Joint appraisal report

Country	Solomon Islands
Reporting period	January to December 2014
cMYP period	Ends in 2015, one for 2016-20 to be prepared
Fiscal period	January to December (Government budget process starts in July and approved in November by the Parliament)
Graduation date	January 2015

1. EXECUTIVE SUMMARY

1.1. Gavi grant portfolio overview

- As one of the only two Pacific island countries receiving Gavi support, Solomon Islands (SI) presents unique challenges not comparable to other countries – small populations spread across many islands, high service delivery costs, and dependence on external assistance such as DFAT from Australia. Almost half of Government expenditures, including that in Health sector, are supported by development partners.
- Health sector receives almost 20% of all Government expenditures, signifying high attention on the sector. It should be noted that the Government expenditures include the budget support by Australia.
- Small country population limits intensity of in-country technical assistance with small offices/teams of WHO/UNICEF, fewer country visits. Gavi mission in June 2015 happened after an interval of two and a half years.
- Gavi support is integrated within the EPI program. Currently, 73% of all vaccines costs are funded through Gavi support.
- Gavi collaboration was limited to Pentavalent vaccine till about three years back. The country then decided to seek Gavi support for HSS and new and under-utilized vaccines (NVS) – PCV, MR SIA, HPV (demo), and IPV. The collaboration is substantial now.
- Overall the EPI program presents a mixed picture. Whereas the country has introduced the PCV, HPV pilot project besides a large MR campaign, decline of coverage by 13% between 2012 and 2014 accompanied and a large Measles outbreak in 2014 presents a depressing picture.
- HSS proposal was designed on filling up gaps in service delivery – these objectives need to be reviewed in view of fundamental system challenges such as program management. As such, reprogramming of the current HSS grant is considered a more appropriate option for SI considering long term objectives.
- JA recommendations are in line with overall roadmap towards successful graduation.

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)

Achievements

- New introduction of vaccine was done in 2014 for PCV and HPV (demo). Social mobilization activities were also carried out prior to the new vaccine introduction.
- Capacity building training on RED strategy and micro planning were conducted for 3 Gavi targeted provinces. Health workers are now equipped with skills on routine micro planning as well as SIA micro planning.

- Measles campaign was supported through extensive micro planning, training and implementation in the provinces. The national coverage for MR outbreak response campaign was recorded as106%.
- Equipment such as 26 CCE and 15 OBM was procured and distributed to the target provinces to strengthen cold chain capacity, outreach services and supportive supervision.
- After a long delay in initiating the grant, the HSS programme could utilize about 50% of the first tranche of the grant in 2014.

Challenges

- The national immunization coverage is not improving since 2012. Penta 3 coverage has declined from 90 % in 2012 to 77% in 2014.
- Lack of good census data leads to erroneous interpretation. Provincial targets are usually higher than national estimates of the population.
- The national team was engaged in the flash flood emergency response activities from April to May 2014. The Government then became busy with SIA for Guadalcanal & Honiara City Council in June/July 2014. Then the nationwide measles outbreak response became the priority from September to December 2014. According to WHO, SI is always in some kind on emergency or in a crisis mode.
- Limited capacities, including staff in the Government and partners, resulted in inadequate follow up on previous recommendations from the EPI review and other assessments.
- Current financial processes lead to delays resulting into organization of few outreach activities (only 2%). This has been underscored as the main reason for declining coverage.
- Financial weaknesses are substantial. All cash support from Gavi – HSS, VIGs, operational costs – is lumped together and as such no separate financial statements are prepared. There has not been any external audit carried out till date.

Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)

1. Accelerate programmatic interventions such as supportive supervision from national to provincial to clinics/zone supervisors (RED strategy), monitor coverage in health facilities; use data to identify missed populations.
2. Resolve financial processes that leads to delay in implementation of program activities to minimize potential disruption in reaching targeted populations and reduction in coverage. Outreach services and periodic mop up vaccination in low coverage zones should be conducted as catch-up campaign.
3. Develop a National integrated RCH Communication Strategy, including immunization, to create demand for services.
4. Improve provincial cold chain capacity through procurement, adequate maintenance and repair services.
5. Implement effectively the system of birth registration for better tracking and estimation of service coverage.

1.3. Requests to Gavi's High Level Review Panel

Grant Renewals

New and underused vaccine support

- Renewal of Pentavalent vaccine
- Renewal of Pneumococcal vaccine
- Renewal of IPV (to be introduced in Q3 of 2015)
- Second year support for HPV demonstration project already approved

Health systems strengthening support

- No approval of third tranche in view of the proposed reprogramming/submission of a new HSS proposal taking into account the activities from the graduation assessment and for full duration of new Heath strategy for five years.

1.4. Brief description of joint appraisal process

The joint appraisal was carried out jointly by UNICEF, WHO and Gavi with overall leadership by the Ministry of Health and Medical Services. In-country colleagues from the Government, World Bank, DFAT, WHO and UNICEF fully participated in the mission. The external participants comprised of representation from UNICEF HQ, UNICEF (EAPRO), WHO WPRO, WHO Suva and Gavi Secretariat. To reduce the burden on limited in-country resources, it was agreed to combine the JA with graduation assessment which also justifies large external team for the mission.

In hindsight, it is more appropriate to separate the two exercises since the recommendations tend to overlap. It is also noted that country information and issues relating to Gavi support are not fully understood in absence of a dedicated Gavi country mission. As such, SI should consider organizing an annual mission in the future.

2. COUNTRY CONTEXT

2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants.

The SI National Immunization Program has benefited immensely from the Gavi support for new vaccines and health system strengthening. Although progress has been made, there are key issues that affect implementation and performance of the Gavi grants in country. These include;

1. Human resource constraint and low capacity at the Provincial levels. SI health system has significant human resource constraint both in terms of numbers and capacities, at the national and subnational levels. This has limited implementation capacity.
2. Cumbersome process of funds disbursement at National level to the provinces (long waiting time) leading to delays. The MHMS has been undergoing a reform process both structurally and financially. The processes as they evolve have largely impacted on getting funds out for program implementation, which might take weeks to months to be available. The Gavi funds have been relatively more accessible since these are largely separate from the Ministry of Health central account. The processes of the MHMS have to be streamlined to improve funds availability and accessibility, minimizing delays.
3. Low implementation capacity at the Provincial level. Funds transferred to the provinces have remained unutilized in some instances due to low capacity of implementation at the provincial level. Strengthening capacity of implementation and empowering the provinces more will accelerate progress of implementation.
4. Competing priorities with other health interventions. The health care workers have multiple responsibilities and sometimes faced with emergency responses that take staff time away from implementing planned routine immunization services.
5. Child Health Officers at the provincial level still are on hospital shift rosters. The provincial staff does both programmatic and or clinical duties, which reduces the available time for program implementation and oversight.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

3.1. New and underused vaccine support

3.1.1. Grant performance and challenges

The Gavi support for the SI government started with Pentavalent (DTP-Hep B-Hib) vaccine introduction in 2008 into its routine immunization program. In 2013, the country received approval for Health System Strengthening (HSS) support, which remains valid through 2017. This support is meant to complement other funding for supporting to the health system in the areas of health information system, cold chain and logistics, human resources for health.

In the current year (2015), the country with Gavi support has introduced Human Papilloma Virus (HPV) vaccine demonstration project in two provinces of Isabel and Honiara city council targeting girls aged 9-12 years with two doses of the vaccine. The vaccine and programme cost for the HPV vaccine demonstration are supported entirely by Gavi. In addition, Gavi support has aided the country to introduce Pneumococcal conjugate vaccine 13-valent (PCV13) nationally, and is preparing for the introduction of IPV vaccine in the third quarter of this year, as recommended by the global polio end-game plan.

In 2014, the country received approval from Gavi for the conduct of an MR supplemental immunization activity (SIA) as a preventive campaign targeting ages 1-15 years to mop up accumulated susceptible among the population. With the Measles outbreak that occurred in mid-2014, the country conducted a nationwide SIA campaign as part of the outbreak response activity using the approved Gavi funds for the campaign. The campaign covered population till 30 years' age with additional resources coming from the Government and MR Initiative. The country currently uses one dose of MR in its routine immunization schedule and is considering introducing the second dose of MR.

According to the most recently-completed APR, the vaccine coverage targets have been set to 95% in line with the regional coverage targets defined by the Regional Framework for Implementation of GVAP in the Western Pacific, endorsed by the Regional Committee in 2014. Administrative coverage for all antigens in 2014 are found in the WHO-UNICEF Joint Reporting Form (JRF), submitted yearly to WHO. Reported Pentavalent coverage in 2014 reached 83% and 77% for the first and third dose respectively; with more than 7 out of 10 provinces having coverage between 50% and 79%, 2 provinces having coverage between 80% and 90%, while only one province has coverage above 95%. Coverage for the third dose of pentavalent vaccine has remained consistently below 90% since 2008, and decreased to 83% in 2013, and to 77% in 2014.

In 2014, the reported coverage for the first dose of measles was 76%, which is similar to the 2013 coverage. The country is yet to introduce the second dose of MR into its routine immunization schedule. In 2014, the country experienced a nationwide measles outbreak, which affected immunization program implementation. To better protect the population from the scourge of measles outbreaks, the country is considering introducing 2nd dose of MR into its routine immunization schedule. As part of the outbreak response, the country conducted an MR SIA in all the 10 provinces with a national coverage of 106% in the targeted age group of 6 months to 30 years age. A rapid coverage assessment done following the MR campaign showed coverage of 95%.

At the time of the joint appraisal, coverage for the newly introduced PCV13 was not available. It is understood (not yet validated), that the nationwide introduction went as planned. For the HPV vaccine demonstration project, data is not yet compiled but coverage for Honiara City Council is pegged at 98% of targeted girls.

The country will be introducing IPV vaccine in September with support from Gavi and is aimed nationwide.

Currently, the country is conducting a national Demographic and Health Survey (DHS) and the summary of findings should be available at the end of the year or early 2016.

In 2014 no stock–outs of vaccines were reported. At the time of the appraisal, the NIP is being revised to reflect the new vaccines recently introduced (PCV-13, HPV and IPV), as well as revised national and regional targets.

3.1.2. NVS renewal request / Future plans and priorities

The information on the achievements in 2014 and targets for 2016 are provided in annex A, inserted from the annual progress report. The targets are ambitious as compared to actual achievements in year 2014.

The program is getting ready for introduction of IPV from September 2015 to align with Global Polio Eradication program priorities. During the country mission, the government officials enquired about their eligibility and feasibility for the introduction of Rotavirus vaccine. Partner organization such as World Bank and WHO were in favor of conducting a cost-benefit analysis for both HPV and Rotavirus vaccine to examine the disease burden for SI and assess the benefits from vaccine introduction. Other than the disease burden, the country is considering impact on the health system before making an informed decision. Sharing from experiences in other countries, these include – (a) cold chain requirements for the bulkier new vaccines; (b) affordability and financial sustainability of potential introduction of HPV and/or Rotavirus vaccine into the national immunization programme, along with the current vaccine schedule for SI. The previous cMYP will expire in 2015 and the new c-MYP for the next five years is due. Similarly, the EVM assessment was carried out three years back but with weak implementation of the activities of the improvement plan.

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

1) **Achievements:**
   a) HSS progress: After prolonged delay in implementation, HSS funds were expended largely towards purchase of Cold Chain equipment and implementation of integrated planning at Provincial level. In 3 pilot districts fully integrated RMNCAH-Immunization plans and budgets were developed in 2014, and implemented in 2015
   b) Progress was made in conceptualising a more efficient and sustainable service delivery platform by integrating immunization within RMNACH planning and budgeting at all levels.
      i) 2015 marked the first year of integrated planning at the Provincial level, though zonal and facility level integration of 'Reach Every Child' activities (e.g. microplanning, outreach) is yet to be achieved.
      ii) Significant progress has been made in integrating RMNACH data into the new DHMIS II system, which already includes immunization data. DHMIS2 will eventually offer a more robust platform for assessing performance at all levels.
      iii) Cold chain logistics capacity has been strengthened though purchase of critically needed boats and vehicles, which has helped reduce vaccine stock-outs.
   c) Feasibility: The Consensus of the MHMS, partners and mission team was that while the objectives of the current HSS grant were still largely valid, the HSS proposal activities required

i) substantial updating to align with new National Health Strategy and Role Delineation Policy
ii) to optimally leverage and complement other HSS investments (DFAT, Global Fund) a HSS framework should be developed, based upon RDP, to increase the focus of Gavi HSS investments on overcoming critical bottlenecks to implementing integrated planning at zonal and facility levels, ensure integrated microplans are developed, implemented and monitored at facility level, and focus on improving the effectiveness and scope of outreach activities. Cold Chain and Supply Chain strengthening should continue as originally planned, with efforts made to rationalize CC equipment procurement and distribution.

2) Degree of participation of key stakeholders: Major partners include UNICEF, DFAT, and WHO, all of whom contribute actively to monitoring and implementation. The ICC is chaired by the Under Secretary of Health, and the Permanent Secretary (PS) MHMS has made improving performance of HSS efforts a priority.
3) Implementation bottlenecks, corrective actions, and lessons learned:
   a) 1st tranche nearly fully utilized.
   b) 2nd tranche (in process of transfer) will be utilized for priority activities defined under the graduation mission report's recommendations. These include
      i) Rota and HPV Cost-Benefit Analysis (CBA).
      ii) Developing the HSS framework & a reprogrammed/new HSS proposal for Gavi support.
   c) The new/reprogrammed HSS proposal will cover the financial envelope consisting of two undisbursed tranches (app. $1.4 million) and another three years of additional HSS for years 2018 to 2020 (amounts to be communicated
   d) Lessons learnt:
      i) Lack of clarity on roles/responsibilities of Province, vs National level for HSS slowed implementing, but recent work on RDP is directly addressing this.
      ii) Urgent need is for quick completion of an HSS framework, based upon RDP, which will optimally guide reprogramming Gavi HSS funds to optimize capacity building and increasing programmatic and financial sustainability required to successfully transition through the GAVI graduation process.

Financial performance and challenges:

1) Key challenges regarding the financial management of HSS grant
   a) Given the likely graduation from Gavi support over a five-year timeline, the government must ensure it has sufficient capacity and systems in place to manage the flow of all funds to support immunization activities through normal and formal budget channels.
   b) Gavi's investment approach should aim to strengthening national PFM systems.
   c) Building capacity of Solomon Islands Government (SIG) PFM systems will ensure long term sustainability in the lead up to graduation; assist in managing and mitigating risk in the use of Gavi funds; and complement existing work by development partners to strengthen SIG systems through the HSSP SWAp Partnership Arrangement.
   d) Recommendations:
      i) Gavi cash/grant transfers to MHMS will be appropriated through the HSSP earmarked budget support, and appear in the original budget of MHMS
      ii) GAVI direct procurement contribution will appear in the non-appropriated development budget;
      iii) GAVI funds will flow through the SWAp HSSP bank account
2) Country has not received performance payments under the Gavi Performance Based Funding (PBF) approach, neither is it eligible due to declining performance.
3) Overall financial capacity of entity managing HSS grants
   a) Gavi funds for vaccines have traditionally not been included in the MHMS budget information. With the current arrangement, Gavi contribution to the health sector in Solomon islands, whether direct procurement of vaccines or cash/grant contributions, should at least be recorded in the non-appropriated development budget, particularly

since MHMS staff is responsible for activity implementation (which is the budget ledger where donors use separate systems for implementation).

b) The MHMS, its partners and the graduation mission team recommend all Gavi Alliance grants coming to the Solomon Islands for service implementation are to be appropriated in the national budget, along other earmarked budget support, and be available for spending on 1st January each year. The funding agreement could still stipulate that funds will be transferred based on target indicators; however, funds should appear in the budget.

3.2.2. Strategic focus of HSS grant

1) The health sector is undergoing major reform and restructuring, with a Role Delineation Policy (RDP) being developed as part of the New NHSP that will clarify roles and responsibilities of the National Line ministries compared to decentralized functions and authorities delegated to the Provincial, Zonal and Health facility levels.
2) The NHSP and RDP are to provide a vision and operational framework for Health Systems Strengthening (HSS) for SIG.
3) It is noted that a powerful enabler would be development of a specific HSS framework, based upon the RDP that could serve to quickly map and assist the government to rationalize existing HSS efforts (e.g. Global Fund, One UN support, and Gavi HSS grants). This will
   a) establish a common definition of HSS based upon the RDP,
   b) Use the HSS definition and framework as the basis for a reprogrammed or new GAVI HSS grant that will better complement and leverage on-going HSS efforts and ensure funding gaps could be optimally identified and filled.
4) Optimizing HSS impact by aligning HSS investments with the new national health strategic plan and the RDP.
   a) The growing decentralization shifts focus to Provincial Government for Program implementation, with monitoring performance increasingly the role of Provincial and Zonal authorities.
   b) This requires that completion of the Role Delineation process be supported by all partners, so that revised job descriptions and standard operating procedures for an integrated and decentralized service delivery system can be fully implemented and ensure that HSS investments are results focused.
   c) New HSS activities include Provincial quarterly performance review meetings, increase supervision, and regular facility based reviews of microplan and outreach implementation by zonal supervisors.
5) Fundamental issues constraining delivery of basic RMNCAH services including immunization, such as
   a) continuing uncertainties in the boundaries between national, Provincial, and zonal authorities for decentralized supervision, planning and resources management. This constrains improvements in the performance of outreach and other services provision, leading to a downward drift in immunization coverage.
   b) Weak supervision and monitoring of performance at facility level
   c) Insufficient outreach, and persistent inequities in coverage, largely due to insufficient number and scope of outreach activities.
   d) Previous recommendations to strengthen EVM have largely not been implemented, such as strengthen stocks management through rationalized procurement and effective distribution of Cold Chain and Temperature Monitoring equipment, and mapping of local catchment areas and target populations as a basis for results-focused micro-panning and effective outreach.
   e) While the framework for a more effective and sustainable immunization program, integrated within RMNCAH services, is largely in place, implementation of critical functions of the health system lag far behind, notably microplanning, outreach, and a functioning cold chain.

6) Recommendations

a) Based upon the RDP, designing & implementing a HSS framework for targeting donor and domestic investments, to be adopted by MHMS as soon as possible.
b) Place a sustainable services delivery system such as
   i) Putting in place a functional Cold chain storage and distribution system – efficiencies measured by reduced vaccine wastage. This is within the overall scope of the National/Provincial Medical Stores
   ii) Add program efficiencies and improve quality through regular microplanning and a functional supervision system
c) Overall, an incremental approach for GAVI HSS investments will continue to be used, with 2015-16 aiming to accelerate progress in the 3 pilot Provinces and then taking effective practices to scale nationally during 2016-20.

7) Summary of recommendations from graduation workshop
(these were made prior to June 2015 by GAVI Board approved changes to the GAVI Eligibility and Transition Policy. The impact of the new policies are still to be fully known)
   a) Reinforce the commitment by SIG to sustainably finance the recommendations from this and previous missions for:
      i) strengthening EVM and integrated supply chain management;
      ii) Implementing HSS to ensure sustained high immunization coverage;
      iii) Use opportunity of graduation grant to strengthen programmatic and financial sustainability to successfully manage the transition from GAVI financial support.

8) Post mission in light of the new GAVI eligibility policy being adopted, the MHMS and mission team made the following recommendations and suggested actions to go forward:
   a) The activities and budget to be funded by current HSS grant:
      i) A consultancy to map current HSS efforts, and to assist MHMS to clarify its definition and its framework for HSS investments, based upon the new NHSP and RDP. Under the guidance of the MHMS, prepare a reprogrammed or new Gavi HSS application
      ii) A consultancy to complete a cost benefit analyses of introducing and taking to national scale Rotavirus and HPV
      iii) The MHMS finalizes the Graduation assessment report after the consequences of revision on Gavi eligibility policy are known in July 2015 so as to reflect the new graduation deadline and take into account the changed financial implications
      iv) Decisions on HPV and Rotavirus can be deferred until Cost Benefit Analysis is completed (e.g. in March 2016). This permits the Rota and HPV CBA to be fully completed, and sufficient time to assess the impact on financial sustainability of vaccine introduction in light of a new graduation date.
   b) In terms of continuing Gavi financial support
      i) Use outputs of HSS consultancy to submit a reprogrammed or new HSS proposal

This permits more time to use the new HSS framework to ensure that any new GAVI HSS proposal takes into account the latest work on the RDP and SDPs

3.2.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

- Gavi HSS grant is for a period of four years. It is valid till end of 2017. Two out of four tranches of funds have been sent to the country.
- The remaining part of the HSS grant is not considered most appropriate towards addressing the gaps. It suffered from implementation delays, has a patchy approach in its design and planned when SI did not envisage transitioning towards graduation. This is essential so as to create a service delivery platform that allows for regular and efficient delivery of basic MCH services including immunization.
- Some activities identified as part of current assessment should be included in this year's plan. These activities, which would otherwise be funded through a graduation plan, are

time sensitive leading to major decisions (like new vaccine introduction) or major investments (such as cold chain infrastructure and maintenance).

- A new Health sector strategy is being developed for a period 2016 to 2020. As such it is recommended that a full reprogramming of the currently unutilized part of the grant be carried out including additional funding envelope to cover full range of five years of new health sector strategy. The request can be sent to Gavi as a new application.
- The design of new application should take into account the gaps, programmatic and financial, to allow long term sustainability of the new introductions and activities.

3.3. Graduation plan implementation *(if relevant)*

Not applicable as the graduation assessment was simultaneously carried out with this joint appraisal.

3.4. Financial management of all cash grants

For the reporting period of 01 January to 31 December 2014, the GAVI- Health Systems Strengthening (HSS) fund reported a balance of 198,994 USD to be carried over into 2015. The HSS fund was utilized for eight activities, including micro-planning workshops, outreach activities (micro-plans), conducting annual immunization week, specific training for EPI supportive supervision, training on sentinel surveillance on AFPs, measles & tetanus, procurement of transportation (e.g. boats) via the WHO and cold-chain equipment via UNICEF. However specific expenditures on each activity were not reflected in the financial statement, and confusion with other GAVI funds, such as NVS, were observed in the reporting of HSS funds.

It is worth noting that the current financial reporting does not distinguish between different GAVI funds. The management of GAVI funds are also fragmented, e.g. GAVI VIG funds (one-off grant from 2008) was not tracked, whilst GAVI PCV, HPV Demo and MR funds are channeled towards the same account as HSS funds.

Total expenditure for the immunization programme is approximately 2.02 million USD in 2014, an increase from 1.27 million USD in 2013. Government expenditure on immunization programme remained at similar levels, from 1.08 million USD in 2013, to 1.09 million USD in 2014. Government expenditure on immunization programme represented 53.74% of the total expenditures, a decrease from 85.19% in 2013, but remains the major source of financing for the immunization programme.

As a proportion of the total General Government Expenditure on Health, the government expenditure on immunization programme has also remained at similar levels, from 2.04% in 2013 to 2.05%* in 2014. From the available data, the government has not allocated in excess of 2.91% of total government budget on immunization expenditures since 2009.
*GGHE as reported in 2013

Government expenditures primarily covered for personnel costs (84.56%), traditional vaccines (8.21%), and SIAs (campaign) costs (2.76%). It is worth noting that the overall expenditure on traditional vaccines, from all sources, had increased from 0.11 million in 2013 to 0.28 million in 2014. This significant increase was contributed by the introduction of Measles and Rubella new vaccine support from GAVI for the measles response campaign in 2014. Despite the government expenditure on traditional vaccine had decreased from 0.11 million in 2013 to 0.09 million in 2014, other than the aforementioned MR response campaign, the government had continued to fund traditional vaccines to its entirely since 2012, although it is important to stress again that other sources of donor funding, such as DFAT, also contribute significantly

to the current government budget. The government also increased its financing for injection and supplies costs to its entirety in 2014.

Vaccine costs (for both traditional and new vaccines), from all sources, are approximately 0.39 million USD, representing 19.27% of total EPI program expenditures in 2014; this has increased in absolute terms, but remain similar in proportionate terms when compared to 2013. Gavi is the only* external donor towards vaccine costs (* excluding external funding channeled through the government), and the Solomon Islands has increased its reliance on Gavi from 44.03% in 2013, to 73.04% in 2014 for both traditional and new vaccine costs. It is worth noting the vaccine schedule for Solomon Islands will include the introduction of IPV in 2015, and it is likely to introduce HPV in 2017. These introductions are likely to increase vaccine costs significantly for the Solomon Islands. With graduation from GAVI in mind in the next 5-6 years, the Solomon Islands must consider the financial sustainability of its immunization programme, where self-sufficiency and full ownership is required.

3.5. Recommended actions

Actions	**Responsibility** (government, WHO, UNICEF, civil society organisations, other partners, Gavi Secretariat)	**Timeline**	**Potential financial resources needed and source(s) of funding**
Segregated reporting for different Gavi grants	MHMS, World Bank	2015 onwards	None
Timely completion of audits	MHMS	By September 2015	Provided
Complete the DHS	EPI program	Report in next APR	Already funded
HSS reprogramming/new application	MHMS (support from UNICEF, WHO)	January or March 2016 deadline	Identified as part of TA by WHO and UNICEF
cMYP development	WHO	December 2015	Part of TA by WHO
PIE	WHO	2016	Part of TA by WHO
EPI review and EVM follow up actions	WHO and UNICEF	Report progress in 2016	Part of TA by WHO and UNICEF

4. TECHNICAL ASSISTANCE

4.1 Current areas of activities and agency responsibilities

The Interagency Coordinating Committee on Immunization is the governance structure overseeing the immunization program in the country. The Under Secretary Health Improvement chairs it with alternate chair by the Director of Reproductive and Child Health Division. Members Include UNICEF, WHO, Pediatrician, Specialist Obstetrician, Director of the National Medical

Stores, and representative for the CSO in country. The ICC meets on a regular basis and for 2015 has met twice already.

The Solomon Islands immunization program continues to benefit from substantial partner support over the years. WHO, UNICEF has largely supported with technical assistance. UNICEF has a long term TA based in country that continually supports the MHMS with prioritization and program implementation. In addition, provide supports with ensuring vaccines are delivered to the country on time and technical support in the areas of cold chain and logistics. UNICEF has supported with procurement and distribution of cold chain equipment to the provinces. Going forward, UNICEF is willing to support the MHMS to revamp its cold chain capacity gaps by innovative ways through testing of an outsourced model of distribution, installation and maintenance. To better maximize efficient utilization of resources, UNICEF working with other partners is supporting the MHMS with conducting a vaccines wastage study and a hepatitis B outside the cold chain project. UNICEF also supports the MHMS with cash support for program implementation of some targeted EPI interventions. WHO being the lead technical agency in the country has continually supported with regular technical assistance for specific activities as needed and recently procuring some additional cold chain equipment.

Going forward UNICEF will need funds to assist MHMS in implementing cold chain rehabilitation and maintenance contracts. This will help reduce number of broken down cold chain in the system and increase cold chain space availability. This could start as an initial pilot, which will then be rolled out across the country. To accelerate implementation of activities and reaching every child, funds could be directed to station 2 or 3 local National professionals in the most populous provinces to support micro planning and monitoring of outreach service implementation especially in low coverage zones to be monitored closely by UNICEF. This will have an overall impact of improving planning at the provincial level and ensuring reaching every child.

The following areas are the current focus of NIP MHMS, Solomon Islands.

- Strengthening routine immunization system
- Identification of high risk communities and implementation equity-focused strategies
- Strengthening immunization supply chain system
- Application for vaccine support and new vaccine introduction
- Strengthening data management and vaccine-preventable disease surveillance
- Developing/updating the existing policies/strategies/guidelines
- Human resource capacity building
- Developing/updating national strategic communications plan
- Developing/updating outbreak plan and guidelines

The WHO and UNICEF have been working together to assist NIP in various aspects of immunization programme, from policy and strategy development to daily operation of the programme. In term of programmatic areas, two organizations have jointly provided assistance to the following areas:

- strengthening routine immunization system and implementation of high risk communities strategies
- strengthening immunization supply chain system
- Introduction of new vaccine implementation
- programme review and evaluation (e.g. EPI review)

In addition, WHO is involved in supporting vaccine preventable disease surveillance, strategies/ policy/guidelines development/update in all areas of immunization programs, post introduction evaluations, development of applications of new support to Gavi and human resource capacity building in all areas of immunization programs at all levels (including outside country).

While UNICEF assisted MOH in improving provision of immunization services in the context of integrated health services and through an equity lens. UNICEF also supported in introduction of PCV, HPV and IPV in 2015, preparing Gavi APR and Graduation plan, while facilitating the Joint Appraisal Mission in June 2015. UNICEF also procured and distributed vaccines and cold chain equipment and contributed to the 2014 measles outbreak through supplies and technical assistance.

4.2 Future needs

Solomon Islands may opt to submit a new application for a new HSS grant and the main focus of the grant is to strengthening immunization system and increasing the immunization coverage. Due to capacity constraints at all levels of the immunization systems, extensive/increased technical and programmatic support from partners particularly in-country partners are essentially required.

UNICEF and WHO will provide support to implement the new HSS grant in the following objective areas stated in approved HSS proposal:
1.Increase immunization coverage in high risk communities
2.Strengthen the cold chain system through improved equipment and management
3.Increase community awareness of, and demand for, immunization
4.Strengthen the surveillance of vaccine-preventable diseases
5.Strengthen management capacity to support the immunization program

UNICEF:
UNICEF will provide technical support to implement the above HSS objectives with the following focus:

1. Provide administrative and technical support to GAVI processes within Solomon Islands: UNICEF technical officers will continue to contribute to preparations and write up of the APR and JA annual reports and relevant documents/ annexes.
2. Strengthen routine immunization system: UNICEF will continue to support the MHMS in updating microplans and implementing outreach activities in remote areas. UNICEF will also help the ministry focus on the marginalized populations and reaching the unreached. Estimated budget: 30,000 USD
3. Strengthen immunization supply chain system: UNICEF will continue to identify the cold chain needs through a cold chain inventory system, and procure appropriate technology cold chain equipment and support in distribution and maintenance. In addition, UNICEF will continue to support the ministry in implementing the EVM improvement plan.
4. New vaccine introduction: UNICEF has already contributed greatly to the introduction of HPV and PCV and will support the ministry in introducing IPV in 2015. UNICEF will support the ministry in assuring that vaccines are distributed to all service delivery facilities and that the relevant health care workers are properly trained.
5. Developing/updating the existing policies/strategies/guidelines: UNICEF will support the ministry in updating the cold chain guidelines and contribute to the EPI national policy revision.
6. Developing/updating national strategic communications plan: UNICEF will provide technical support in drafting a national strategic communications plan focusing on EPI and behaviour change for the purpose of improving coverage. Estimated budget: 30,000 USD
7. UNICEF Country Office (CO) recruited an international EPI consultant in 2014 to support the ministry in implementing the above mentioned activities. The funding for this post ends June 30 2015. UNICEF CO proposed a P2 fixed term EPI specialist post for Solomon Islands which was accepted by Regional Office; however, funding is limited at this stage.

In addition, given the remote landscape of the country, one person is insufficient in technically supporting the national level ministry of health and providing operational assistance at the 10 provincial levels. This situation has raised an urgent need to enhance HR in UNICEF CO, not only to secure the current HR, but also ensure sufficient expertise/staff time to carry on the tasks highlighted above, particularly in the area of supply chain, vaccine management and routine immunization.

Proposal: Funding request for a P2 EPI specialist to be based in Honiara to support the ministry of health especially with GAVI processes and outputs (item 1 above) and the mentioned above activities. This post is estimated to cost 170,000 USD annually. In addition, it is proposed to recruit and place either 3 national EPI officers at 3 selected priority provinces (with low coverage) or recruit an international consultant (at P2 level) to support three selected priority provinces. The national EPI officers or the international consultant would be stationed at the priority provinces (4 months in each priority province for the international consultant) to support the provincial ministry of health staff in capacity building, supportive supervision and development of microplans and outreach activities. The three national EPI officers or the proposed international consultant are estimated to cost 90,000 USD annually. Total budget, including item 2 and 6, is 320,000 USD.

WHO:

It is proposed that both WHO and UNICEF will be providing support in the following areas at national and provincial level. At the provincial level it is proposed that WHO provide support in some provinces and UNICEF in some provinces. The details of support that would be provided by WHO would be the same as detailed in UNICEF section.

1. Strengthening Routine Immunization:
2. Strengthen immunization supply chain system:
3. New vaccine introduction: Focus on Post introduction evaluation of new vaccines
4. Developing/updating the existing policies/strategies/guidelines:

WHO will also provide support in the following areas

- VPD surveillance including laboratory (shipment of specimens to the reference laboratory) support
- Capacity building (inside and outside country) and
- Programme management

Estimated budget for above activities: USD: 60,000

WHO Human Resources Support:

The human resource capacity in WHO country office in Solomon Islands and the Division of Pacific Technical Support (DPS) in Fiji, there is a very critical need to have financial resources to support through one professional staff for EPI or a consultant to support the immunization programme activities.
Proposed budget for the above: USD 190,000

The total budget for the activities and human resources will be USD 250,000

5. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT & ADDITIONAL COMMENTS

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism:

The ICC/HSCC members were invited to the mission debrief where the findings and recommendations were presented. Participants at the meeting signed on the attendance sheet. The meeting was chaired by the Permanent Secretary. They approved of the findings, conclusions and recommendations of the mission, including the appraisal and the graduation assessment.

Issues raised during debrief of joint appraisal findings to national coordination mechanism:

1) There is a legislative drive towards Provincial decentralization wherein the Provincial Government takes responsibility for budgets and implementation. The recommendations should take into account this major development.
2) DFAT commented on the need for long term costing of the vaccines, also noting the Government financing includes external support routed through the budget.
3) WHO Representative underscored the need for redesign of HSS proposal and expressed caution for introduction of Rotavirus vaccine without evidence on its impact or programmatic implications.
4) The PS and DFAT asked about the financial implications for HPV. A financial projection model of the potential increment cost of rolling out HPV vaccine throughout the country was presented to the PS and country officials for their consideration.
5) The timelines of the findings from DHS were clarified (available by early 2016).
6) Currently there are no plans for a census. However, there could be a possibility of its being conducted in or after 2018.

The concluding remarks from the PS were that the recommendations are in line with the discussions during the week.

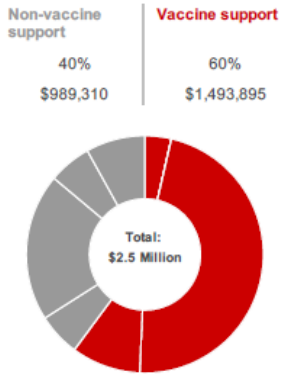
Any additional comments from

- Ministry of Health:
- Partners:
- Gavi Senior Country Manager: The TA needs of a small population country like Solomon Islands are substantial since the Government officers are stretched on demand for their time across large span of activities. The Partner country offices are small in size of the budget and number of staff. The in-country costs are high, as also the costs on travel by partner colleagues from their respective HQ and Regional offices.

Annex A. Key data (this will be provided by the Gavi Secretariat)

Solomon Islands

Total population (2015)	584,482
Birth cohort (2015)	17,318
Surviving Infants (surviving to 1 year per year, 2015)	16,699
Infant mortality rate (deaths < 1 year per 1000 births, 2013)	25/1000
Child mortality rate (deaths < 5 years per 1000 births, 2013)	30/1000
World Bank Index, IDA (2012)	2.78
Gross Nation Income (per capita US$, 2013)	1,600
Co-financing status (2015)	Intermediate
No. of districts/territories (2013)	10



Data refers to disbursed values, date as per above chart

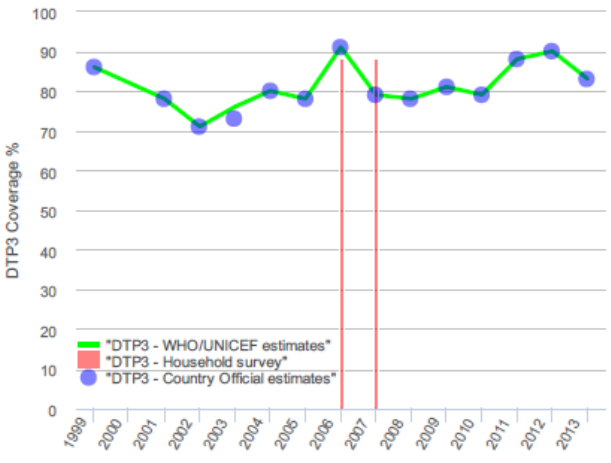
Gavi support for Solomon Islands

Type of support	Approvals 2001-2020 (US$) (31 Mar 2015)	Commitments 2001-2020 (US$) (31 Mar 2015)	Disbursements 2000-2015 (US$) (31 Mar 2015)	% Disbursed (31 Mar 2015)	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Cash Support (CASHSUPP)	$145,000	$170,000	$145,000	100%								■	■				
Health system strengthening (HSS 1)	$1,008,620	$2,049,340	$499,310	50%					■			■	■	■			
HPV Demo (NVS)	$88,500	$102,500	$88,834	100%								■	■				
IPV (NVS)	$71,000	$117,000	$826	1%								■	■	■			
Measles-Rubella (NVS)	$186,000	$186,000		0%								■					
MR - Operational costs (OPC)	$145,000	$145,000	$145,000	100%								■					
Penta (NVS)	$1,094,262	$1,094,262	$1,169,420	107%	■	■	■	■	■	■	■	■					
Pneumo (NVS)	$273,000	$912,500	$234,817	86%								■	■	■	■	■	■
Vaccine Introduction Grant (VIG)	$300,000	$300,000	$200,000	67%	■							■					
Total	**$3,311,382**	**$5,076,602**	**$2,483,207**														

■ Red line on table indicates duration of support based on commitments.
Commitments: Multi-year programme budgets endorsed in principle by the Gavi Board. These become financial commitments upon approval each year for the following calendar year.
Approvals: Total Approved for funding

Solomon Islands DTP3 / immunisation coverage

DTP3 - WHO/UNICEF estimates (2013)	
Grade of confidence	*N/A*
DTP3 - Official country estimates (2013)	83%
M:F sex ratio at birth (2015)	1.07
Household survey: DTP3 coverage for male (2007)	92.30%
Household survey: DTP3 coverage for female (2007)	83.80%
Household survey: Last DTP3 survey (2007)	88%
% districts achieving > 80% DTP3 coverage (2013)	50%
% districts achieving < 50% DTP3 coverage (2013)	10%
MCV WHO/UNICEF estimates (2013)	76%
Polio WHO/UNICEF estimates (2013)	85%



Number	Achievements as per JRF		Targets (preferred presentation)							
	2014		2015		2016		2017		2018	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2014	Current estimation	Previous estimates in 2014	Current estimation	Previous estimates in 2014	Current estimation
Total births	20,448	18,031	21,020	21,020	21,608	21,608	22,213	22,213	22,834	22,834
Total infants' deaths	613	541	631	631	648	648	684	684	902	902
Total surviving infants	19835	17,490	20,389	20,389	20,960	20,960	21,529	21,529	21,932	21,932
Total pregnant women	20,448	17,181	21,020	21,020	21,608	21,608	22,213	22,213	22,834	22,834
Number of infants vaccinated (to be vaccinated) with BCG	18,403	14,669	18,918	18,918	16,992	16,992	17,387	17,387	17,791	17,791
BCG coverage*[1]*	90 %	81 %	90 %	90 %	79 %	79 %	78 %	78 %	78 %	78 %
Number of infants vaccinated (to be vaccinated) with OPV3	17,454	13,565	18,350	18,350	16,482	16,482	16,865	16,865	17,257	17,257
OPV3 coverage*[2]*	88 %	78 %	90 %	90 %	79 %	79 %	78 %	78 %	79 %	79 %
Number of infants vaccinated (to be vaccinated) with DTP1*[3]*	17,851	14,470	18,758	18,758	17,398	17,398	17,802	17,802	18,216	18,216
Number of infants vaccinated (to be vaccinated) with DTP3*[3][4]*	16,661	13,549	17,535	17,535	16,482	16,482	16,865	16,865	17,257	17,257
DTP3 coverage*[2]*	84 %	77 %	86 %	86 %	79 %	79 %	78 %	78 %	79 %	79 %
Wastage*[5]* rate in base-year and planned thereafter (%) for DTP	5	5	5	5	5	5	5	5	5	5
Wastage*[5]* factor in base-year and planned thereafter for DTP	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib	16,616	14,470	18,758	18,758		19,447		19,991		
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib	16,616	13,549	17,535	17,535		18,366		18,881		
DTP-HepB-Hib coverage*[2]*	84 %	77 %	86 %	86 %	0 %	88 %	0 %	88 %	0 %	0 %
Wastage*[5]* rate in base-year and planned thereafter (%)	5	5	5	5		5		5		
Wastage*[5]* factor in base-year and planned thereafter (%)	1.05	1.05	1.05	1.05	1	1.05	1	1.05	1	1

Maximum wastage rate value for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	0 %	5 %	0 %	5 %	0 %	5 %	0 %	5 %	0 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Pneumococcal (PCV13)		0	17,002	17,002	17,398	17,398	17,802	17,802	18,216	18,216
Number of infants vaccinated (to be vaccinated) with 3rd dose of Pneumococcal (PCV13)		0	17,002	17,002	17,398	17,398	17,802	17,802	18,216	18,216
Pneumococcal (PCV13) coverage*[2]*	0 %	0 %	83 %	83 %	83 %	83 %	83 %	83 %	83 %	83 %
Wastage*[5]* rate in base-year and planned thereafter (%)		0	5	5	5	5	5	5	5	5
Wastage*[5]* factor in base-year and planned thereafter (%)	1	1	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05
Maximum wastage rate value for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	0 %	5 %	0 %	5 %	0 %	5 %	0 %	5 %	0 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	16,264	13,271	17,943	17,943	17,398	17,398	17,802	17,802	18,216	18,216
Measles coverage*[2]*	82 %	76 %	88 %	88 %	83 %	83 %	83 %	83 %	83 %	83 %
Pregnant women vaccinated with TT+	17,176	15,015	18,077	18,077	16,426	16,426	17,000	17,000	17,593	17,593
TT+ coverage*[7]*	84 %	87 %	86 %	86 %	76 %	76 %	77 %	77 %	77 %	77 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0	0	0	0	0	0	0
Vit A supplement to infants after 6 months	0	0	0	0	0	0	0	0	0	0
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	7 %	6 %	7 %	7 %	5 %	5 %	5 %	5 %	5 %	5 %

Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
Provide implementation status of recommendations of EVM improvement plan keeping in view introduction of four NUV	Status of implementation as of September 2014 provided with APR.
Provide Bank statements	Provided
Conduct graduation assessment and develop the plan	In progress (report available for HLRP)
Conduct a coverage survey or DHS or MICS	DHS in progress, aimed for completion by early 2016. Government Statistical Bureau is coordinating DHS

Annex C. Description of joint appraisal process (e.g. team composition, how information was gathered, how discussions were held)

The joint appraisal was carried out jointly by UNICEF, WHO and Gavi with overall leadership by the Ministry of Health and Medical Services. In-country colleagues from the Government, World Bank, DFAT, WHO and UNICEF fully participated in the mission. The external participants comprised of representation from UNICEF HQ, UNICEF (EAPRO), WHO WPRO, WHO Suva and Gavi Secretariat. To reduce the burden on limited in-country resources, it was agreed to combine the JA with graduation assessment which also justifies large external team for the mission.

Scheduling of the dates was particularly challenging due to availability of key stakeholders at same time. Due to small size of country offices, most Government and Partner agency officials have many tasks and responsibilities.

In hindsight, it is more appropriate to separate the two exercises since the recommendations tend to overlap. It is also noted that country information and issues relating to Gavi support are not fully understood in absence of a dedicated Gavi country mission. As such, SI should organize an annual mission in spite of small size of Gavi support as compared with many other countries.

Annex D. HSS grant overview

General information on the HSS grant							
1.1 HSS grant approval date			22 November 2012				
1.2 Date of reprogramming approved by IRC, if any			N/A				
1.3 Total grant amount (US$)			USD 2,049,340				
1.4 Grant duration			5 years				
1.5 Implementation year			Dec/2012 – Dec/2017 (assumed to be December)				
(US$ in million)	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	
1.6 Grant approved as per Decision Letter	0.499	0	0	0.509	0.503	0.538	
1.7 Disbursement of tranches	1	0	0	1	1	1	
1.8 Annual expenditure	0	0	0.23	N/A	N/A	N/A	
1.9 Delays in implementation (yes/no), with reasons			Yes; HSS funds were not utilized in the initial two years and only commenced in 2014. Limitations described in 3.2.1, previous APRs, and other consultation reports persist, and the full implementation of the HSS funds is yet to be achieved.				
1.10 Previous HSS grants (duration and amount approved)			N/A				

1.11 List HSS grant objectives

Increase proportion of zones with MCV1 (MR) > 80% from 65% to 85% by end of 2014

1.1 Conduct micro-planning workshops in all zones, where MCV1 coverage <80% incl. Mapping by each province.

1.2 Implement micro plans and monitor progress to reach disadvantaged areas at least 6 times per year

1.3 Supply procurement for PCV 13 routine and MR SIA's vaccination (vaccines, cold chain, others)

1.4 Procurement of boats, Out Board Motors and Safety Kits supplies

Reduce proportion of zones with Drop-Out rate Penta1 and MCV1 > 10% by end of 2014

2.1 Conduct Annual World Immunization Week at national and provincial levels

2.2 Develop specific training for EPI supportive supervision &training on EPI supportive supervision, including PCV

Increase completeness and timeliness of monthly EPI reports by all provinces from 50% to > 85% by mid-year and end year of 2014

3.1 Conduct EPI supportive supervisions at provincial and zone levels

3.2 Conduct training on sentinel surveillance on AFPs, suspected measles, Rubella/ CRS, neonatal tetanus for staff at NRH and 2 provincial hospitals

1.12 Amount and scope of reprogramming (if relevant)

The first tranche of HSS funds are nearly fully utilized. The second tranche is being transferred and is likely to be utilized for priority activities identified in the graduation plan. Hence the reprogrammed HSS proposal will cover the financial envelope consisting of two undisbursed tranches (app. $1.4 million), funding needs of the graduation plan and another three years of additional HSS for years 2018 to 2020 (amounts to be communicated by Gavi).