation of electronic individual records (with unique identifier) in vaccination program to improve the quality of vaccination data.
% activities conducted / budget utilisation	- 100% of district staff participated in coordination meetings organized by the central level - 100% of district were visited for the purpose of integrated supportive supervision and data quality audit (ISS-DQA) - 100% of health centers were equipped with computers to be used for vaccination electronic individual records and …% of health facilities were trained immunization e-tracker software.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	- Organize quarterly evaluation meetings between central level and the 30 districts - Conduct integrated support supervision to health facilities in the 30 districts - Procurement of Desktops vaccination electronic individual records - Training of health providers in use immunization e-tracker software
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[Error! Bookmark not defined.]	- Use of immunization e-tracker software
Objective 3:	
Objective of the HSS grant (as per the HSS proposal or PSR)	**Improving community access to uptake of priority health services, including EPI/VPD services, at district level so as to improve health outcomes in the populace**
Priority geographies / population groups or constraints to C&E addressed by the objective	- Sensitization of the population to increase the uptake of vaccination services through short messages and radio spots on immunization, - Build the capacity of community health workers in social mobilization for a better follow-up maternal and child health - Straighten the vaccination outreach sessions for reaching hard to reach population.
% activities conducted / budget utilisation	- 100% of planned outreach sessions were financially supported though HHS funding in social mobilization for a better follow-up maternal and child health - 100% of community health workers were trained on social mobilization
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	- Support Civil Society Organizations working at community level in training health facility personnel in delivery of quality priority health services and carrying out community sensitizations - Procurement of motorbikes in order to facilitate health centers to reach remote areas (vaccination outreach session) and facilitate vaccine supply from district stores Training of CHWs in social mobilization and how to better follow-up maternal and child health - Organize Coordination meetings with community health workers
Major activities planned for upcoming period (mention significant changes / budget reallocations and	

associated **changes in technical assistance**[8]	
Objective of the HSS grant (as per the HSS proposal or PSR)	**Reinforcing the capacity of epidemic and infectious disease surveillance (EIDS) at all levels, and extend its scope to new diseases**
Priority geographies / population groups or constraints to C&E addressed by the objective	- Build the capacity of epidemic and infection diseases surveillance teams at decentralized level and regular follow up on reported events - Financial support for transportation of samples of VPDs surveillance from health facilities to National Reference laboratory for testing analysis.
% activities conducted / budget utilisation	- 100% of district surveillance focal points were trained in VPDs surveillance; - 100% of health facilities were financially supported for sample transportation.
Major activities implemented & **Review of implementation progress** including key successes & outcomes / activities not implemented or delayed / financial absorption	- Train 500 staff in epidemic and infectious diseases surveillance, data collection tools and guidelines - support operational cost of routine surveillance (Sample transportation, field visit…) - Organize quarterly field visits/follow ups to verify findings or reported events
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**	
Objective of the HSS grant (as per the HSS proposal or PSR)	**Enhancing the capacity of health system management at district level for effective and efficient delivery of priority health services, including EPI/VPD services**
Priority geographies / population groups or constraints to C&E addressed by the objective	- Building the capacity of district staff in efficient management of vaccines and other medical supplies - Increase the number of health centers with efficient waste management system.
% activities conducted / budget utilisation	- 100% of district middle level health managers (MLM) in efficient management of vaccines and other medical supplies - 95.5% of planned incinerators were constructed in 21 selected health centers.
Major activities implemented & **Review of implementation progress** including key successes & outcomes / activities not implemented or delayed / financial absorption	- Train middle level health managers management skills (planning, coordination and supervision) - Build 21 incinerators in identified health centers which currently have no or obsolete incinerators
Major activities planned for upcoming period (mention significant changes /	

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

budget reallocations and associated **changes in technical assistance**	

Achievements against agreed targets

Rwanda has managed HSS 2 grant effectively, which has largely contributed to improvement and sustenance of immunisation coverage in addition to increasing equity of access to and uptake of immunization. During the last five years, coverage of all vaccines increased considerably, At the beginning of HSS 2, the coverage for fully immunized children was 90% (DHS 2010) and has increased to 93% (DHS2014/15) and 95% (ICS 2017) and improvements in equity of access to immunization where more than 90% of districts have reached Penta 3 coverage >80% over years. Those are some of the key registered successes of the program. Pull system across all districts in combination with active distribution in selected districts were used for vaccines collection from central level to district level and from districts to health centers. This was possible due to the availability of HSS2 funds that resulted to no stock out of vaccines or vaccine devices reported at all levels. Cold chain equipment was regularly maintained even though this area needs to be reinforced.

Other key achievements include funding outreach vaccination sessions countrywide in order to reach hard-to-reach / remote areas and to facilitate equity in vaccination. In this regard, the programme has purchased motorcycles to equip some health centres with effective means of transport for outreach activities- though more than 50% of health centers still do not have motorcycles. Unfortunately there will be few children living in hard-to-reach areas, we will use opportunity from HSS3, to strengthen outreach vaccination sessions by integrating them to community maternal and child health interventions such as vitamin A, administration of de-worming tablets, growth monitoring and post natal consultations.

With a disbursement rate of 100%, the HSS2 budget implementation progress records a budget execution of 97% by end of June 2019.

Usage and results achieved with performance based funding (PBF)

PBF funding for 2014 and 2015 awards has been used for construction of vaccine warehouse, which will accommodate cold rooms for vaccine storage at central level and vaccine devices. After the warehouse construction, the MOH/RBC will no longer have to hire warehouses for the immunisation program- hence the associated savings will be allocated to other MOH priorities. This state-of-the art standard warehouse will help in maintaining high quality storage conditions of vaccine and vaccine devices, thereby sustaining high potency and reducing vaccine and other EPI commodity wastage.

5.2. Performance of vaccine support

- ***NVS introductions and switches***

The IPV has been successfully introduced into the routine immunization program in Rwanda, despite few challenges. The associated PIE conducted in 2018 found that its introduction did not impose any change on Cold chain management, vaccine management, and transport and logistics capacities, already adequate countrywide. The IPV vaccine wastage has been below the acceptable level in all 20 HCs. The staff in HFs were already aware of the Multi-dose vial policy (MDVP); all 20 staff in-charge of vaccination knew that IPV should be given at 14 weeks. As part of the evaluation, 271 mothers/caregivers were interviewed immediately after vaccinating their children (at the age of 14 weeks), to seek anecdotal evidence of vaccine acceptability. It was found that mothers/caregivers were very much in favor of the IPV being introduced, when compared with the previous new vaccine- Measles Second Dose (MSD) introduction.

Campaigns/SIA:

Measles vaccination campaign in Rwamagana

A measles vaccination campaign carried out in Rwamagana prisons, 26 - 28 December 2018 which ended reaching an overall target of 97.2%. The prison totaled 437 confirmed and suspected cases and 11,546 cases were vaccinated including 510 personnel involved in the campaign, RCS staff, prisons' guards and prison clinic staff and Police training center in Rwamagana District.

Measles vaccination campaign carried out in Mageragere and Muhanga Prisons

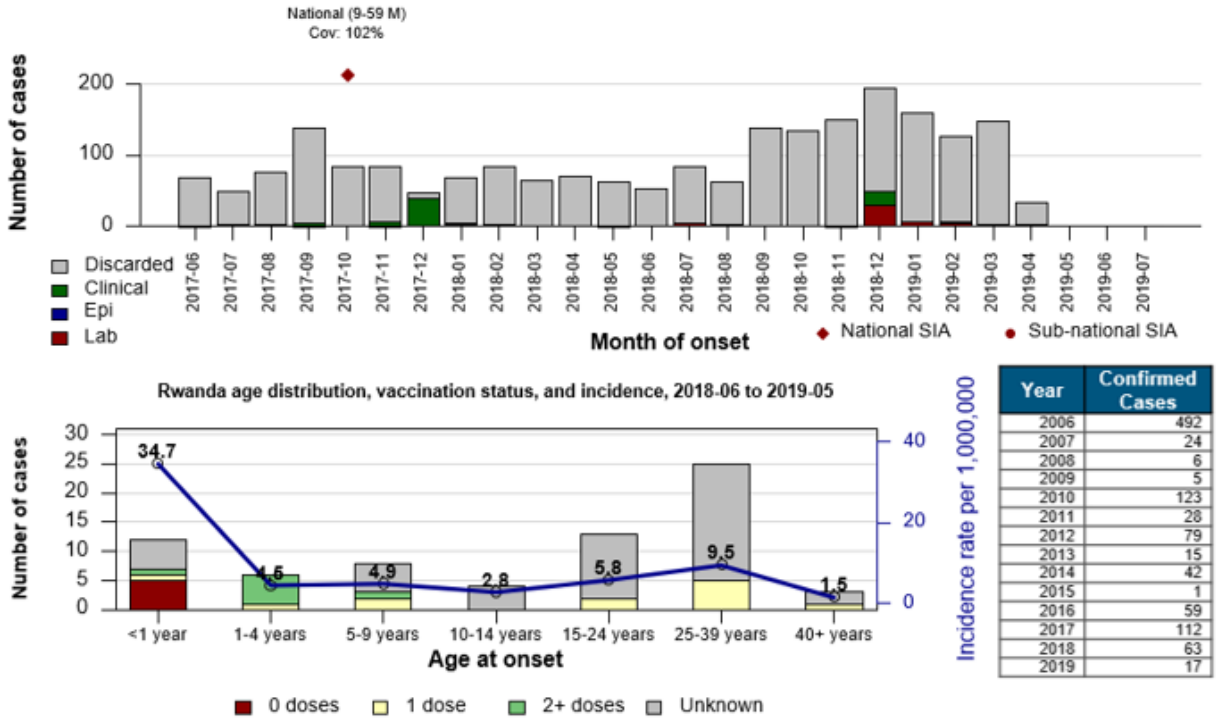
In December 2018, following a confirmation of an outbreak in Mageragere prison (3 cases confirmed by lab among 11 suspected cases) and Muhanga Prison (12 cases tested measles IgM positive among 173 suspected cases), a measles vaccination campaign was organized and conducted from 19 - 21 December 2018 as a response to the outbreaks.

The mass vaccination was implemented in the 2 prisons with a target population of 9126 including RCS staff, prisons' gardens and prison clinic staff in Mageragere and 5741 in Muhanga prison). The campaign ended reaching an overall target of 95,4% and 99.2% respectively in Mageragere and Muhanga.

Such campaigns in 2018 were conducted in Kibungo and Huye prisons with coverages above 95%.

- **Situation analysis for measles and rubella**

Fig. XX: Incidence of measles in zero-dose children < 1year



Year	Confirmed Cases
2006	492
2007	24
2008	6
2009	5
2010	123
2011	28
2012	79
2013	15
2014	42
2015	1
2016	59
2017	112
2018	63
2019	17

- Highest incidence of reported measles cases found in zero-dose children under 1 year.
- High number of cases also found in age group 15-39 years (potential caregiver transmission).

Update of the country's measles and rubella 5 year plan

The planned MR Campaign: In 2015, Rwanda introduced Measles Elimination mode surveillance, based on the Measles Elimination Plan (2012-2020). Given the current level of routine immunisation coverage in Rwanda and the latest MR campaign conducted in 2017, with this PSR/FPP Rwanda will be conducting targeted campaigns based on measles epidemiological analysis. Referring to GAVI board decision, Rwanda PSR 2019 – 2024 provides room for conducting the next MR campaign in 2022-2023.

Key actions related to Gavi vaccine support in the coming year

Introduction of Hep B Birth dose to be supported from 2021.

Rwanda had to introduce IPV in 2015 but due to global shortage of IPV supply, the introduction delayed up to March 2018. Rwanda having switched from tOPV to bOPV in April 2016, this situation has created a significant number of accumulated children who have not been vaccination against type 2 Poliovirus for a period of 2 years. A catch campaign remains a pending issue.

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

The CCEOP-ODP was done and submitted to UNICEF. There has been changes in equipment models following WHO instructions public announcement on negative temperature alarms for Vestfrost refrigerators. The new COP was approved by Rwanda MoH and resubmitted to UNICEF and, having paid the co-financing, the country is ready to receive the 1st consignment. CCEOP implementation first year is scheduled in January 2020.

5.4. Financial management performance

Rwanda has been managing the second GAVI HSS grant, which programmatically ended in December 2018. The HSS 2 grant was used as planned by the central level, sub-national levels and Civil Society Organizations. The last report sent to Gavi was for the period ending on 31 December 2018 and the budget absorption rate was at 78% and the projected budget absorption rate is 100% by June 2019.

In compliance with financial reporting and progress in addressing audit requirements, according to the existing reporting system, sub-recipients (District hospitals and CSO) report to RBC/SPIU on quarterly basis and RBC/SPIU reports to GAVI every six months.
Regarding the financial management systems, some changes were reported since previously all different grants from GAVI (HSS, VIG,) were managed from one bank account; this made it difficult to provide bank statements by grant category as required by the IFMS software which is a comprehensive cashbook format. 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 funds only.

On annual basis there are regular audit exercises. In 2018, GAVI Funded projects were audit by both

From recommendation of JA 2017, a presentation to the ICC on the status of implementation of audit recommendations from cash programme audits conducted in 2016 was made. Regarding the financial management systems, some changes were reported since previously all different grants from GAVI (HSS, VIG,) were managed from one bank account; this made it difficult to provide bank statements by grant category as required by the IFMS software which is a comprehensive cashbook format. 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 funds only.

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

Rwanda being in the low income group, the country does not have a transition plan monitoring.

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

The activities related to technical assistance were implemented through consultancies; contractual staff to support the EPI for TCA planned activities and subnational support.

Some TCA planned activities were implemented with delays. This was due to EVD preparedness activities including EVD vaccination activities, which required fully involvement of immunization program staff for planning implementation, monitoring and reporting.

6. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
1. Conduct cEVMA & develop 3 years IP	EVM completed in November 2018 and cIP developed for 5 years to harmonize with UNICEF/WHO recommendation.

2. CCEOP implementation activities	The CCEOP deployment plan was developed in 2017 and submitted to UNICEF. The system design is ongoing to be completed by October 2019. The capacity building on CCE maintenance : Pending as the activity is to be implemented alongside deployment and the installation of CCE in health facilities.
3. Sustain public demand for quality immunization services to maintain high coverage and reduce drop-out rate	The story lining through *Itetero* group was appropriately conceived and subsequently, messages were develop and shared for *Itetero* radio program.
4. REC strategy implementation and monitoring to improve coverage and Equity	The training of vaccinators of health centers were organized . Monitoring of implementation at Health facility level is still ongoing
5. SMT training	The training was conducted in March 2019 for EPI Supervisors in all district. The SMT tool is in use.
6. Support REC strategy implementation in all districts	• The REC guide was adapted from RED • Support was provided to organize training of Health care providers at health center level • The training of EPI Supervisors in the new structure at district levels was conducted in 2019. • Sensitization meeting on vaccination card retention was organized. And was attended by districts directors of health and education, directors of district hospitals and district health officers in charge of immunization.
7. Support computerization of vaccination data	• The immunization e-registry software was developed, tested • District data managers and EPI supervisors were trained on the use of the software • Training was extended to health center level facilitated by EPI supervisors and data managers at district level Currently, the software is being used in 36 out of 42 district hospitals.
8. Monitor the implementation of immunization data quality improvement plan	• The field visits to monitor and supervise the quality of immunization and VPDs surveillance data was conducted in 10 ditricts. The report was produced and shared. • Annual data quality review was conducted and report was drafted.
9. Support the introduction of IPV in routine immunization and conduct post introduction evaluation	• Technical support was provided for planning and implementation of IPV introduction • A consultant was recruted to support the post introduction evaluation (PIE) of IPV. The report was produced.
10. Support to build capacity of ESR for Measles risk assessment and NVC documentation on measles elimination	• Training on Measles risk assessment was conducted • Documentation of national verification for measles elimination was produced and shared with Regional Verification commission. The report was reviewed and feedback provided for improvement.
.- Conduct quarterly field visits to monitor VPDs performances indicators Initiate mentorship on vaccination services delivery at health center level	• Field visits were conducted and VPDs surveillance indicators were monitored. Sensitization meetings were organized to discuss the findings and elaborate action plan to address challenges • Mentorship tools and training materials were developed.

	• EPI supervisors (42) were trained on mentorship
11. Support the establishment and operationalization of NITAG, AEFIs and MEV committees	• Support was provided to organize NITAG, AEFIs and MEV committees workshops. • All planned meetings were conducted
12. Support the development of PSR : Provide technical support to MOH to conduct situation analysis, technical development of PSR, operational budget/workplan and performance framework Support in country review and planning workshop	• A consultant was recruited to support the MOH to conduct situation analysis, technical development of PSR, operational budget/work plan and performance framework. • In country review and planning workshop was organized
Additional significant IRC / HLRP recommendations (if applicable)	NA

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being prioritised in the new action plan (section 7 below).

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

Twenty five key activities have been identified and planned for the next year in areas of Programme Implementation/Coverage & Equity, Programme Management – LMC, Demand Promotion & ACSM, Supply Chain & Procurement, Health Information Systems (Data), Programme Implementation/Coverage & Equity, Policy & Regulatory Framework, Vaccine-Specific Support and health Financing/Sustainability.

This table draws from the previous JA sections, summarizing key findings and agreed actions, as well as indicating required resources and support, such as associated needs for technical assistance[9].

Key finding / Action 1	**Provide technical assistance to conduct equity assessment(develop TORs, Hiring Consultant,organize workshops, report dissemination)**
Current response	
Agreed country actions	To conduct equity assessment
Expected outputs / results	Coverage and equity improved
Associated timeline	6 - 12 months
Required resources / support and TA	YES (UNICEF)
Key finding / Action 2	**Technical assistance for immunization suply and logistic expert to implement CCEOP-ODP, EVM cIP**
Current response	
Agreed country actions	To implement CCEOP-ODP, EVM cIP (Hiring SSA)
Expected outputs /	All new CCEs are installed and maintained. EVMA score maintained above

[9] The needs indicated in the JA will inform the TCA planning. However, when specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. TA needs should however describe - to the extend known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. The TA menu of support is available as reference guide.

results	80%
Associated timeline	6 - 12 months
Required resources / support and TA	YES (UNICEF)
Key finding / Action 3	**Support 2 EPI staff for short course on Vaccinology and 1 staff on medical engineering or CCE maintenance short course**
Current response	
Agreed country actions	To support 2 EPI staff for short course
Expected outputs / results	improved skills EPI program staffs on vaccine managment and CCE maintenance
Associated timeline	3 - 6 months
Required resources / support and TA	YES (UNICEF)
Key finding / Action 4	**Support KABP study (continue from 2019)**
Current response	
Agreed country actions	Support KABP study
Expected outputs / results	Immunization coverage improved at national and subnational levels
Associated timeline	6 - 12 months
Required resources / support and TA	YES (UNICEF)
Key finding / Action 5	**Support to develop evidence based IEC materials including health workers communication tools**
Current response	
Agreed country actions	To develop evidence based IEC materials
Expected outputs / results	DPT3 above 80% at subnational levels
Associated timeline	6 - 12 months
Required resources / support and TA	YES (UNICEF)
Key finding / Action 6	**Technical assistance to develop Immunization communication strategy(Develop Tor, Hiring consultant, organize workshop and dissemination)**
Current response	
Agreed country actions	To develop Immunization communication strategy
Expected outputs / results	Immunization coverage maintained above 93%
Associated timeline	6 - 12 months
Required resources / support and TA	YES (UNICEF)
Key finding / Action 7	**Support developement of National Logistics Working group (Develop TOR, organise innitition workshops)**
Current response	
Agreed country actions	To develop the National Logistics Working group
Expected outputs / results	Logistic of vaccines improved at all levels
Associated timeline	> 2 years / long-term
Required resources / support and TA	YES (UNICEF)
Key finding / Action 8	**Support Upgrade vaccine managment with electronic stock managment using DHIS2 (continue from 2019, cascade training for vaccinators(504))**
Current response	
Agreed country	To upgrade vaccine managment with electronic stock managment using

actions	DHIS2
Expected outputs / results	Vaccines management and reporting improved at all levels
Associated timeline	6 - 12 months
Required resources / support and TA	YES (UNICEF)
Key finding / Action 9	**Support implementation of the imunization supply chain system redesign(continuing from 2019)**
Current response	
Agreed country actions	To implement the imunization supply chain system redesign
Expected outputs / results	Vaccines distribution and starage optimized at all levels
Associated timeline	> 1 year
Required resources / support and TA	YES (UNICEF)
Key finding / Action 10	**Technical assistance to conduct CCE assessment/CCE inventory following CCEOP-ODP implementation(develop TORs, Hiring consultant, dissemination of CCEA report)**
Current response	
Agreed country actions	To conduct CCE assessment/CCE inventory following CCEOP-ODP implementation
Expected outputs / results	Improved cold chain at all levels
Associated timeline	6 - 12 months
Required resources / support and TA	YES (UNICEF)
Key finding / Action 11	**Implementation of immunization e-tacker: 1. Training of additional staffs (504 nurses)2.documentation of the implementation of immunization e-tracker**
Current response	
Agreed country actions	**Implementation of immunization e-tacker: 1. Training of additional staffs (504 nurses)2.documentation of the implementation of immunization e-tracker**
Expected outputs / results	Improved immunization data quality
Associated timeline	> 1 year
Required resources / support and TA	YES (UNICEF)
Key finding / Action 12	**1. Support EPI to conduct operational research that will identify root causes of low and substandard coverage rates (> 100%) in priority districts and develop action plan to address challenges.**
Current response	
Agreed country actions	To identify root causes of low and substandard coverage rates (> 100%) in priority districts and develop action plan to address challenges.
Expected outputs / results	Immunization coverage increased and sustained, High quality immunization data
Associated timeline	> 1 year
Required resources / support and TA	YES (WHO)
Key finding / Action 13	**1. Support EPI to address gaps in REC microplanning and implementation in the context of reaching the under-immunized and unimmunized children (dissemination of REC guide and tools).** **2. Support EPI to conduct bi-annual review of routine immunization and**
Current response	
Agreed country	To address gaps in REC microplanning and implementation in the context

actions	of reaching the under-immunized and unimmunized children 2. Support EPI to conduct bi-annual review of routine immunization and
Expected outputs / results	Immunization service delivery improved
Associated timeline	> 1 year
Required resources / support and TA	YES (WHO)
Key finding / Action 14	**Provide technical support for the development of AEFI crisis management plan**
Current response	
Agreed country actions	To develop of AEFI crisis management plan
Expected outputs / results	Improved management of AEFIs
Associated timeline	3 - 6 months
Required resources / support and TA	YES (WHO)
Key finding / Action 15	**Support RBC/ESR to produce measles and Rubella elimination strategic plan (5 years), revise and disseminate surveillance technical documents**
Current response	
Agreed country actions	To produce measles and Rubella elimination strategic plan (5 years)
Expected outputs / results	Availability of Measles Rubella elimination plan and guiding document
Associated timeline	6 - 12 months
Required resources / support and TA	YES (WHO)
Key finding / Action 16	**Support capacity building for Measles and Rubella laboratory and epidemiological surveillance and case investigation in the framework of measles elimination**
Current response	
Agreed country actions	Support capacity building for Measles and Rubella laboratory and epidemiological surveillance
Expected outputs / results	Enhanced human resources capacity towards MR surveillance
Associated timeline	3 - 6 months
Required resources / support and TA	YES (WHO)
Key finding / Action 17	**Support ESR to revitalize Congenital Rubella Syndrome (CRS) Surveillance including the development of CRS related guiding documents, establishment of Surveillance sentinel sites and building capacity of HCP on the CRS surveillance**
Current response	
Agreed country actions	To revitalize Congenital Rubella Syndrome (CRS) Surveillance
Expected outputs / results	CRS surveillance system strengthened
Associated timeline	> 1 year
Required resources / support and TA	YES (WHO)
Key finding / Action 18	**Initiate e-case based surveillance to improve timeliness of measles case notification and investigation**
Current response	
Agreed country actions	To improve timeliness of measles case notification and investigation
Expected outputs / results	Timeliness for VPDs notification and investigation is improved
Associated timeline	> 1 year

Required resources / support and TA	YES (WHO)
Key finding / Action 19	**Provide technical support to monitor and evaluate the implementation of immunization e-registry at health center levels, and conduct annual review of immunization data quality and use**
Current response	
Agreed country actions	To monitor and evaluate the implementation of immunization e-registry at health center levels
Expected outputs / results	High quality immunization data generated and used for decision making
Associated timeline	> 1 year
Required resources / support and TA	YES (WHO)
Key finding / Action 20	**Provide technical support to document immunization best practices through dissemination of regular immunization bulletin and articles in international journals**
Current response	
Agreed country actions	To document immunization best practices
Expected outputs / results	Rwanda EPI performance and achievements are documented
Associated timeline	> 1 year
Required resources / support and TA	YES (WHO)
Key finding / Action 21	**Train central level AEFI and NITAG Committee Members in Vaccinology**
Current response	
Agreed country actions	To train central level AEFI and NITAG Committee Members in Vaccinology
Expected outputs / results	EPI Staff, AEFI and NITAG Committee members skilled to effectively support immunization program
Associated timeline	3 - 6 months
Required resources / support and TA	YES (WHO)
Key finding / Action 22	**Support MOH to implement and monitor activities of EPI committees including NITAG, AEFI committee and NVC for measles elimination**
Current response	
Agreed country actions	TTo implement and monitor activities of EPI committees including NITAG, AEFI committee and NVC for measles elimination
Expected outputs / results	EPI committees are fully functional and achieve their mandate
Associated timeline	6 - 12 months
Required resources / support and TA	YES (WHO)
Key finding / Action 23	**Provide technical support to carry out sustainable immunization financing study, document the evidence in support of continued and increased investment, and develop financial sustainability plan for the VPD / EPI program**
Current response	
Agreed country actions	To carry out sustainable immunization financing study
Expected outputs / results	Financial sustainability data is generated for informed decision making
Associated timeline	6 - 12 months
Required resources / support and TA	YES (WHO)

Key finding / Action 24	**Techincal assistance and capacty building by HISPs (within country or nearby/within the region) on the installation, configuration, ToT, and maintenance of the BNA, immunization e-tracker, Action Tracker and Scorecard Applications for DHIS2.**
Current response	
Agreed country actions	Capacty building on the installation, configuration, ToT, and maintenance of the BNA, immunization e-tracker, Action Tracker and Scorecard Applications for DHIS2.
Expected outputs / results	Improved immunization data quality and use at all levels
Associated timeline	> 1 year
Required resources / support and TA	YES (HISP Rwanda & UiO)
Key finding / Action 25	**System configuration of Rwanda and capacity building on EIR to integrate Birth Notification and implementation of notification to CRVS by email or SMS**
Current response	
Agreed country actions	Capacity building on EIR
Expected outputs / results	Improved immunization data quality and use at all levels
Associated timeline	6 - 12 months
Required resources / support and TA	YES (HISP Rwanda & UiO)

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

8. 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 necessary key documents were uploaded in the country portal and, a JA preparation meeting was held in Musanze District from 9 to 13 September 2019 to finalize the documentations required for the actual 2019 Joint Appraisal review. The review exercise was conducted from 16 to 20 September 2019 in Ubumwe Grand Hotel, Kigali. This revies 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, USAID, Girl Effect and Gavi Secretariat.

The implementation progress and performance of Gavi’s vaccine and cash grant support to Rwanda and its contribution to improved immunisation outcome were key points of discussions and summary of findings from the JA meeting was presented by the EPI and the Gavi Secretariat to the ICC meeting which convened on 26 September 2019 with aim of considering and endorsing the Rwanda JA report for the year 2019.

The ICC meeting, which was chaired by Hon. Minister of State in Charge of 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. On key recommendation from the ICC meeting was that key recommendations from the EPI Review 2019 would be considered for inclusion of key related activities in the JA next priorities.

9. ANNEX: Compliance with Gavi reporting requirements

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

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.