



Section 1 Pentavalent programme

Solomon Island VACCINE SUPPORT

This Decision Letter sets out the Programme Terms of a Programme.

1. Country: Solomon Island				
2. Grant Number: 1115-SLB-04a-X				
3. Date of Decision Letter: 21 October 2013				
4. Date of the Partnership Framework Agreement: 29 April 2013				
5. Programme Title: New Vaccine Support				
6. Vaccine type: Pentavalent				
7. Requested product presentation and formulation of vaccine: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID				
8. Programme Duration¹: 2008-2015				
9. Programme Budget (indicative) (subject to the terms of the Partnership Framework Agreement):				
	2008-2013	2014	2015	Total ²
Programme Budget (US\$)	US\$890,762 ³	US\$65,500	US\$102,000	US\$1,058,262
10. Vaccine Introduction Grant: Not applicable				

¹ This is the entire duration of the programme.

² This is the total amount endorsed by GAVI for the entire duration of the programme. This should be equal to the total of all sums in the table.

³ This is the consolidated amount for all previous years.

11. Indicative Annual Amounts (subject to the terms of the Partnership Framework Agreement):⁴

The Annual Amount for 2014 has been amended.

Type of supplies to be purchased with GAVI funds in each year	2008-2013	2014
Number of Pentavalent vaccines doses	-	29,700
Number of AD syringes	-	30,500
Number of re-constitution syringes	-	-
Number of safety boxes	-	375
Annual Amounts (US	US\$890,762 ⁵	US\$65,500

12. Procurement agency: UNICEF. The Country shall release its Co-Financing Payments each year to UNICEF.

13. Self-procurement: Not applicable.

14. Co-financing obligations: Reference code: 1115-SLB-04a-X-C According to the Co-Financing Policy, the Country falls within the group intermediate. The following table summarises the Co-Financing Payment(s) and quantity of supply that will be procured with such funds in the relevant year.

Type of supplies to be purchased with Country funds in each year	2014	2015
Number of vaccine doses	7,900	14,700
Number of AD syringes	8,100	
Number of re-constitution syringes		
Number of safety boxes	100	
Value of vaccine doses (US\$)	US\$15,192	
Total Co-Financing Payments (US\$) (including freight)	US\$17,500	US\$32,500

15. Operational support for campaigns: Not applicable

16. Additional documents to be delivered for future disbursements: The Annual Progress Report 2013 must be provided by 15 May 2015

17. Financial Clarifications: Not applicable.

18. Other conditions: Not applicable.

Signed by,

On behalf of the GAVI Alliance



Hind Khatib-Othman

Managing Director, Country Programmes

21 October 2013

⁴ This is the amount that GAVI has approved.

⁵ This is the consolidated amount for all previously approved years.

Section 2 IRC report

Type of report: Annual Progress Report

Country: Solomon Islands

Reporting period: 2012

Date reviewed: July 2013

1. Background Information

Surviving Infants (2012): 16,769 (JRF and APR) and 16,621 (UNDP)

DTP3 coverage (2012)

JRF Official Country Estimate: 90%

WHO/UNICEF Estimate: 90%

Table 1. NVS and INS Support

NVS and INS support	Approval Period
Pentavalent	2008 - 2015

Table 2. Cash Support

Cash support	Approval Period
HSFP	2013 – 2015

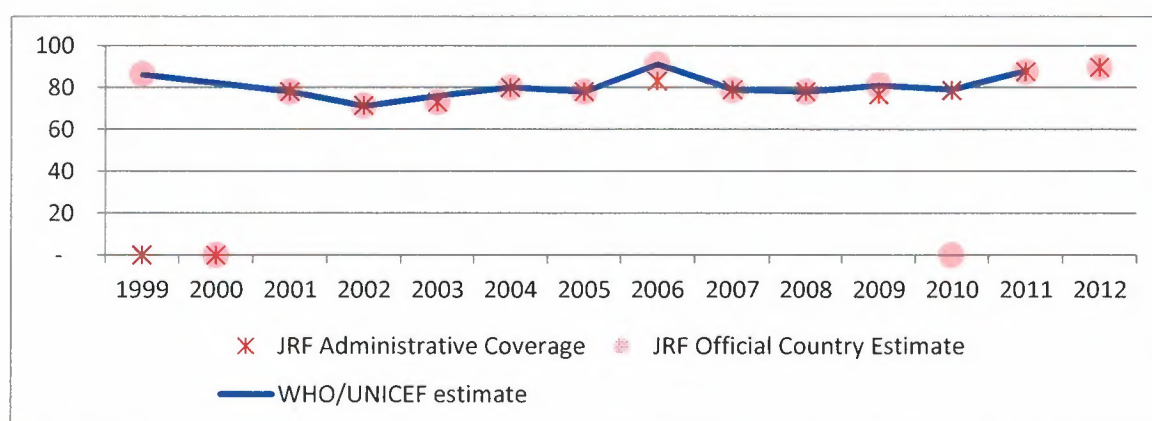
2. Composition and Functioning of Inter-agency Coordinating Committee (ICC) / Health Sector Coordinating Committee (HSCC)

The ICC is the sole functioning committee addressing immunisation. It met twice in 2012. Minutes are provided of the APR 2012 ICC meeting on 9th May 2013, at which the 2012 APR was endorsed (all ICC, MoH and MoF endorsing signatures have been provided). The meeting also discussed EPI activities, e.g. cold chain strengthening, and priority actions for 2013 and beyond, such as addressing data management and EVM and cold chain issues at primary levels of vaccination service delivery. The implementation of the GAVI-funded HSS activities and preparation of for MR and PCV vaccination were also identified as priorities. There is no CSO membership of the ICC; this situation

was discussed in the IRC report on the 2011 APR (report dated March 2013, due to late submission of the APR in February 2013) and also in the 2011 IRC report on the 2010 APR. The country has again stated it will review membership so as to enhance representation.

3. Programme and Data Management

The country's DTP3 coverage was tracking along at around 80% 2007-2010 (the country estimate and the WHO-UNICEF estimate always corresponding), but then jumped to 88% in 2011 and 90% in 2012.



Coverage targets for 2012 were met except for BCG and OPV. It is apparent that data management challenges are significant. The HSS M&E Framework report notes that there are coherent links between the HSS and the national M&E frameworks. Impact and outcome indicators have been well chosen; however, GAVI equity and DTP3 coverage and drop-out rate indicators are not included. The M&E framework is weak in its attention to advocacy and community mobilisation. All such issues should be addressed in forward HSS planning.

The APR describes the following activities undertaken from 2010 onwards to improve administrative data management: EPI data recording training provided to health workers, EPI management training for provincial EPI co-ordinators and capacity development on micro-planning for local level EPI staff members. The APR indicates that no coverage survey was conducted in 2012 and that the administrative data system is the only source of immunisation data. There is mention of the first ever in-country EPI review having been conducted in November 2012.

4. Gender and Equity Analysis

No sex-disaggregated data are currently being collected; the APR indicates there are plans to do so in future (no further information provided). No information is provided as to whether there is any discrepancy in coverage rates between males and females. The APR states that no gender barriers exist in terms of access to immunisation services. It also describes that reasons for children not being immunised are multiple, while mainly due to family members being unavailable and/or lack of education on immunisation benefits: both such barriers are likely to be informed by gender and equity



issues. The APR describes how such issues will be addressed through enhanced EPI communication, as set out in the EPI strengthening Action Plan. These activities should be reported on in the 2013 APR, as should links into proposed HSS community activities. There is no discussion in the APR of strategies specifically targeting hard to reach populations or geographic areas, or of measures tailored to assess whether there is equity of access to immunisation services and then to address any identified inequities.

5. Immunisation Services Support (ISS)

Not applicable; no ISS fund to be disbursed.

6. New and under-utilised Vaccines Support (NVS)

Documents submitted by the country indicate no cash support was received for NVS in 2012 and that no report is made in the 2013 APR. To date the country has not conducted a PIE for Penta. There were no programmatic or financial clarifications pending from the 2011 APR review.

The immunisation programme had a number of successes in 2012 including conduct of SIAs for MR, cholera campaigns, provincial and national EPI reviews, formulation of micro plans for specific geographies, and the conduct of an EVM. Major challenges related to data management and cold chain; plans and financing are in place to address issues. Priority actions for 2013 and 2014 include: achieving 80% fully immunised coverage nationally, improve the cold chain and EVM, introduce MR and PCV, and implement the HSS programme.

Penta 2012 performance

The total doses of Penta received in 2012 was 52,130 as shown in the APR including both GAVI and co-financing purchased doses, though the APR mistakenly shows this as the amount in the decision letter. 7,130 doses were deferred to 2013. UNICEF confirms all of this. The APR also states that the government purchased additional vaccine to 16,400 doses to constitute a buffer in March 2012. While UNICEF reports no stock issues for 2012, the APR states that there were almost zero stocks in Q4 2012, due to the 2011 APR not being submitted. The country procured its own co-financed vaccines, to ensure no stock out. Penta wastage is reported at 5%.

The most recent EVM was conducted in August 2012; its results show that 3 of 9 indicators score 71% (Vaccine Arrival Process, Storage Capacity, Buildings, Cold Chain Equipment and Transport). Other indicators score between 21% (MIS and supportive functions) and 57% (vaccine storage temperature), while stock management achieves 33%. The EVM sets out 28 recommendations for immediate action. The May 2013 update on the EVM Implementation Plan shows that 28 of 50 tasks have been addressed. These are not always explicitly linked to the 2012 EVM recommendations. The report comments that on-going tasks are chiefly related to supply of additional solar refrigerators and other cold chain equipment, as well as review of SOPs, the VCC Policy and ToRs. However, 'tasks requiring local budget allocation were not implemented'.



The national EPI review that was conducted in November 2012, using external technical assistance, included the development of an action plan for vaccine management (no details provided of either in the current APR). The country should address as a priority the recommendations set out in the 2012 EVM and report on progress against these in the 2013 APR. Information should also be provided on sources of financing for these activities.

2014 vaccine request

Target specification: the 2012 APR and JRF figures for surviving infants are consistent, at 16,769. The vaccine requirement for 2014 is 56,968 doses, including country contributions and buffer stock. The country is not requesting a change to the current 1-dose vial, liquid presentation.

The request for Penta for 2014 uses a surviving infant figure that is much higher (19,835) than the figure for 2012 (16,769). No explanation for this jump is provided in the APR. A target of 84 % Penta 3 coverage is shown in the APR for 2014, while 90% was achieved in 2012. Again, no explanation is given. The request shows a 9% drop out rate and a 5 % wastage rate.

7. Vaccine Co-financing, Financial Sustainability and Financial Management

The country is in the intermediate co-financing group for 2014. It began mandatory co-financing of Pentavalent vaccine in 2008. The country is deemed a high performer, with timely payment of its co-financing obligations; it is voluntarily co-financing higher amounts than the minimum required (46 vs. the required 26 cents required). The CRO pre-screen notes that in recognition of its co-financing approach, the country received a reward at the GAVI Partners' Forum in December 2012. The 2012 APR does not mention other sources of immunisation co-financing. It notes that in terms of technical assistance for financial management, etc., there is a need for a programme management officer assigned to GAVI activities.

8. Injection Safety Support (INS) and Adverse Events Following Immunisation Systems

INS is not supported. There is an injection safety plan (no details provided). Sharp waste management is through boxes; there is incineration and burying of remains. There is no dedicated national pharmacovigilance capacity or expert review committee, while the 2012 APR reports there is an institutional development plan for vaccine safety. The APR does not refer to any AEFI. No sentinel surveillance activities are reported, although there is a wish to establish a sentinel site for paediatric bacterial meningitis.

9. Health Systems Strengthening (HSS)

The country is not reporting on HSS activities in 2012, as these are planned to begin in 2013 once governance and financial matters have been addressed. The country states that it expects to fulfil the financial procedures required by GAVI and finalise the HSS Aide Memoire, before the end of 2013.

The GAVI Decision Letter of 31 May 2012 indicates a total HSS budget allocation of USD2,399,340, with planned 2013 disbursement of USD599,810. These amounts are amended in the Decision Letter of 22 November, due to the introduction of GAVI support through the HSS-PBF channel. The total HSS budget is now USD 2,049,540, with a 2013 allocation of USD 499,310. Performance-based Financing will be applied from 2014.



No request is made for the 2014 tranche of funding that will continue to improve the cold chain and transport along with training, communication, and recruitment of additional personnel.

10. Civil Society Organisation Type A/B

Not applicable.

11. Risks and mitigating factors

A major risk for the Solomon Islands is that there might again be delays in submission of the APR, resulting in severely delayed funding for GAVI-supported windows. The country has successfully addressed this challenge for the 2012 APR. Data management challenges and the need for enhanced attention to gender and equity issues continue. EVM challenges are also significant but appear to have been prioritised by the country.

12. Summary of 2012 APR Review

The major progress of the last two years is that coverage with Penta 3 has increased to 90% after staying a number of years at around 80%. The request for Penta vaccine needs clarification concerning the number of surviving infants, since this figure has taken an unexplained jump in the request. Clarification is also needed for the target coverage, since the request shows lower target coverage than the achievement of the last two years.

The country is commended for its continued, effective co-financing. Due to the delays in submitting the 2011 APR, the change to PBF and the GAVI revision of the HSFP budget, the country is not reporting on the NVC and HSS windows for 2012. The country should address as a priority the recommendations set out in the 2012 EVM and report on progress against these in the 2013 APR. Attention to CSO representation should now be addressed.

13. IRC Review Recommendations

ISS: not applicable.

NVS

For Penta: approve 2014 NVS support based on country request target, subject to satisfactory clarifications detailed in Section 13.

HSS



The country has not made a request for funding, as disbursement of the approved 2013 allocation is pending (and in addition, as the support is now HSS-PBF, further disbursement amounts for 2014 and beyond will in part depend on performance criteria).

Clarification Required with Approved Funding

Short-term clarifications

(a) Programmatic clarifications

NVS: clarify the number of surviving infants with the GAVI Secretariat to agree on the number of doses to be supplied. Clarify the target coverage rate.

Mid-term/long-term clarifications

(a) Programmatic clarifications

a. NVS

The country should address as a priority the recommendations set out in the 2012 EVM and report on progress against these in the 2013 APR. Information should also be provided on sources of financing for these activities.

b. HSS: N/A