Republic of Rwanda
Ministry of Health

World Health Organization

RWANDA COVID-19 INTRA-ACTION REVIEW (IAR)

RWANDA

FOREWORD

On 30 January 2020, the Emergency Committee convened by the Director General under the International Heath Regulations (2005) regarding the outbreak of the novel coronavirus declared the Corona Virus outbreak a Public Health Emergency of International Concern. The fist case of COVID-19 was reported in Rwanda on 14th March 2020. The National COVID-19 steering committee chaired by the Prime Minister was instituted and this has enabled a whole of Government approach to planning and responding to the COVID-19 pandemic. Several public health and social measures were put in place to slow down the spread. The National COVID-19 preparedness and response plan guided the response efforts under the coordination of the National Joint Task Force.

It has been 8 months since the first case of COVID-19 was reported in Rwanda, the Government of Rwanda has implemented a robust response to contain the pandemic. As a country we had to pause, reflect and take stock of the ongoing COVID-19 response to enable us to move forward stronger and better since the pandemic is expected to continue into months ahead. The recommendation of the 4th COVID-19 IHR emergency committee meeting for member states to conduct intra-reviews was therefore timely and as a country we immediately implemented intra action reviews with support from the World Health Organization and participation of health development partners.

Through the review, best practices, challenges and recommendations for improving on the response were identified. I am glad that the findings of this review were immediately utilized in updating the COVID-19 preparedness and response plan. Rwanda will document some of the best practices and share globally. I have appointed a team to follow up on implementation of the recommendations in this report. I must say this was a timely exercise, it was implemented at a period when several countries are experiencing a resurgence in COVID-19 cases. With the festive seasons ahead, the risk of resurgence is anticipated in Rwanda too. Implementation of these recommendations will therefore help in ensuring that any resurgence is managed appropriately, and the impact minimized.

I am delighted to present this intra-action review report which will provide an opportunity for continuous improvement of COVID-19 response in Rwanda and facilitate peer learning between Rwanda and other countries. Let us all join hands to implement the identified recommendations.

Dr Daniel M. NGAMIJE
Minister of Health

EXECUTIVE SUMMARY

The COVID-19 pandemic has brought unprecedented social and economic disruptions globally, while case and death numbers have soared. Rwanda reported the first case of COVID-19 on 14th March 2020. The Government of Rwanda has been working together with partners to contain the pandemic. Response efforts have been guided by the National COVID-19 preparedness and response plan which came to end in August 2020. With the expectation that the COVID-19 pandemic may continue into the months ahead there was need for Rwanda to review the ongoing response efforts to facilitate continual learning and improvement.

Following the 4th COVID-19 IHR Emergency Committee meeting, the WHO secretariat was asked to support countries to conduct Intra-Action Review (IAR) of the COVID-19 outbreak response to document and share best practices, identify challenges and provide recommendations for adjusting/ improving the response. To address this recommendation, WHO developed IAR guidance and tools to support countries to conduct of IAR both at National and Sub-national levels. Rwanda conducted intra-action reviews at national and provincial levels between 27th October 2020 and 9th November 2020 with technical and financial support from the World Health Organization (WHO).

The objectives were: i) To collectively analyse the ongoing in-country response to COVID-19 by identifying challenges and best practices ii) To identify recommendations for addressing the identified challenges and scaling up or institutionalization of the best practices iii) To document and apply lessons learned from the response efforts iv) To use the findings of the intra-action review to update the national COVID-19 preparedness and response plan. The review covered all pillars outlined in the COVID-19 preparedness and response plan. A total of 311 people from the Ministry of Health, Rwanda Biomedical Centre, Prime Minister's Office, Ministry of Local Government, Rwanda Directorate General of immigration and Emigration, Rwanda National Police, National and international organizations participated in the IAR workshops at the different levels (64 in Kigali City, 50 in Eastern province, 40 in Northern province, 49 in Southern province, 55 in Western province and 53 at the National level). This report provides consolidated findings of the intra-action review from national level, Kigali city and the four provinces.

The hall mark of the Rwanda response was quick and decisive actions from the Government Leadership. Some of the key achievements include:

- Prompt implementation and enforcement of public health and social measures

- Setting up provincial level command posts to accelerate decentralization of the response efforts in Rwanda

- Increase in number of laboratories with capacity for COVID-19 testing from one (1) in March to twelve (12) by October 2020

- Increase in population testing rates from 0.25 per 10,000 population in March 2020 to 465 per 10,000 population by October 2020 due to testing of high risk groups which led to early identification of clusters

- Rapidly increasing the number of treatment centres from one in March 2020 to 26 by August 2020 through repurposed infrastructure as the number of cases increased. The bed occupancy rates always remained below 100%

- Increase in COVID-19 ICU bed capacity from 0 in March 2020 to 36 in October 2020 with low case fatality rates of 0.7%

- Low health worker infection rates of 3.6% with no reported deaths among health care workers

Key Messages

1. Strong coordination structures from the village to the national level with high political commitment has greatly contributed to effective COVID-19 response in Rwanda.

2. COVID-19 response in a huge operation with a large number of players at all level. There is need to ensure robust information sharing mechanisms between the actors and clearly defining the reporting pathwas for each player

3. Establishment of the provincial command posts and deployment of technical personnel to the provinces will accelerate attainment of response capacities at the district level. There is need to invest in building capacities of the provincial level command posts based on approved public health emergency operations centres charter

4. During the response, it was difficult to determine the needs across the pillars since COVID-19 was a new disease. Rwanda has experienced different scenarios ranging from no cases to community transmission and should now use the information to conduct scenario based forecasting for different needs

5. Logistics and operations support is a key pillar that enables all the other pillars to function effectively. There is need for a real time logistics management information system

Best practices and areas of improvement were identified across all the pillars and some were similar in all pillars (cross cutting) while some were specific to certain pillars.

Box 1 shows highlights of best practices while Table 1 shows highlights of challenges and recommendations..

Box 1: Highlights of best practices for Rwanda COVID-19 Response

Cross Cutting:
- Leveraging on capacities built during Ebola Virus Disease (EVD) preparedness
- Digital innovations and use of virtual platforms

Coordination
- Setting up village COVID-19 committees with daily reporting systems and structure from the village to the National level.
- Virtual coordination: In Western Province, coordination between provincial and district level was enhanced through online meetings with the district command posts

Data Management
- Digitalization of COVID-19 Data systems for all response components with GIS based systems for real time data collection and spatial analysis
- System for virtual care of patients at home: It enables direct interaction with patient and health professionals

Risk Communication and Community Engagement (RCCE)
- Video conferencing to enhance RCCE coordination at central and decentralized levels
- Engagement of Village and Isibo leaders as well as opinion leaders

Surveillance and Points of Entry
- Utilization of different technologies & innovative approaches in case investigations & contact tracing such as use of bracelets
- Exit & entry requirements put in place which included systematic screening, testing & isolation of all incoming & outgoing travelers, IPC facilities at points of entry

Laboratory
- Developed an action plan to scale up testing. This provided opportunity for increasing the laboratory testing capacity and for resource mobilization
- Design and implementation of pooled testing approach which is cost-effective
- Infection prevention and control
- Innovative Capacity building: Developed and implemented a comprehensive cascade training plan in collaboration with Rwanda College of Physicians
- Monitoring and enforcement of IPC measures

Case Management
- Involvement of all clinical sectors and Medical associations in implementing case management interventions
- Use of Robots in Treatment centres

Logisticts and operations support
- Mechanisms for emergency procurement were put in place
- A centralized management of ambulances, fleet, drivers, vehicle maintenance services and fuel allowed better transport facilitation

Continuity of essential health services
- Reorganization of services and trsnsport system to allow access to essential services and specialized care
- Conducted surveys review to assess or monitor access to essential health services

Table 1: Highlights of challenges and recommendations for Rwanda COVID-19 Response

Challenges	Recommendations
Cross Cutting	
Communication across sectors, levels and stakeholders was a challenge	• Develop a communication plan clearly Defining information sharing mechanisms between different actors and reporting pathways • Video-conferencing: Between command posts, within pillars and inter-pillar
Inadequate Human Resources, equipment, supplies and infrastructure	Determine needs based on different scenarios and conduct needs assessment for HR, supplies, infrastructure
Lack of funds for COVID-19 research	Create mechanisms for providing regular updates, cascade trainings, virtual trainings
Coordination	
Provincial level command posts activated but with limited capacity	• PHEOC charter to be developed and ensure the PHEOCs meet the minimum requirements • Enhance capacities of the provincial level command posts: HR, Equipment
COVID-19 resource tracking done separately for Government and partners resources do not include status of implementation	Develop a tool to jointly track investments including updates on implementation status
Data Management	
Multiple systems for data management with limited interoperability.	Improving the existing data system by creating a platform with different backend system
Limited knowledge and capacity at decentralized level compared to the central level	Build capacities of the district teams on data management
Risk Communication and Community Engagement	
Difficulty in coordinating proper use of approved messages by Non Government Organizations in the communities	• Remind partners of the existence of compass Rwanda which shows the approval mechanisms • Develop a brand manual
Spreading of rumors and misconceptions about COVID-19 via social media	Conduct regular mass and social media monitoring at all levels to allow for timely addressing rumors and misconceptions
Surveillance and Points of Entry	

Deficiency of a clear plan for integrated multi surveillance approaches	Develop a comprehensive COVID-19 surveillance strategy incorporating all the surveillance strategies
Centralized surveillance data analysis	Decentralize surveillance data to the districts to allow for use of data for decision making at the district level
Laboratory	
Insufficient linkages between NRL and decentralized laboratories and unclear sample networking system	Establish a platform for coordination within the pillar and Develop a sample networking guide
Challenges in Maintenance of equipment and lack of back up of some equipment in decentralized laboratories	Allocate budget for equipment maintenance and procure additional equipment
Infection Prevention and control	
Insufficient alignment between IPC guidelines and supply chain of related commodities	Alignment between guidelines and supply chains to have a common understanding of supply needs
Reporting format not harmonized	Establish the harmonized reporting formats
Case Management	
Lack of diagnostic tools including laboratory and imaging services in the COVID-19 treatment centers	Avail diagnostic services in COVID-19 treatment centres
Insufficient follow up of recovered patients post discharge in terms of systematic follow up of recovered patients	Institute a robust follow up mechanism for discharged patients
Logistics and operations support	
Procurement Procedures regulations not set for health emergencies	Put in place a legal framework for emergency situations
Requisition, validation and distribution of supplies done manually	Integrate the COVID-19 logistics planning activities into the CPDS mechanisms
Continuity of essential health services	
Initial COVID-19 structure did not include continuity of essential health services	Update the coordination structure to include continuity of essential services
Challenge in follow up and tracking of patients with chronic diseases	Engage community health volunteers in conducting follow up

These recommendations have been used to inform the development of the new COVID-19 preparedness and response plan. Selected best practices will be identified for documentation and sharing with the global community. The IAR core team will monitor implementation of these recommendations

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CONTENTS

1. INTRODUCTION, RATIONALE AND METHODOLOGY OF THE REVIEW

1.1 INTRODUCTION

TSince the World Health Organization (WHO) declared the 2019 novel coronavirus outbreak a public health emergency of international concern on 30 January 2020, with the disease later designated as COVID-19, the pandemic has brought unprecedented social and economic disruptions globally, while case and death numbers have soared. Rwanda reported the first case of COVID-19 on 14th March 2020. Following the declaration, the Government of Rwanda implemented several public health and social measures aimed at slowing down the spread of COVID-19. The National Public Health Emergency operations center (NPHEOC) was activated to coordinate the response efforts with the National COVID-19 preparedness and response plan (March-August 2020) as the guiding document. The plan outlined the preparedness and response strategies and activities based on the following preparedness and response pillars:

- Leadership and Coordination

- Epidemiological Surveillance

- Laboratory

- Case Management

- Infection prevention and control (IPC)

- Risk communication and community engagement (RCCE)

- Logistics

In collaboration with development partners, the Government of Rwanda has been implementing preparedness and response interventions across the different pillars to mitigate the impact of the outbreak. The focus of the response had been on prompt detection of cases, scaling up testing capacities, isolation and treatment of confirmed cases and contacts tracing.

1.2 RATIONALE

As of 31st October 2020, a total of 5137 confirmed of COVID-19 including 35 deaths had been reported in Rwanda. The public health and social measures that the Government of Rwanda put in place at the beginning of the outbreak contributed to slowing down the spread of the COVID-19. However with easing of lockdown measures and cross borders movement of goods, different clusters of cases were reported in different parts of the country. With the expectation that the COVID-19 pandemic may continue into the months ahead there was need for Rwanda to review the ongoing response efforts to facilitate continual learning and improvement. In addition, the national COVID-19 preparedness and response plan came to an end in August 2020. The outputs of the

intra-action review will be used to guide the review of the National COVID-19 preparedness and response plan.

1.3   OBJECTIVES

- Share experiences and collectively analyse the ongoing in-country response to COVID-19 by identifying challenges and best practices

- To identify recommendations for addressing the identified challenges and scaling up or institutionalization of the best practices

- To document and apply lessons learned from the response efforts to date to enable health systems strengthening

- To use the findings of the intra-action review to update the national COVID-19 preparedness and response plan

1.4   SCOPE

The Review focused on the following pillars

- Leadership and Coordination
- Epidemiological Surveillance and points of entry
- Laboratory
- Case Management
- Infection prevention and control (IPC)
- Risk communication and community engagement (RCCE)
- Logistics
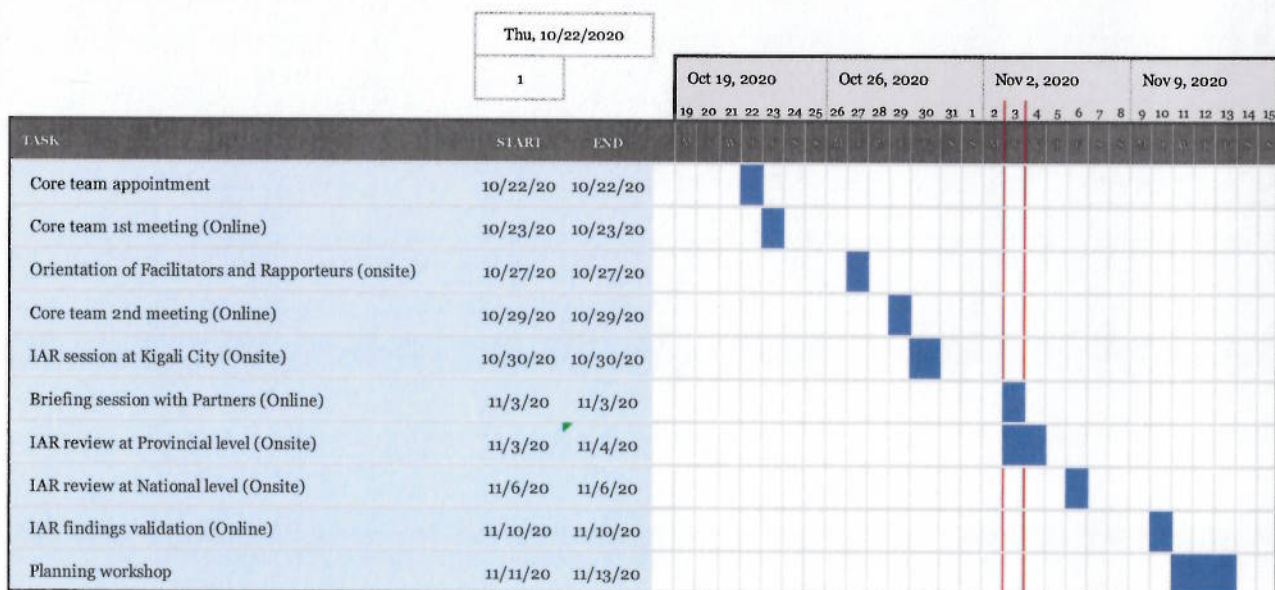- Continuity of essential health services
- Data Management

1.5. LEVELS OF REVIEW

The Rwanda intra action review was done at National and Sub-National levels

2. INTRA ACTION REVIEW METHODOLOGY

The core team was appointed to spearhead planning and implementation of the intra-action review. The team brainstormed and agreed on the road-map below for the implementation of intra-action review in Rwanda:

Rwanda Intra-Action Review

TASK	START	END	Oct 19, 2020	Oct 26, 2020	Nov 2, 2020	Nov 9, 2020
Core team appointment	10/22/20	10/22/20				
Core team 1st meeting (Online)	10/23/20	10/23/20				
Orientation of Facilitators and Rapporteurs (onsite)	10/27/20	10/27/20				
Core team 2nd meeting (Online)	10/29/20	10/29/20				
IAR session at Kigali City (Onsite)	10/30/20	10/30/20				
Briefing session with Partners (Online)	11/3/20	11/3/20				
IAR review at Provincial level (Onsite)	11/3/20	11/4/20				
IAR review at National level (Onsite)	11/6/20	11/6/20				
IAR findings validation (Online)	11/10/20	11/10/20				
Planning workshop	11/11/20	11/13/20				

Thu, 10/22/2020 — 1

3. PARTICIPANTS

A total of 311 representaives from the Ministry of Health, Rwanda Biomedical Centre, Prime Minister's Office, Ministry of Local Government, Rwanda Directorate General of immigration and Emigration, Rwanda National Police, National and international organizations participated in the IAR workshops at the different levels (64 in Kigali City, 50 in Eastern province, 40 in Northern province, 49 in Southern province, 55 in Western province and 53 at the National level). This report provides consolidated findings of the intra-action review from national level, Kigali city and the four provinces.

4. FINDINGS

KEY ACHIEVEMENTS

- Robust coordination structures with functional District, Provincial and National level PHEOCs
- Prompt implementation and enforcement of public health and social measures
- Setting up provincial level command posts to accelerate decentralization of the response efforts in Rwanda
- Increase in number of laboratories with capacity for COVID-19 testing from one (1) in March to twelve (12) by October 2020
- Increase in population testing rates from 0.25 per 10,000 population in March 2020 to 465 per 10,000 population by October 2020 due to testing of high risk groups which led to early identification of clusters
- Rapidly increasing the number of treatment centres from one in March 2020 to 26 by August 2020 through repurposed infrastructure as the number of cases increased. The bed occupancy rates always remained below 100%
- Increase in COVID-19 ICU bed capacity from 0 in March 2020 to 36 in October 2020 with low case fatality rates of 0.7%
- Low health worker infection rates of 3.6% with no reported deaths among health care workers

BEST PRACTICES, CHALLENGES AND RECOMMENDATIONS

4.1. Country-level coordination, planning and monitoring

Observations

Best practices	- Multisectoral response governance bodies established at different levels to create clear command lines - Use of ICT to strengthen coordination: In the Western Province, coordination of the districts was done through online meetings with the district command posts to share experiences and facilitate information sharing - Involvement of the community to mitigate impact of COVID-19 through: i) Setting up village COVID-19 committees with daily reporting systems and structure from the village to the National level. This led to relaying of information/measures as well as assessing and reporting local needs

Best practices	ii) Communication via local radio, megaphones, drones and all available means was effective
	• Greater involvement of the private sector led to faster and home-grown solutions to supply problems e.g. in production of hand sanitizers
	• Decentralization of the COVID-19 response with subsequent setting up of the command posts at the provincial level
	• Development of new procurement and financial policies to ensure prompt procurement equipment and supplies to respond to the pandemic
	• At high level, the Development partners coordination group (DPCG) used the existing platform to discuss the impact of COVID-19 across sectors
	• Prompt implementation of evidence based interventions. The response strategies were promptly reviewed based of new evidence and knowledge
	• Due to the spirit of volunteerism, several individuals participated in the response without any pay. This included professionals, youth volunteers and other individuals
	• Active mobilization and participation of all stakeholders in supporting vulnerable population with subsequent setting up of structures for chanelling food support to the vulnerable groups
	• National COVID-19 Plan and guidelines developed quickly to guide operations and resource mobilization
	• In Southern province, there was peer learning and peer review among districts on outbreak response and active participation of the private sector foundation (PSF) in response
Challenges	• Absence of SOPs of COVID-19 related to Leadership & Coordination at the beginning of the pandemic.
	• When COVID-19 was reported in the Country, the role of the existing PHEOC setup for Ebola was initially not clear
	• The provincial public health emergency operations centres were activated in the 4 provinces without full information on their terms of refence, mandates and their linkages with the district teams
	• Though Multisectoral response governance bodies were established, communication and information sharing across the different levels, sectors and key players in the response was not optimum
	• Budget constraints affected timeliness of response interventions
	• COVID-19 resource tracking was done separately for Government and health development partner resources

Challenges	- Health Development partners jointly tracked COVID-19 resources with an improvised tool to avoid duplication in activities. However the tool had limitations including: - No indication of implementation status of the activities - No indication on whether the funds had been spent or not - Shortage of human resources, infrastructure and equipment to coope with the emergency - Limited knowledge on COVID-19 and outbreak management especially since COVID-19 was a new disease with frequent adjustements in strategies

Recommended actions

For immediate implementation:

- Develop SOPs related to leadership and Coordination

- Revise the mandate, membership and functioning of PHEOC before and during an emergency for the National, provincial and district PHEOCs

- Scale up coordination at the different levels through online mechanisms like it was done in Western province

- Sustain the village level committees

- Share daily/weekly response updates among the key players

- Review the existing partner coordination mechanisms and embed COVID-19 coordination within the existing Government coordination systems

- MoH to articulate the best format to map donor commitments to track COVID-19 investments

- Determining upfront the role of each partner in a crisis as well as response channels/structures. Beyond COVID, ongoing and consistent communication channels between MoH and partners for better coordination and joint planning

- Conduct needs assessment to determine the equipment requirements and develop a single equipment procurement plan

- Provide regular written updates as new evidence becomes available or as strategies change

- E-learning on emerging and re-emerging health conditions

- ncrease Investment into private health activites (Private companies' dealing with waste management and IPC)

For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:

- Effective planning and budgeting for unforseen emergencies during annual planning and budgeting

- Modify the Health Resource Tracking Tool (HRTT) to be fit for purpose and use it for tracking COVID-19 resources going forward

- Develop a training plan that will eneable the country to train and staff each ICU unit adequately with some minimal capacity at provincial level.

- Training in health security studies (i.e. Msc epidemiology , biomedical engineering)

- Specialized infectious disease facilities/hospitals (Fixed and Mobile)

- Strengthen Public health emergency center to constantly monitor threats and advise on course of actions

4.2. Data Science and IT solutions (Data management included)

Observations

Best practices	- Digitalization of COVID-19 Data systems (paperless system): I. Case investigation form II.Laboratory process III. Results (SMS,E-mail,certificate, self-results portal) IV. Passenger locator form for travelers - Home-grown digital innovations: i) GIS based systems (The system is being used in all areas of COVID-19 interventions for real time data,storage, spatial analysis, mapping) ii) Electronic cargo truck drivers system (this is the system that was developed to enable crossborders movement within EAC) - Development of contact tracing system linking cases and contacts - Electronic Medical Records (EMR) for COVID-19 (the system was developed for daily follow up of patients in treatment centers, recording clinical events and treatment offered to patient. It is a live system) - Development of home-based care data system (The system was developed to assess HBC eligibility, Case identification, Household assessment, patient follow up and generate key indicators) - System for virtual care of patients at home. It enables direct interaction with patient and health professionals) - Evacuation system (based on GIS and ODK) (Evacuation system was developed to track rapid response process)

Challenges	• "Linkage between DHIS2, EMR and HBC to ensure data quality and reduce both time and human resources
	• Lack of passenger locator system for land border
	• Multiple systems and dependency of systems with limited interoperability
	• Limited knowledge and capacity at decentralized level
	• Lack of enough human resources for data management

Recommended actions

a. For immediate implementation:
- Develop COVID-19 tracking system at land borders
- Capacity building of decentralized level

b. For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:
- Strengthen the data management team capacity with required expertise
- Improving the existing data system by creating a platform with different backend system

4.3. Risk communication and community engagement

Observations

Best practices	• Pre-existence of the National Emergency Operations Centre with the Risk Communication and Community Engagement (RCCE) Task Force at central and decentralized levels.
	• The Country had the National Response Plan which included the Risk Communicaiton and Community Engagement (RCCE) compotent and all related Standard Operating Procedures (SOPs) in place.
	• Application of the multisectoral, multi-channel approach to RCCE with focus on equity, equality and inclusion.
	• Video conferencing to enhance RCCE coordination at central and decentralized levels.
	• Strengthened capacity of the existing and newly established RCCE Task Forces and media practitioners at all levels.
	• Maintaining the existing and establishing new mechanisms for feedback collection and rumour tracking.
	• Adressing the message fatigue by regularly reviewing and updating the RCCE strategies and approaches.
	• Availability of key messages and communication materials developed at the national level and disseminated at district and community levels.
	• Availability of the trained RCCE Task Force members at District level.
	• Targeted mobilization for people with poor behaviours on COVID-19 prevention measures.
	• Engagement of Village and Isibo leaders as well as opinion leaders

Challenges	• Lack of dedicated RCCE financial, human resources and capacity development opportunities at decentralized levels. • Spreading of rumours and misconceptions about COVID-19 via social media channels. • Difficulty in coordinating proper use of approved messages by Non Government Organizations in the communities

Recommended actions

For immediate implementation:

- Finalize and disseminate a comprehensive Multi Hazard RCCE Strategy
- Develop a new evidence - based COVID-19 Risk Communication and Commuity Engagement Plan inspired by the National Multi-Hazard RCCE Strategy and the lessons learned during the COVID-19 pandemic.
- Continue to develop/update/adapt all necessary communication materials to use via a variety of channles and disseminate them to all levels.
- Continue to design and disseminate new mass media campaigns and community engagement interventions based on emerging behavioural patterns among key audiences;
- Conduct regular mass and social media monitoring at all levels to allow for timely addressing rumours and misconceptions.
- Maintain the existing mechanisms for feedback collection and rumour tracking and reinforce the new ones, including through the technology-based solutions/applications.
- Update the Terms of Reference of RCCE Task Forces and their members from the central up to the village level.
- Conduct regular capacity development of existing and new RCCE Task Forces at all levels.
- Continue to document successes and challenges of the RCCE interventions to share with decision-makers, private sector and international donor community to enhance the resource mobilization effort;
- Maintain and enhance partnerships with the mass media outlets at all level and ensure regular communication through various formats (e.g. press conference, field visits, interactions with the COVID-19 survivors, engage social media influencers and artists, etc...).
- For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:
- Equip the remaining districts with Electronic billboards, drones, radios in markets and taxi parks and any other innovative equipment to facilitate wide and timely communication with the community.
- Update the Terms of Reference of RCCE Task Forces and their members from the central up to the village level.
- Establish the roster of national and international RCCE experts.
- Conduct regular mapping of RCCE stakeholders and available human and financial resources.
- Explore opportunities of sustaining additional RCCE Human Ressource capacities at the central level to support interventions at all levels.
- Explore opportunities of partnering with academia to establish a cross-sectoral Social and Behaviour Change training course.

4.4. Surveillance and Points of Entry

Observations

Best practices	• Case investigation forms, guidelines & SOPs were provided during COVID-19 preparedness phase to give orientation to healthcare providers to appropriately detect, manage & respond to COVID-19 cases • Utilization of different surveillance approaches in case identification such as Lab surveillance and Community surveys..etc • Investments in field epidemiologists (graduates & trainees) Additionally, at decentralized level, RRT and surveillance teams had previously (over the years) received trainings on outbreak detection, management and response as well as EVD • Utilization of different technologies & innovative approaches in case investigations & contact tracing such as use of bracelets • Findings from case investigations were used in informing decisions • Exit & entry requirements were put in place which included (systematic screening,testing & isolation of all incoming & outgoing travellers, IPC facilities at points of entry
	• Lack of tailor made Covid-19 Surveillance SOPs & guidelines for specific groups. Available SOPs were also bulky, difficult to use (In English only) and lacking job aids • Surveillance of COVID-19 was not continous at all levels and didn't consider the use of different existing surveillance approaches such as ILI & SARI surveillance, Mortality surveillance, community surveillance. It was mainly based on several adhoc surveillance approaches and missed a well defined plan for that integrated multi surveillance approaches • Insufficient epidemiologists to support response across the country as well as limited skilled personnel caused workload and inexhaustiveness of field investigations. • Insufficient adjustments in surveillance strategic approaches during the transition of the COVID-19 outbreak from containment phase to mitigation phase • Inadequate harmonization in implementation of agreed on protocols in neighbouring countries • Absence of public health strategy at POEs resulted in no pre-planned isolation holding areas and essential infrastructures at POEs. Additionally, there were no optimum measures to mitigate infection risk among essential workers at borders • Centralized surveillance and data analysis made it difficult for districts to effectively conduct and use their own surveillance data for rapid decision making at their levels • Some policies that were being implemented during the response were verbal & not written

Recommended actions

For immediate implementation:

- Develop a comprehensive COVID-19 surveillance strategy, guidelines, tools and implementation plan that take into consideration all surveillance approaches

- Decentralize surveillance data to the districts to allow for use of data for decision making at the district level

- Develop POE public health strategy and establish a joint committee to monitor the implementation of regional protocols and agreements

- Build capacities of frontliners at both national level & district level on COVID-19 guidelines, SOPs & Protocols

For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:

- Increase enrollment intake of FELTP graduated & trainees & ensure that they are from different sectors

- Integrate COVID-19 in IDSR & influenza sentinel surveillance and train health care providers

- Establish a multisector collaboration at central and decentralized levels for information sharing on public health events/threats

4.5. THE NATIONAL LABORATORY SYSTEM

Observations

Best practices	- Plans, guidelines and SOPs for detection of common infectious diseases outbreaks (Ebola, Influenza, rift-valleys) were already available and the team leveraged on these documents - Developed the action plan to scale up testing which provided an opportunity for increasing the laboratory testing capacity and for resource mobilization - Digitalization of Laboratory system from sample collection until results dissemination using HMIS, where results are delivered via phone short message service (SMS) and E- mail. - Design and implementation of pooling testing approach which is cost-effective for SARS-CoV-2 testing - Scale up of SARs-CoV-2 testing from 1 site to 12 sites within 5 months - Established collaboration with international reference laboratory for Proficiency testing (PT) materials for SARs-CoV-2 testing - Appointment system in the country was in place where national reference laboratory (NRL) was conducting accreditation throughout network laboratories - Update of lot to lot validation and verification of equipment according to supplies - Very good performance as evidenced by 100% Score in External Quality assurance from WHO/AFRO

Challenges	• Incomplete COVID-19 Policies and procedures of sample collection and testing at decentralized levels
	• Insufficient supply of reagents and consumables for SARS-CoV-2 testing.
	• Maintenance of equipment and lack of back up equipment in decentralized laboratories.
	• Biosafety standard during the outbreak of COVID-19 outbreak.
	• Insufficient staffing and equipment especially at the decentralized laboratories
	• Lack of funds for research on SARS-CoV-2.
	• Ongoing Accreditation for decentralized laboratory network
	• Insufficient transport facilities (permanent) to get samples collected at PoEs to the testing laboratories

Recommended actions

For immediate implementation:

- Institute an automated inventory tracking of laboratory supplies

- Avail the reagents and consumables for SARS-CoV-2 testing

- Procure back up equipment and related PCR needs to strengthen the molecular laboratory for SARS-CoV-2 testing in all testing sites.

- To allocate the budget for COVID-19 related laboratory biosafety equipment and waste management.

For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:

- To allocate the budget for maintenance of equipment

- To allocate the budget for research projects on genomic and other SARS-CoV-2 topic

- To allocate budget for the implementation of quality management and accreditation at all testing laboratories.

- To allocate the budget for training of laboratory staff on laboratory preparedness to public health emergencies.

4.6. Infection prevention and control

Observations

Best practices	• COVID-19 IPC leveraged on existing capacities from EVD IPC investments in IPC for EVD including POE/ isolation/ Quarantine infrastructure, health worker capacity, SOPs and guidelines, supplies, and organizational structures
	• Strong Coordination of IPC staff from central level to the district level
	• Quick provision of commodities/material related to epidemics response leveraging on the pre-exisiting stock of EVD preparedness
	• Involvement of private sector in production of IPC supplies
	• Innovative Capacity building approaches including virtual and onsite mentorship
	• Automatic hand washing facilities in all public places (markets,schools)and HFs installed
	• Good Collaboration with private sectors, Health professionals, local leaders, security organ on IPC implementation.
	• Monitoring and enforcement of IPC measures
Challenges	• Insufficient facilities to enable adequate IPC/Standard Precautions e.g WASH Services, isolation/quarantine, waste management , laundry maintenance and water supply
	• Insufficient capacity of medical and non-medical health staff to provide services while practicing adequate IPC and standard precautions
	• Alignment of specifications on use of IPC supplies: some supplies provided with varying specifications, making use difficult as protocols are around one set of specifications
	• Insufficient PPE and environmental cleaning supplies
	• Some guidelines and SOPs are not covering completely the government of human resources on IPC
	• Insufficient training, mentorship and monitoring on IPC
	• Insufficient alignment between guidelines and supply chain
	• Reporting format not completely harmonized

Recommended actions

For immediate implementation:
- Conduct a baseline assessment of IPC/WASH services at detailed level in HF, community and public places
- Review and strengthen official IPC training materials, consider separating from Case Management
- Deliver separate IPC trainings for targeted groups (ie medical staff and non-medical/support staff).
- Ensure sustainability of connectivity and ability of HF staff to join virtual training and meetings

- Review IPC guidelines and SOPs to ensure each is appropriate, based on learning in 2020.
- Develop SOP on IPC supply management
- Increase human resources capacity on IPC in MOH and RBC
- MOH/RBC to ensure IPC kits/ supplies are delivered to all HF, pending supply availability in RMS
- Share training database with key IPC partners to assess what has been delivered and to whom it is designed .
- Put in place a coordination mechanism to specifically coordinate IPC assessments, monitoring, capacity building, planning, financing, and implementation
- Alignment between guidelines and supply chains to have a common understanding of supply needs
- Establish the harmonized reporting formats
- Reinforce Collaboration and coordination of COVID-19 response teams

For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:

- Review IPC/WASH Standards and indicators and link monitoring of IPC/WASH facilities to existing monitoring systems.
- Invest in upgrading and maintaining IPC infrastructures and equipment, waste management equipment and laundry services
- Increase supportive IPC mentorship and supervision
- Conduct periodic capacity assessment to measure improvements (link to Quality Improvement Program)
- Invest in connectivity and improve software platforms to scale up virtual, low-cost, low-infection risk training
- Quarterly monitoring availability and usage of IPC supplies
- Avail a dedicated area for covid-19 screening and triage in all health facilities,

4.7. Case management and knowledge sharing about innovations and the latest research

Observations

Best practices	• Availability of COVID-19 guidelines related to case management
	• Involvement of all clinical sectors and Medical associations in implementing case management interventions
	• Availability of holding rooms at Health Centers before transfer at Hospitals Isolation
	• Implementation of home based care approach with efficient referral system for transfer of severe cases.
	• Training a broad range of facilitators in COVID-19 response (doctors, nurses, involvement of youth volunteers to support

Best practices	• Not mixing COVID-19 patients with other patients in the hospitals (using different facilities for COVID-19 patients) • Home delivery/supplies of medications to the elderly & extension of extra care to flagile community • Flexibility in response to expand COVID-19 management: increase of treatment centers, facilities, staff, and materials to match with the burden of cases
Challenges	• Insufficient diagnostic tools including laboratory and imaging services in the COVID-19 treatment centers • Insufficient knowledge of staff in managing critical COVID-19 patients • Insufficient equipment and infrastructure including ICU and High Dependancy Care Units • Insufficient number of staff trained to provide care to COVID-19 patients • Insufficient experience in handling post discharge patients • Insufficient isolation facilities meant for infectious response • Insufficient psychological support for the patients and their families

Recommended actions

For immediate implementation:
- Avail diagnostic services in COVID-19 treatment centres
- Set up and equip high care facilities (ICU and HDU) in each of the provinces
- Cascades of trainings for health care workers
- Equip isolation rooms established in health facilities across Rwanda
- Institute a robust follow up mechanism for discharged patients

For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:
- Develop guidelines of staff recruitment and demobilization after the outbreak
- Construct a facility for infectious diseases

4.8. Operational support and logistics in the management of supply chains and the workforce

Observations

Best practices	• Early preparedness and response planning for needed equipment and materials supplies before the first case was reported • Availability of guidelines on COVID-19 for logistics support at different levels (national, district, quarantine, isolation, and treatment Centers) • Ebola/malaria supplies and existing national stock was used as a starting point • Existing integrated supply chain system allowed proper management of supplies

Best practices	• Public Institutions including Districts were enabled to conduct emergency procurement processes by single sourcing or requesting for purchase orders under the guidance of RPPA • Existence of a multi-disciplinary team in the COVID-19 management team (IT, administration, pharmacists, medical professionals, biomedical engineers, civil engineers, epidemiologists, logistics staff, EHO, Security organs, communication staff) • Ability to mobilize public/private institutions and NGOs for logistical support in the first 5 months. A centralized management of ambulances, fleet, drivers, vehicle maintenance services and fuel allowed better transport facilitation across the country against all needs • Public Institutions including Districts mobilized vehicle fleet in all institutions such as hospitals, security organs, schools...etc. Vehicle maintenance & needed fuel were provided using existing contracts. In addition, using existing government contracts additional vehicles were rented. • Mobilization of Public servants and Volunteers to participate in COVID-19 response • Mobilization of social support for the population in need, during lockdown and afterwards • Mobilization of funds for emergency procurement of needed supplies • Flexibility of different institutions to avail their infrastructure to be used as treatment centers , quarantaine sites during COVID-19 rapid response. Different infrastructures were used/rehabilitated to manage suspected & confirmed COVID-19 cases eg schools,hotels,health centers, renting houses etc • In order to scale up human resources, material, funds during COVID-19 response, the districts: conducted different needs assessment to identify priorities, Mobilized funds from different financial entities, Engaged central level & different partners for support, etc • Availability of robots and other technologies to ease the healthcare services while providing protection to helth providers and their patients, through collaboration between the GoR and Partners (UNDP, etc)
Challenges	• Insufficient financial resources for logistics (transport, medical equipment and lab commodities, nonmedical equipment, ...) • Requisition, validation and distribution of supplies done manually • Procurement Procedures regulations not set for health emergencies • Incomplete records of consummed materials/ health commodities at sites • Lack of pre-identified personel and healthcare professionals to use in emergency situations • Insufficient equipment for critical care intervention (oxygen therapy equipment, ICU) • Incomplete procedures for the recruitment and dispatch of a surge human resource capacity • Insufficient transportation facilities at the district level

Challenges	• Limited budget to respond to logistics matters at the district level (payments for medicines, for services,...)
	• Public/Private Institutions and NGOs withdrew their contribution in logistics support too early

Recommended actions

For immediate implementation:

- Avail adequate national stockpile of emergency supplies and develop full methods of resupplying
- Put in place a legal framework to recruit and manage human resources in emergency situation
- Strengthen the health and social structures at the community level namely isibo and CHWs to be able to respond to emergency situations.
- Put in place instructions that details procurement methods in relation to types and levels of emergency situations
- Setting up of isolation units in targeted health facilities and sites for emergency case management
- Design a procedure manual (SOP) for stock management in emergency situation.
- Develop tools for the site logistics management

For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:

- To include in the National Budget, the budget line for public health emergencies
- Establish preparedness and planning tools for emergency situations management
- Engage institutions and NGOs to have a certain percentage of their resources dedicated for emergencies
- Have a pre-determined source of staff for emergency situations. Put in place a mechanism for availing human resources in emergency situation
- Ensuring that existing and new isolation and treatment units meet all necessary standards
- Set up proper ICUs for management of severy and critically ill COVID-19 cases

4.9. Maintaining essential health services during the COVID-19 outbreak

Observations

Best practices	• Effective coordination and collaboration among health facilities, communities and district administration to ensure health services continuation
	• Reorganization (special arrangement) of transport system for patients (patients who needed high level health care services such as Pregnant women, elective cases, mental health cases), COVID19 suspected cases and health care workers
	• Reorganization of services to allow access to essential and specialized care by introduction of outreach model for NCDs including cancer patients, MCH services, Dental diseases, mental disease, bed nets distribution, creation of temporally sites for immunization e.g cancer, HIV drugs, outreach services for MCH, NCDs through collaboration between MoH and RSSB
	• Enhanced IPC measures at HFs including screening and triage of patients, use of PPEs, establishment of mobile and permanent hand washing stations, etc)
	• Use of volunteers (youth volunteers, red cross volunteers) to ensure minimum personnel are assigned to COVID19 related duties (isolations, transit sites, treatment sites) thus ensure health service continuity
	• Quick establishment of isolation rooms at HFs, quarantine and treatment Centres for COVID-19 based on the trend of the pandemic
	• Commitment of multi-sectorial staffs and re-appointment of districts staffs based on their various profiles for command posts;
	• On-site capacity building for multi-sectorial staffs involved in COVID-19 prevention and response at decentralized level
	• Conducted surveys/indicator review to assess or monitor access to essential health services such as reproductive, maternal and child health services and utilization of service in general
	• Use of digital platforms to assess challenges and needs at HFs
	• Regular monitoring of essential health commodities
	• Specific arrangement to allow provision of NCDs, HIV/AIDS medicines for 2 to 3 months and supply of health commodities by drones;
Challenges	• Delayed or unclear guidance was issued initially for maintain essential health services as the Global COVID-19 Preparedness and Response Plan only focused on the 8 pillars directly related to Emergency prepared and response
	• Limitation to conduct MCH campaign during the peak of the pandemic, outreach activities especially child growth monitoring, follow up of pregnant women and newborns due to COVID-19 measures
	• Challenges to implement IPC standards due to insufficient IPC supplies at some places; infrastructure not allowing proper patient flow pre-designed regarding to IPC standards in case of Pandemic; Inadequate disposal of untreated waste (used chlorine), insufficient or instable source of water in public places

Challenges	• Shortage of health providers due to many sollicitations (Response team, tracing team, data managers, lab. technicians,....)
	• Challenge in follow up of patients with chronic diseases, palliative care patients and tracking them
	• Difficulties in supply chain of COVID19 related items due to global shortage (PPEs, Testing Kits) and also supply chain of some medicine because of global shotdown (difficult to ship medicines and health commodities)
	• Limited ambulances and other operational vehicles for covid-19 coordination activities;
	• Insufficient isolation infrastructures adapted to vulnerable groups (e.g. children, pregnant women,...)

Recommended actions

For immediate implementation:

- Update the COVID-19 Treatment guideline to include the key essential services
- Continue to establish designated rooms/units within the health facilities for management of COVID-19 separate from Non COVID -19 patients
- Strength capacity of health care workers in screening and Triaging and isolation of patients
- Ensure the continuity of risk reduction and mitigation measures for COVID-19 transmission, strengthening IPC facilities to implement priority measures, in all health service delivery points
- Continue to strengthen and establish isolation facilities at Provincial and District levels by equiping and capacity building of health facilities
- Institutionalize monthly /quarterly data analysis to monitor the use of services
- Routinely report and analyse the overall impact of the pandemic on health service provision and utilization by using a small set of core indicators

For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:

- Assess supply chain management, monitor and report on the availability of health supplies in health facilities
- Map lists of essential services to resource requirements, including medicines, diagnostics, medical devices, and other supplies. Use and adapt existing reference lists as appropriate to monitor availability.
- Reorganization of health services and resume services which were reprogrammed (clinical outreaches, campaigns, ect)
- Utilizing online learning platforms and mobile technology to provide key training (e.g. on management of time sensitive conditions and common undifferentiated presentations in frontline care), clinical decision support and direct clinical services (e.g. telemedicine), as appropriate
- Develop and orient health care providers on digital tools to improve service delivery

- Renovate or improve existing infrastructures per IPC standards
- Construction of permanent hand washing stations where it is still missing
- Central level and Districts to mobilize resource and procure ambulances and operational vehicles based on the existing gaps

KEY MESSAGES

1. Strong coordination structures from the village to the national level with high political commitment has greatly contributed to effective COVID-19 response in Rwanda.

2. COVID-19 response in a huge operation with a large number of players at all level. There is need to ensure robust information sharing mechanisms between the actors and clearly defining the reporting pathwas for each player.

3. Establishment of the provincial command posts and deployment of technical personnel to the provinces will accelerate attainment of response capacities at the district level. There is need to invest in building capacities of the provincial level command posts based on approved public health emergency operations centres charter.

4. During the response, it was difficult to determine the needs across the pillars since COVID-19 was a new disease. Rwanda has experienced different scenarios ranging from no cases to community transmission and should now use the information to conduct scenario based forecasting for different needs.

5. Logistics and operations support is a key pillar that enables all the other pillars to function effectively. There is need for a real time logistics management information system.

6. ANNEXES

Annex 1: List of participants and Intra-Action Review (IAR) team.

Republic of Rwanda

Ministry of Health

Attendance List

World Health Organization

Rwanda COVID-19 Intra-Action Review (IAR) Workshop
Central Level Intra Action Review
Kigali, 6ᵗʰ November 2020

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ANNEX 2: AGENDA OF THE REVIEW

Republic of Rwanda
Ministry of Health

World Health Organization

RWANDA COVID-19 INTRA-ACTION REVIEW (IAR)

TIME	SESSION	RESPONSIBLE PERSON
08:30-09:00	Registration and administrative formalities and instructions	Admin
09:00-09.20	Introduction of the participants	Dr. Theophile
09:20-9:40	Opening Remarks · Director General RBC · WHO Country Representative · Hon. Minister of Health	Dr. Albert
09:40-10:00	Introduction: Response plan and actual timeline of the response	
10:00-10:20	Intra-Action Review Overview	Dr. Jose Nyamusore
10:20-10:40	Intra-Action Review Methodology	Dr. Elizabeth Mgamb
10:40-11:00	**Coffee break**	**Admin**
11:00-13:30	**Session 1 - What worked well? What worked less well? And why?** *Participants work to identify best practices, challenges enabling factors and limiting factors*	Lead Facilitators
13:30-14:30	Lunch	Admin
14:30-15:30	**Plenary: What worked well? What worked less well? And why?** *Different pillars present the identified best practices, challenges enabling factors and limiting factors*	Dr. Albert
15:30-17:00	**Session 2 - What can we do to improve the COVID-19 response?** *Participants work to identify what can be done to strengthen the ongoing COVID-19 response.*	Lead Facilitators
17:00-17:30	**Session 3 - The Way Forward:** *discussion on the best way to implement these activities moving forward.*	Dr. Albert
17:30	Coffee break and Departure	Admin