Gavi 2020 multi-stakeholder dialogue: immunisation planning in light of COVID-19

Introduction

2020 has been marked by the unprecedented crisis caused by COVID-19. Though the longer-term trajectory of the pandemic remains uncertain, evidence shows that immunisation services in Gavi-supported countries have been disrupted. Millions of people are expected to miss out on immunisation, likely leading to a resurgence of VPDs, further exacerbating existing inequities and putting the most marginalised and poorest communities at greater risk. Gavi-supported countries have already had the opportunity to re-allocate or re-programme[1] existing HSS and TCA support to respond to immediate needs presented by the COVID-19 pandemic.

In Rwanda, since the confirmation of the first COVID-19 case on 14th March 2020, the Government of Rwanda has issued instructions aimed at controlling and preventing its spread. This COVID-19 pandemic has had and continue to manifest severe devastating socio-economic effects on households who rely on daily incomes for their livelihoods. In particular, the COVID-19 Lock Down (important outbreak management strategy) paralysed all forms of casual livelihoods activities. It is expected that the negative effects will continue during the transition phase and until the national economy fully recovers from COVID-19 shock. The Gavi Alliance is fully committed to assisting countries to restore immunisation services that have been scaled-back, brought off-track or otherwise affected during the pandemic response.

As an alliance, multi-stakeholder engagement remains key to Gavi's portfolio management approach. It is particularly critical in 2020 as a forum for engagement on how the Gavi Alliance partners and other stakeholders can support countries as they deal with the different phases of the COVID-19 pandemic and seek to maintain and restore primary health care, including immunisation services that have been disrupted. Civil society organisations (CSOs), in particular, will have a vital role to play in engaging communities to rebuild trust and demand, deliver services where there are gaps in government provision and in overcoming gender-related barriers.

From the Gavi Alliance guidance, Rwanda has not conducted a traditional Joint Appraisal in 2020. However, the Country has sustained the multi-stakeholder dialogue to review the immunisation programme performance in 2019, the impact of the COVID-19 pandemic on immunisation, discuss the needs for maintaining and restoring immunisation services in the context of primary health care, plan for short-term catch-up activities. For further re-allocation/planning within the country's recovery plan, the country intends to conduct an assessment of COVID-19 pandemic impact on immunisation services to inform the long term resilience of vaccination programme.

The 2020 multi-stakeholder dialogue exercise

This 2020 multi-stakeholder dialogue for Rwanda has involved a number of partners in a preparatory meeting which took place in Bugesera, La Palisse hotel, from 13 to 16 October 2020. The meeting has produced a report and defined key priorities (interventions/activities) to deal with Covid-19 impacts on immunization.

[1] This document refers generally to the reallocation of Gavi support. Changes might also be categorized as reprogramming which is used for more significant modifications and may require to be reviewed by the Independent Review Committee.

The 2020 multi-stakeholder dialogue report

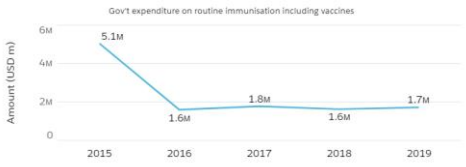
1. Country situation pre-COVID-19, based on information received by Gavi

Contextual Information

PEF Tier: Tier 3 | Fragility Status: Non-fragile | 1. Initial self-financing

Indicator Name	Year	Source	Value
GNI per capita	2019	World Bank	820
Nurses/Midwives per 1000 population	2018	WHO - GHO	12
Population	2020	UNPD	12,952,209
Surviving Infants	2020	UNPD	387,519
Under-5 mortality (per 1000)	2018	UNICEF	35

Health financing (and trends)



1.1. Overview of performance of vaccine support (end of 2019/early 2020; pre-COVID-19)

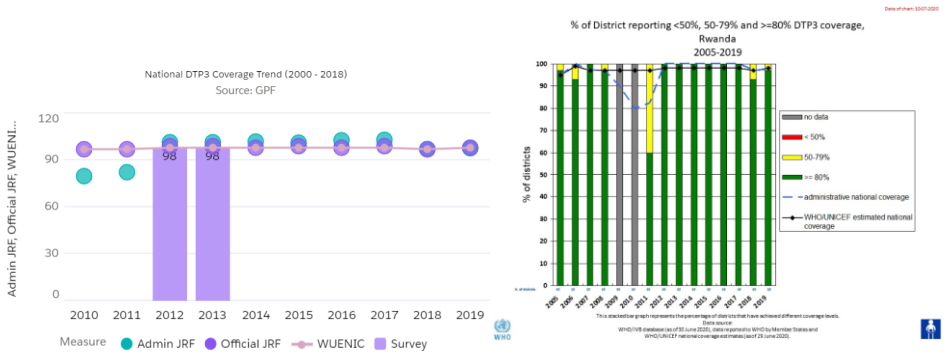
Vaccine	Introduction Date	2017 Coverage (%)	2018 Coverage (%)	2019 Target
PENTA	01-2002	98	97	98
PNEUMO	01-2009	98	97	98
ROTA	05-2012	98	98	98
HPV	03-2014	-	-	95
MEASLES	01-2015	97	99	97
IPV	03-2018	-	81	98

Vaccine Name	Type	Sub-Type	Status	CP Date ↑	Phase
MENA	Campaign	-	Forecasted	2020-12-31	NA
IPV	Campaign	Catch-up	Planned	2021-03-31	NA
MENA	Routine	-	Forecasted	2021-12-31	NA
YF	Routine	-	Forecasted	2021-12-31	NA
MR	Campaign	Follow-up	Forecasted	2023-12-31	NA

Performance against Alliance KPIs

Indicator	Source Name	Year	Value	Previous Value	Trend
Measles containing vaccine (second dose) coverage at the national level (MCV2)	WUENIC	2019	92	96	▼
Pentavalent 3 coverage at the national level (Penta 3)	WUENIC	2019	98	97	▲
Drop-out rate between Penta1 and Penta3	WUENIC	2019	1	1	→
Difference in Penta3 coverage between children of urban and rural residences	Survey	2019	0	0.7	▲
Difference in Penta3 coverage between the highest and lowest wealth quintiles	Survey	2019	0	3.2	▲
Penta3 coverage difference between the children of educated and uneducated mothers/care-takers	Survey	2019	0	3.7	▲
EVM	EVM	2018	88.9	78.8	▲
# of Underimmunised Children	Calculated	2019	7199.4	10770.81	▲

Trends and district equity



Progress against indicators and targets achievement
Table provided by CMM

Vaccine Programme	Source (2019)	Intermediate results Indicator	Reported actuals	Rel. % change
PNEUMO	Admin (JRF)	Number of surviving infants who received the first recommended dose of PCV vaccine (PCV1)	363,076	3%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of PCV vaccine (PCV3)	357,128	3%
PENTA	Admin (JRF)	Number of surviving infants who received the first recommended dose of pentavalent vaccine (Penta1)	362,705	3%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of pentavalent vaccine (Penta3)	356,591	3%
MCV	Admin (JRF)	Number of children in the target population who received the second recommended dose of measles containing vaccine (routine) (MCV 2)	326,545	-2%
	Admin (JRF)	Number of surviving infants who received the first recommended dose of measles containing vaccine (MCV1)	349,590	-1%
IPV	Admin (JRF)	Number of surviving infants who received the first recommended dose of IPV	NA	NA
All others	EVMA Reports	Effective Vaccine Management Score (composite score)	NA	NA
	JRF	Occurrence of stock-out at national or district level for any Gavi-supported vaccine	No	NA
	Admin (JRF) & Survey	Percentage point difference between Penta 3 national administrative coverage and survey point estimate	NA	NA

Relative % change refers to the percentage increase/decrease of the reported value from the year prior.
The cell is green when the relative change increased, yellow when it remained the same and red when the relative change decreased.

1.2. Overview of HSS grant implementation (end of 2019/early 2020; pre-COVID-19)

HSS implementation summary (as of 30 June 2020)

Recipient	Grant Amount	Funds Disbursed	Expenditure	Country cash balance
RBC/HSS-2 (2013-2019)	10,339,970	10,339,830	10,066,679	273,151
RBC/HSS-3 (2020-2024)	9,750,800	2,005,466	433,376	1,572,090
RBC/PBF	4,920,000	3,935,930	1,987570	1,948,360
Total	**25,010,770**	**16,281,226**	**12,487,625**	**3,793,601**

Note:

- HSS-2 started in 2013 and ended on 30 June 2019 including no cost extension period. The balance equal to USD 273,151 contributed to bridge fund between HSS2 and HSS3.
- The last PBF award related to HSS2 is not in the summary as the funds were disbursed after 30 June 2020 (15 July 2020).

HSS key milestones achieved in 2019

1.3. Overview of other Gavi support, such as VIGs, OPS, PBF, switch grants, transition grants etc. (as applicable)

				In US$				
	Start Date	End Date	Recipient	Grant Value	Disbursed	Expenditure	Cash balance	Status Update
Transition grant (Bridge fund	July 2019	December 2019	RBC/SPIU	465,924	465,924	454,228	11,696	

between HSS2 and HSS3)								

The disbursed amount was balances on our bank account from closed grants and have been used for the bridge period.

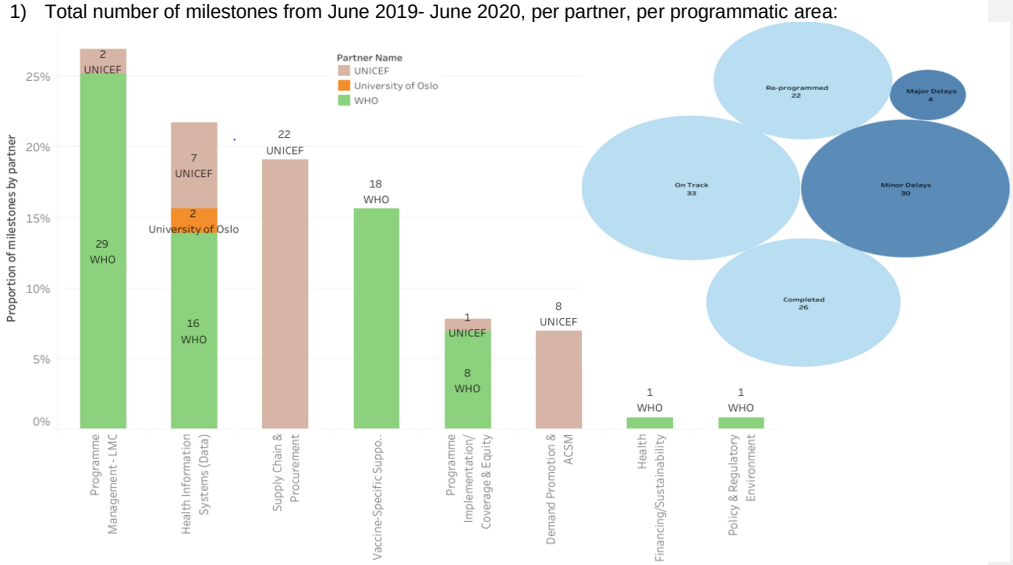
1.4. Compliance, absorption and other fiduciary risk matters

- Comments on financial absorption as of [30 June 2020]:
  - HSS-3 grant: This grant started by January 2020 but the first instalment equal to USD 2,005,501 was done on 7th May 2020 with delay of 5 months. However, routine activities continued and payment was done upon receiving funds in country.
  - Performance Based Financing (PBF): based on performance achieved with HSS-2; Rwanda was awarded with 5 tranches of PBF. By 30 June 2020, 4 tranches were already in country and the last one was received in July 2020.
- Compliance with financial reporting requirements (periodic/annual financial reports, audits):
  On annual basis vaccination programme projects are audited by the Office of Auditor General and the report is shared with the Gavi Alliance. Periodic and annual financial reports are also shared on regular basis (ecery six months) with Gavi to comply with partnership framework agreement signed between Gavi an GoR in 2013.
- Compliance with programmatic reporting requirements (GPF):
- A number of indicators has been defined to drive the implementation of HSS-2 and the current HSS-3 whereby vaccination programme activities are regularly monitored and this is the basis of HSS implementation assessment. For HSS-2 all indicators have been reported on and we achieved the target on most of them. Starting this year, there is an ongoing HSS-3.Other financial management and fiduciary risk comments:
  None

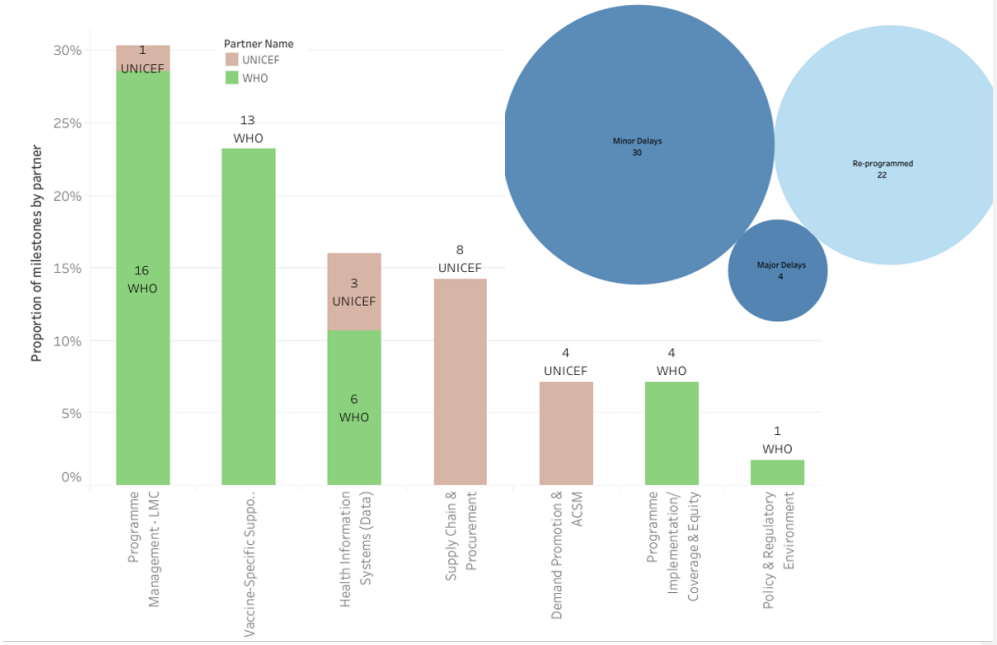
1.5. Overview of PEF TCA progress (end of 2019/ early 2020)

(graph provided by the PEF team)

1) Total number of milestones from June 2019- June 2020, per partner, per programmatic area:



2) Total number of non-completed milestones from June 2019 – June 2020, per partner, per programmatic area:



Progress In Key Areas, Challenges, Constraints, Reallocations, No-Cost Extensions

The implementation of TCA plan 2020 was effective in the first six months from (June to Dec 2019). Key achievements include the completion of the comprehensive EPI review, the development of REC and mentorship Monitoring, evaluation and assessment tools, training of 96 health care providers on AEFI surveillance and the development of measles elimination operational plan. On the UNICEF side the TCA 2019-2020 grant was spent by June 2020with some ongoing activities including the implementation of CCEOP-ODP1 which was delayed by Covid19 but then completed after the lockdown making 100% installation of received CCE under ODP1. The other activity pending is the KAPB study, recently a visa to conduct data collection was granted by the National Institute of Statistics(NISR) and by mid-FOctober 2020 the contractor started data collection at household and health facility levels. The delay in the implementation of the KAPB study caused major delays of the development of the Immunization communication strategy and IEC materials.

The implementation of TCA plan 2020 was challenged by the occurrence of the COVID-19 pandemic with subsequent lockdowns and movement restrictions resulting in low implementation rate and non-achievement of milestones as planned. The reprograming exercise was undertaken for some of the activities for which the implementation was impossible or delayed, and the implementation period was extended by six months from June to December 2020. The COVID-19 protracted pandemic and its consequence, and constraints related to the partner planning cycles which is not harmonized with national cycles are hampering the implementation of TCA plan 2021. It would be critical to consider reallocations of funds previously allocated to the activities whose implementation is almost impossible due to the prevalent situation of COVID-19. Given the delays that have been already experienced, the completion of the implementation of TCA 2020 activities by June 2021 is uncertain. A non-cost extension of TCA 2020-21 for a period of six months (from July to December 2021) would be therefore helpful to achieve the milestones.

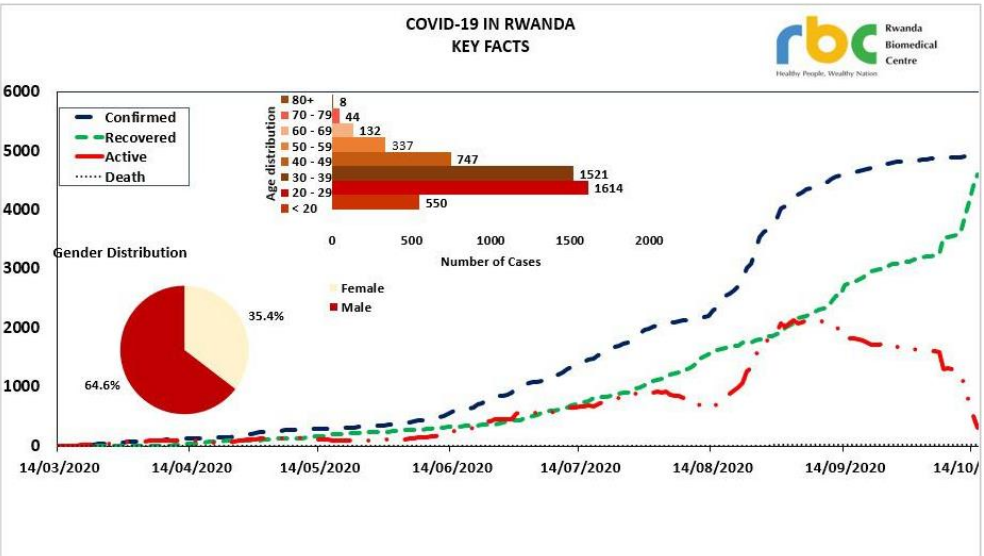
- Girl Effect is in the process of finalising a no cost extension to enable us to complete all planned activities by March 31, 2021.
- Despite COVID-19 there has been lot of progress in key activities such as formative research planning and desk review completed, TEGA baseline and endline research design finalized, tools

developed, and protocol submitted to NISR for approval, digital scoping strategy finalisation, youth engagement strategy and progress on other activities as reported quarterly to Gavi quarter

- Delay in the engagement of the youth volunteers and CHWs on the youth engagement model, due to conflicting priorities for Rwandan government in these times of COVID-19
- Delay in the activities related to the dissemination of the RI and nutrition content targeting teen mothers through the youth engagement model.
- Reallocations of funds related to activities which cannot be implemented due to COVID-19. Reallocations agreed included drama costs, content gathering, broadcasting fees, reduced the scale/ plans with teen mothers but still achieved a lot and with meaningful impact etc.

2. COVID-19 impact on immunisation (in 2020): current situation

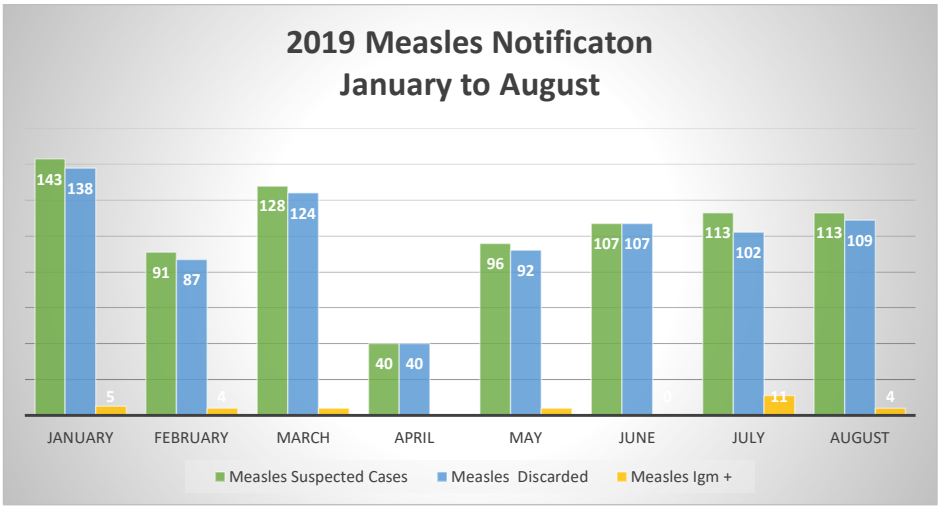
2.1 COVID-19 cases and deaths (as of 14 October 2020)



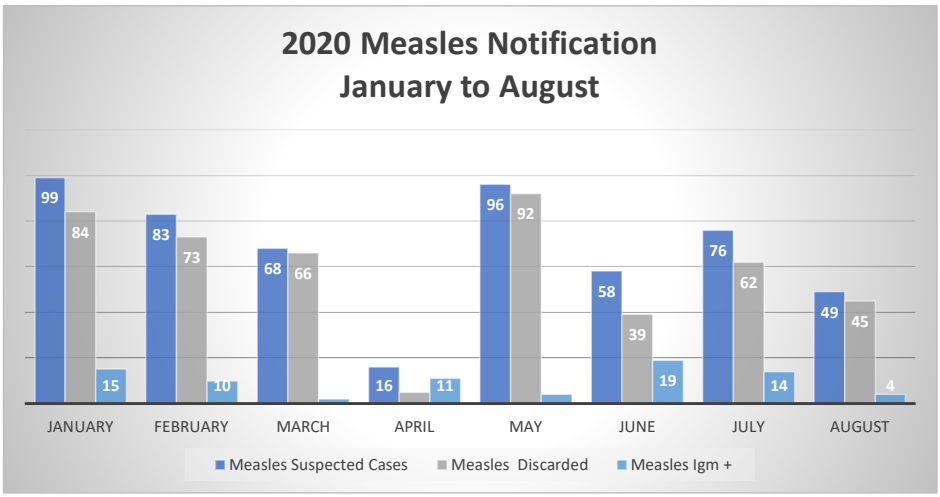
2.2 Disease Surveillance and Incidence

[Information from CCM team and/or https://www.who.int/immunisation/monitoring_surveillance/data/en/]

Impact of COVID-19 on disease surveillance

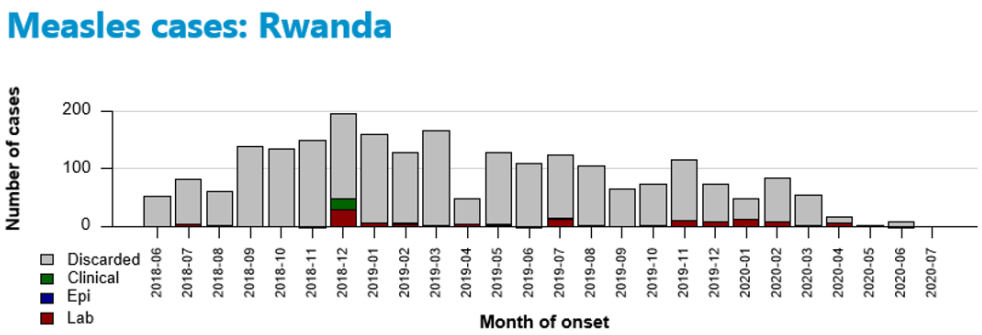


2020 Measles Notification



The comparison of suspected cases notified in 2019 on monthly basis to those of 2020 shows that suspect cases were decreased. The first case of COVID-19 in Rwanda was identified in March 2020, from that period health care workers were not able to conduct active surveillance or active case search, only passive surveillance was conducted as many health care workers were involved in COVID-19 prevention and control activities.

During the COVID-19 period especially in lockdown, activities aiming to improve VPDs surveillance performance indicators were not conducted due to travel and meeting restrictions. Among the activities cancelled includes sensitization meetings, integrated supportive supervisions and trainings.



2.3 Impact of COVID-19 on immunisation

COVID-19 has had a negative impacts on the ability to effectively deliver immunisation services in the following key areas:

Service delivery

- HPV Vaccination which was planned in March 2020, was not done due to closure of schools
- Some mothers didn't attend vaccination sessions during lockdown period: they did not know that there was continuity of vaccination services,
- Some vaccination outreach sessions were not implemented during Covid-19 lockdown period due to difficulties in transport
- Existing infrastructure capacity not allowing health centers to host Information, Education and Communication (IEC) sessions due to social distancing requirements
- Growth monitoring disrupted over temporal restrictions
- Some health centers have been transformed in Covid-19 treatment centers

Health workforce

- Health care providers dedicated to Vaccination services were deployed to support COVID-19 related activities (at all levels: Central, intermediate and service delivery levels)
- During Covid-19 lockdown period, some HFs suffered from lack of healthcare providers due to issue of public transportation. Health providers living in districts different to place of work were locked in their respective districts,
- Covid-19 lockdown increased HF's expenditures related to transport of health providers from their respective residences to HC.

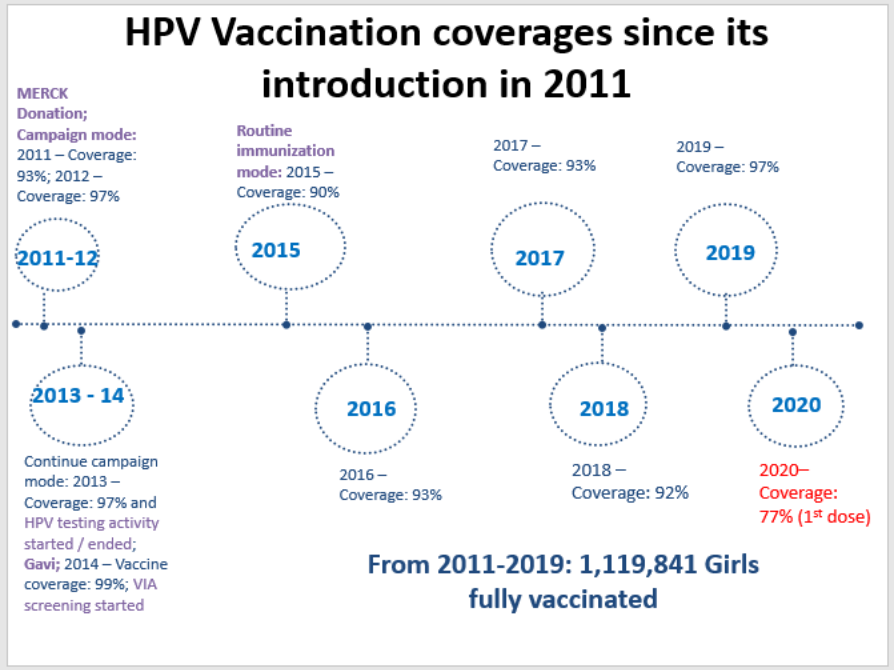
Implementation of planned activities (meetings, trainings, supervisions Etc.)

- Social distancing and mass gatherings impact on implementation of meetings, trainings,
- Supportive supervisions were not conducted during lockdowns
- Increased time per trainee for planned trainings to respect distancing leading to increased budget for training.

Immunization coverage (key indicators)

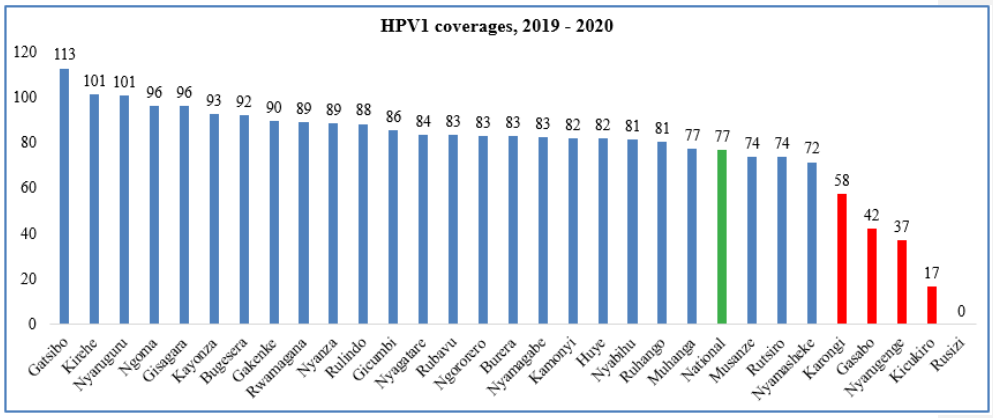
- Decrease of vaccination indicators
- This shows how iSC activities were disrupted by COVID-19 and its lockdown or movement restrictions.

HPV vaccination



Since the introduction of HPV in Rwanda vaccination programme in 2011, the country has the lowest record of coverage of 77%. Never before, a history of an HPV coverage of <90% was recorded

HPV Coverage, 2019 – 2020



Note: The vaccination programme changed the strategy which was used before covid-19 (school based) and HPV vaccine was administered in June 2020 during MCH Week (community based strategy). The average coverage of 77% was reached with 9 districts recording a coverage below 80% including Rusizi District which vaccinated later on in August with a coverage of 43%.

- Increase of defaulters in vaccination

Medical products, vaccines and technologies

- Delayed vaccines and vaccine devices in pipeline, syringes were stuck in Dar es Salaam port 1 months' time.
- Delayed to implement the planned project aiming at optimizing Cold Chain equipment Platform (CCEOP)
- For vaccines availability and distribution to health facilities: No major issue as the available stock of vaccines can be utilized to December 2020

Financing

- PBF funds awarded to vaccination programs now allocated to COVID activities (Around 850,000 USD). without COVID-19 these funds would have used to strengthen vaccination activities
- Low budget execution relating to immunisation activities
- Delayed TCA implementation (UNICEF and WHO) leading to low financial absorption.

Impact on the implementation of Gavi support (vaccines, HSIS, TCA, other),

COVID-19 pandemic hampered the implementation of TCA plan 2020 with a recorf low implementation rate and non-achievement of milestones as planned. The completion of the implementation of TCA 2020 activities by June 2021 is uncertain. A non-cost extension of TCA 2020-21 for a period of six months (from July to December 2021) would be therefore helpful to achieve the milestones.

2.4 Already agreed budget reallocations of HSS grant for COVID-19 response

Approved PBF budget to be annexed

2.5 Already agreed modifications in Technical Assistance (if applicable)

No Covid-19 reallocation conducted for 2019 TCA for Rwanda.

2.6 Unspent funds and savings from Gavi support, available for re-allocation

3. Discussions on priorities, action plan and technical assistance needs; Roadmap for further re-allocation/planning

Short/medium-term activities to maintain/restore routine immunisation
Rwanda has developed an economic recovery plan for a period extending from May 2020 – December 2021. Containing the pandemic and strengthen the Health System (infrastructure, HRH, and IT systems) is priority 1 of this plan. On Social Protection, This action plan will be mainly using the existing instrument to ensure access to basic services including health.

Short/medium-term activities to maintain/restore routine immunisation, to re-activate immunisation services and to address any immunisation gaps resulting from COVID-19, we will define our strategies under the following key areas:

- Strengthen SBCC (IEC material, USSD platform) for vaccination
- Decentralisation, Integration & Synergies
- Strengthen and broaden Digitization of EPI
- Strengthening vaccine preventable diseases surveillance system
- Information, data management and use
- Community and Civil Society Organizations engagement
- REC Strategy
- Infrastructure
- Determine activities targeting immunization Service continuity
- Building a resilient immunization system (eg. Increase minimum stock level; Human resources)
- Strengthening of Supply chain management
- Assessment of COVID-19 pandemic impact on immunisation services

There is need of strengthened partnerships to reach underserved communities and are now considering engaging Rwanda Interfaith Council on Health (RICH) in SBCC.

In line with the economic recovery plan, under Technology and Innovation, the Government intends to build on existing investments in technology (infrastructure and services) to respond to the pandemic, the challenges brought on by the pandemic and support economic recovery. Among the measures proposed in enhancing healthcare delivery approach we have data management systems including digital services that are proving critical to the pandemic response – e.g., mobile/USSD-based app and Increase smartphone penetration.

- Equity approach:

The recovery plan has an element on access to Health: 1,902,740 Individuals from Ubudehe Cat1 (social categorization) without access to basic health insurance will be supported addressing vulnerable households or households with high risk to fall into vulnerability due to COVID-19.

This plan considers catch up activities especially for HPV vaccination for 2020 and 2021 cohorts for girls who missed immunisation due to COVID-19. Integrating HPV Vaccination in MCH Week activities has been on the strategies that the country has used for HPV Vaccination but the achievements in terms of coverage show a need of catch up especially in district with coverage below 80%. One district, Rusizi, needs even a special consideration having a separate schedule as HPV Vaccination was organize later than other districts (August 2020).

COVID-19 Relief and Social Protection Response Framework, in line with the Presidential orientation provided by His Excellency, the President of the Republic of Rwanda, as reiterated on March 27, 2020: “Relevant institutions are working on a Social Protection Plan, to support the most vulnerable in our community,” among other initiatives including working in collaboration with partners in the region and internationally, to manage the pandemic.”

The Social Protection instruments are deemed potentially viable to anchor the national responsive framework because of the intrinsic principles of Social Protection systems in Rwanda including Gender

responsiveness: All Social Protection intervention shall address specific needs and vulnerabilities for both boys and girls, men, and women alike

The new Partnership with Rwanda Interfaith Council on Health (RICH) in reversing COVID-19 impacts on immunization will help the programme to implement the Gavi's Gender Policy especially in the area of "REACH" by promoting an integrated approach on gender to reach under immunised children, individuals and communities.

Supporting REC micro planning is still key strategy for the programme to keep/improve equity. More activities in relation with the policy will be defined from recommendations Coverage and Equity Assessment (CEA) of immunization services. This assessment would define population groups and communities with lower vaccination coverage and determinants associated with inequities in immunization.

Immunisation financing: No issues as there is a secured line budget to support a functional vaccination programme making vaccines available for continuous immunisation service delivery, and co-financing for the vaccine support. The immunisation program is mainly funded by the GoR, Gavi Alliance, WHO and Unicef.

Rwanda has already begun for a potential introduction of a COVID-19 vaccine when the vaccine becomes available.

Support required from Gavi for the planned short/medium-term

The multi-stakeholder dialogue has defined key priorities and indicated the key technical assistance needs to be funded through PEF TCA as follows:

Priority	Rationale	Objective	Needs (TA)
1) HPV vaccination for 2020 and 2021 cohorts	Difficulties in HPV Vaccination resulting from lockdown situation have delayed the 1st dose for the 2020 cohort and then the 2nd dose of this cohort will be administered alongside the 1st dose of the 2021 cohort. This requires enough supplies in terms of vaccine doses and vaccine devices requiring more logistics than usual. Also, catch-up on missed girls of the 2020 cohort is need especially in districts with low coverages.	Increase coverage for the 2020 cohort	No
2) Digitization : focussing on Vaccine Management and Immunization e-tracker and remote temperature monitoring	Effective delivery of immunisation services	To improve management of vaccine management and quality of immunization data	TA needed for digitalisation of Immunization service (SSA)

Commented [R1]: Show if additional needs or already covered

Commented [R2R1]:

3) Speed up the implementation of system redesign	Availability of vaccines and vaccine devices	Ensure availability of vaccines and vaccine devices at all levels	YES
4) EVM IP	Effective delivery of immunisation services	Ensure high quality of vaccination services	Yes(SSA)
5) Implementation of CCEOP ODP2	Increase vaccine storage capacity	Ensure vaccines potency by proper storage	Yes
6) Application for CCEOP2	Increase vaccine storage capacity	Ensure vaccines potency by proper storage	Yes
7) Supp orting REC micro planning	Effective delivery of immunisation services	Increase/maintain high coverage and equity in vaccination services	Yes (SSA, workshop)
8) Covax (Covid-19 vaccination)	Vaccination as a measure to protect the population against Covid-19	To protect the population against Covid-19	Yes
9) Introduction of hep B Birth dose and IPV 2nd dose	Priority defined in Rwanda PSR	Protect new born against hep B	No
10) Implementation of USSD and SMS reminder	Effective delivery of immunisation services	Increase awareness and demand for vaccination	No
11) Engage Rwanda Interfaith Council on Health (RICH) in SBCC	Effective delivery of immunisation services	Increase awareness and demand for vaccination	No
12) Aeration of EPI Warehouse	Need of cooling the warehouse		
13) Immunization policy and strategic planning (cMYP)	Need of updating the cMYP	Define strategies and interventions of the vaccination program.	Yes
14) Support EPI Committees operations	Effectively delivery of immunisation services	Guide EPI on key decisions	Yes
15) Strengthen Itetero radio program	Increase demand generation of vaccination services	Increase uptake of vaccination services	Yes
16) conduct an assessment of the COVID-19 pandemic impact on immunisation services	Need of planning for long term recovery from Covdi-19 impacts	Inform the long planning recovery	Yes
17) Build capacity of private health facilities for VPDS surveillance through training and supportive supervision	VPDs cases are mainly detected and reported by public health facilities and this was worsened during the period of COVID-19. As we have a great number of population attending private health facilities,	Increase the suspicion rate of VPDs cases especially in private health facilities.	No

	we may lack a lot of information about VPDs cases		
18) Strengthen the capacity of districts to monitor, mentor and coordinate VPDS surveillance activities using GIS based technologies and ODK data collection tool	Currently the supervision or mentorship of health facilities using GIS based technologies is done by the central level. Difficulties to conduct these activities was observed during the period of COVID-19 because surveillance officers were fully involved in COVID-19 control activities	Strengthen the capacity of district in monitoring VPDs surveillance	Yes
19) Initiation of electronic case based surveillance at all levels	Currently the hard copy of case investigation form is filled by the surveillance officer at health facilities level and sent to the national level for entering data in the electronic system. Recording errors or loss of information may result from this practice. The initiation of electronic case based surveillance will help to address those problems and to improve the quality of data	Improve VPDs surveillance data quality	Yes
20) Sensitization of health care providers on VPDs surveillance	Sensitization meetings are necessary to help districts with low performance in VPDs surveillance to improve. This activity should be conducted periodically to minimize the impact of staff turn over	Inform and update health care workers on VPDs surveillance strategies and target to be met	No
21) Community mobilization through spots radio and TV talk show and community outreach	Community awareness plays a great role in early detection and reporting of cases. Community members seek medical care on time or inform health authorities when a VPDs case is	Engage the community in VPDs surveillance	Yes

	suspected.		
22) Formative research	Delayed due to lockdown/COVID-19 and research approvals from NISR and RNEC. Field work started in October and finalization of the formative research report will be in December. Share research findings with RBC/partners in October	To understand gender barriers to accessing services and vaccination uptake and how AGYW (incl young mothers) make decisions regarding their health and health of children. The research will contribute to broader research vaccination programme and KAP study.	No
23) TEGA Baseline and Endline	The activity delayed due to COVID-19 however the baseline will happen in January and endline field work in March. Analysis and reporting will happen in April/May.	Baseline will help us understand where AGYWs in priority are along the behavioural pathways (knowledge, attitudes, intention and practices and the results will be used to develop content tailored to needs. At endline AGYWs will be recontacted to see shifts in their behavioural journeys.	No
24) Outcome evaluation	Delayed due to COVID-19 and now field work planned for March and Endline analysis/report planned for April to May.	An impact theory-based evaluation with respect to NN ASRH SBC objectives (girls speak about ASRH with peers, girls access ASRH services). The evaluation will also integrate indicators of attitudes, intentions and behaviours related to RI.	No

25) Digital scoping	Delays caused by the COVID-19 pandemic but lots of progress happened. The digital scoping strategy is being finalized and a content brief being developed. Recommendations to be finalized and shared with RBC and Alliance partners. Oct – Nov, new technology developed and tested and December to March we'll have digital content on new and existing platforms.	To determine and develop best digital technology to raise awareness and share information about RI, nutrition and accessing health services.	No
26) MoU between Girl Effect and MoH	Signing of the Memorandum of Understanding (MoU) between Girl Effect and MoH (October/November)	To enable Girl Effect to be a core member of the Inter-Agency Committee for Immunisation (ICC), Communications Committee and Knowledge Attitudes and Practices (KAP) Steering Committee to contribute GERs technical expertise as well as a mutual learning opportunity.	No
27) Content disseminated to CHWs	Delays in the engagement of the youth volunteers and CHWs on the youth engagement model, due to COVID-19 and shift of priorities for RBC during the times of COVID-19. From October to December will be development content and in February and March content will be distribution through CHWs.	To engage AGYW on RI, vaccination and nutrition messages. We will use the digital content developed in activity and agree mechanisms for sharing with CHWs via RBC/MoH who directly engage with CHWs.	No
28) Build routine immunization (e.g.	Delay in the activities related to the dissemination of the RI	To create awareness and increase uptake	No

immunisations for children under 2 immunisations, (HPV), maternal tetanus) into the ongoing Girl Effect content	and nutrition content targeting teen mothers through the youth engagement model.		
29) Communication approaches for secondary audiences	Delayed hiring of an organization that works directly with boys and men due to lockdown. Agency (RWAMREC) was contracted in September, in October we'll have the partners workshop and in Feb/March we'll engage teen fathers activities	To spark conversations so that messaging reaches our secondary audiences through our core audience or partners	No
30) Content on Smart classroom computers	Delayed because schools were closed during COVID-19 and government institutions shifted their protities due to COVID-19. Implementation in November to December and from January content will be refreshed in all computers in smart classrooms	To leverage smart classrooms to make Ni Nyampinga content on accessing health services, vaccinations and nutrition available in schools.	No

Roadmap for further medium/long-term planning
The multi-stakeholder dialogue has included among the priorities an assessment of the COVID-19 pandemic impact on immunisation services in order to best facilitate the development of a longer-term response plan. The plan will be developed after the assessment.