Joint Appraisal report 2017

Country	Solomon Islands
Full Joint Appraisal or Joint Appraisal update	Joint Appraisal Update
Date and location of Joint Appraisal meeting	Remote
Participants / affiliation[1]	Remote
Reporting period	January 2016 – December 2016
Fiscal period[2]	January 2016 – December 2016
Comprehensive Multi Year Plan (cMYP) duration	2016 – 2020

1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

1.1. New and Underused Vaccines Support (NVS) renewal request(s)[3]

Type of support (routine or campaign)	Vaccine	End year of support	Year of requested support	Target (population to be vaccinated)	Indicative amount to be paid by country	Indicative amount to be paid by Gavi
Routine	IPV	2018	2018	19175		
Routine	PCV	2021	2018	17750	US$101,500	US$130,500
Routine	Penta	2020	2018	18500	US$61,500	US$16,000

1.2. New and Underused Vaccines Support (NVS) extension request(s)

Type of Support	Vaccine	Starting year	Ending year
N/A			

1.3. Health System Strengthening (HSS) renewal request

Total amount of HSS grant	US$ 2,049,340
Duration of HSS grant (from…to…)	2013-2017
Year / period for which the HSS renewal (next tranche) is requested	2017 (with partial implementation in 2018 to bridge to the start of HSS 2)
Amount of HSS renewal request (next tranche)	Balance of most recent tranche: US$ 125,702 (pending audit report) PBF Payment: $120,000 Next tranche: US$ 417,910 (+ 2016 PBF of $120,000)

1.4. Cold Chain Equipment Optimisation Platform (CCEOP) renewal request

Total amount of CCEOP grant	N/A
Duration of CCEOP grant (from…to…)	N/A

[1] If taking too much space, the list of participants may also be provided as an annex.
[2] If the country reporting period deviates from the fiscal period, please provide a short explanation.
[3] Figures in this table are as of 11 August 2017 but should be updated once the final dose figures are confirmed

Year / period for which the CCEOP renewal (next tranche) is requested	N/A	
Amount of Gavi CCEOP renewal request	N/A	
Country joint investment	**Country resources**	N/A
	Partner resources	N/A
	Gavi HSS resources[4]	N/A

1.5. Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[5]

The Solomon Islands Ministry of Health and Medical Services will request the following support from Gavi in September, 2017:

- Health Systems Strengthening
- Cold Chain Equipment Optimisation Platform
- New Vaccine Support: HPV
- New Vaccine Support: Rotavirus

The Solomon Islands also seek to apply for Gavi support to implement an MR campaign in 2018. The Gavi Secretariat is working to determine how best to enable this request in order to ensure the most appropriate support to the country in 2018.

Indicative interest to introduce new vaccines or request HSS support from Gavi	**Programme**	**Expected application year**	**Expected introduction year**
	Routine - HPV	2017	2019
	Routine – Rota	2017	2019
	Campaign – MR	2017	2018
	HSS	2017	2018
	CCEOP	2017	2018

[4] This amount must be included either in an earlier HSS approval or else in the current HSS renewal request in section 1.4 above.
[5] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

2. CHANGES IN COUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

The political environment has remained stable in 2016, with no major natural disasters, allowing the Ministry of Health and Medical Services (MHMS) and EPI team to focus on immunisation-specific objectives.

Significant gains were made, with improved coverage rates, (99% DPT3 coverage in 2016 according to WUENIC with 94% reported admin coverage). PCV and IPV, which were initially introduced in 2015, saw a significant increase in coverage in 2016.

HSS1 saw accelerated implementation in 2016 that has continued into the first half of 2017. Progress has been somewhat hampered, however, by the suspension of disbursements due to unmet financial reporting requirements.

The new Role Delineation Policy for the health sector was finalised, providing a key building block on which the health sector and immunisation programme may continue to build and develop.

The Solomon Islands entered into their first year of accelerated transition in 2017, and the government has shown strong commitment to addressing transition issues. However, the country is facing a steady decline in donor health sector funding, and state revenues are not projected to increase enough to cover all costs at their current levels. Immunisation financing is therefore at the core of the transition issues in Solomon Islands, and all stakeholders are working together under the leadership of the MHMS to plan accordingly throughout this final phase of Gavi support.

In 2016, SI applied, and received approval, for the introduction of a second dose of Measles vaccine in 2018, and will also use 2017 as its last year for Gavi application for new vaccines to apply for the Rotavirus vaccine, and for HPV rollout. If approved, these vaccines will be introduced in the coming years, most probably in 2018/2019.

As 2017 is the Solomon Islands grace year before entering accelerated transition phase, the country will also take advantage of this last opportunity to apply for HSS and CCEOP support this year. In order to ensure a smooth transition out of Gavi support, the Solomon Islands is currently developing a Transition Plan, which will be supported by a transition grant jointly with TCA funding.

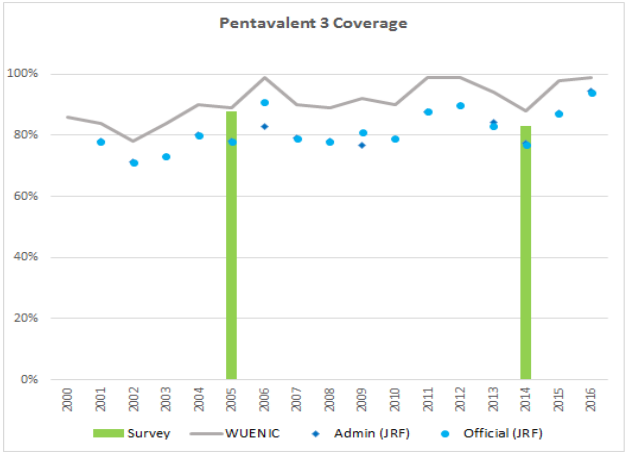
The Solomon Islands appear on the list of countries eligible to access additional TCA for 2018 under the recently approved Fragility, Emergencies, and Refugees Policy. These additional funds, if approved, will be provided jointly with a transition grant.

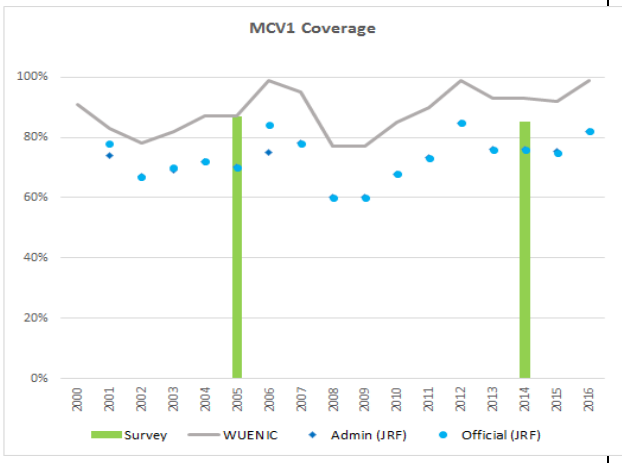
3. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

3.1. Coverage and equity of immunisation

Overall coverage/trends:

Figure 1: Pentavalent (3rd dose) and MCV (1st dose) coverage trends





Overall coverage in 2016 appears to be improving although the trend over time is volatile, possibly due to fluctuations in the estimated number of surviving infants and issues with data quality. Fluctuations in MVC1 coverage specifically are also likely to be caused by catch up campaigns boosting coverage in the years they are carried out.

The recently released 2015 DHS results confirm coverage of over 80% for both Penta and MCV1 (83% for Penta3 and 85% for MCV1). While the DHS shows a slight decrease in coverage from the last DHS of 2007, the report also shows that younger cohorts are more likely to be vaccinated than the older ones, indicating an improvement in service reach in recent years.

While much of the WUENIC data are consistent with the Solomon Islands' administrative data, key differences exist in the reported DTP3, MCV1, and some other non-Gavi vaccine coverage rates: DTP3 Admin - 94% / DTP3 WUENIC - 99%; MCV1 Admin - 82%/ MCV1 WUENIC - 99%.

The country recognises that data quality remains a challenge, and is requesting support in this area under the upcoming HSS2 application. Specifically, it is noted that reporting is often incomplete, meaning that immunisation is not always properly recorded, resulting in lower-than-actual administrative coverage rates. In addition, the 2016 WUENIC data set notes that for a number of vaccines, recent figures have also been calibrated back to levels from past years.

Equity:

There is a lack of strong equity analysis but some recent information is available from the 2016 Solomon Islands Core Indicator Report 2016 and the 2015 DHS.

The 2015 DHS shows almost no disparity between boys and girls, indicating a significant improvement since the DHS of 2006-2007 where the difference was almost 10 percentage points. However, important differences in Penta 3 coverage still remain between the highest and lowest wealth quintiles and children of educated and non-educated mothers.

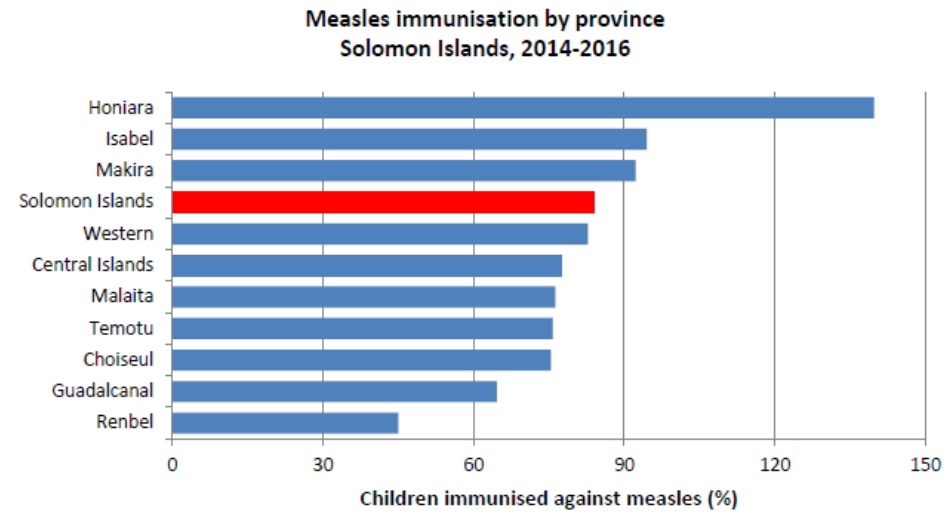
Figure 2: DHS 2015 Equity Indicators

Equity Indicators (DHS 2015 data)	Actual
Difference in Penta3 coverage between the highest and lowest wealth quintiles	9.3%
Penta3 coverage difference between males and females	0.8%
Penta3 coverage difference between the children of educated and uneducated mothers/care-takers	7.7%

The 2016 Core Indicator Report looking at the average number of children immunised against measles between 2014 and 2016 shows striking provincial disparity in measles coverage, where Renbel (45%) and Guadalcanal (65%) have significantly lower coverage than other provinces.

However, the report also cautions that data quality issues remain in the collection of this indicator, as vaccines are recorded based on their distribution point and not the usual residence of the child. This brings the coverage rates for the capital Honiara to well above 100%, as children from outer provinces often come to the capital for immunisation, and may explain the lower rates for other provinces.

Figure 3: Measles immunisation by province 2014-2016 (2016 Core Indicator Report)



The 2015 DHS, while not showing such large geographic discrepancies, does still show that the capital Honiara consistently has better coverage across all vaccines than the more remote or difficult to access areas.

Overall comment:

There is a need for better data and more detailed analysis of why a small portion of children are being missed and key to that is understanding who they are and where they are. Geographic barriers seem to be an obvious issue but the data, due to problems with data collection, aren't conclusive about the scale of the inequity between provinces. Wealth and education (probably closely correlated with geographic location) also impact access to services.

A new HSS grant is currently being developed, and will include a more detailed equity analysis as part of an in-depth coverage survey to be conducted in 2020.

3.2. Key drivers of low coverage/ equity

The Solomon Islands have a small population spread across hundreds of tropical islands which presents a unique challenge for overall service delivery, and immunization in particular. Geographic and logistical constraints limit access to populations on the more remote islands, and the severely limited infrastructure restricts access to populations even on the easier-to-reach, more populated islands.

Immunisation and health service delivery more broadly fall under the responsibility of the provinces, while national coordination of the various health programs, including immunisation, is managed from the central level. Specifically, the National Immunization Unit (NIU) falls under the management of the National EPI Program Coordinator. This position is funded by the SIG, but the additional support staff and the majority of activities are financed by Gavi. Vaccine and cold chain management is the responsibility of the National Medical Stores. Staffing and resources for health service delivery are a significant challenge at the provincial level.

The country's health workforce is concentrated in the capital with more than 70% of doctors living and working in the Honiara (capital city) area.

Outreach services are limited because of insufficient planning and funding in the provinces as well as difficult terrain. Heath facilities and workers require boats and vehicles to conduct outreach activities.

The Ministry of Health has also identified community outreach and demand generation as a gap, but does not have the expertise or resources to work intensively in this area. For this reason, UNICEF has supported a KAP study and the development of an immunisation communications strategy, and the MHMS has identified an NGO counterpart that may be able to carry out these kinds of activities, and is currently determining how best to engage them in this work.

The peculiarities of a sparse island population scattered over a large geographical area put a huge strain on the supply chain and require strong management. Key findings from the recently drafted EVM of 2017 point to weaknesses in the management of the Central Vaccine Store with major problems in storage temperature and temperature monitoring as well as overall lack of preventive maintenance of cold chain equipment. Out of 9 EVM criteria only one is deemed to have met the 80% target score. The assessment finds that little has changed since the 2012 assessment and previous recommendations not addressed.

A recently conducted cold chain inventory revealed that 64% of health facilities benefit from the presence of cold chain equipment. Of those facilities with cold chain equipment, however, 84% are functional. While the majority of second level health facilities are therefore equipped with functional cold chain equipment, the gap in equipment remains primarily at the health facility level. The country has plans to address these gaps through its upcoming CCEOP application.

The 2016 Health Core Indicator Report shows that stock availability both at the NMS and primary health care facilities has improved between 2010 and 2016. Stock levels occasionally dip below standard levels at the national level, at which point the country relies on the availability of buffer stocks in Fiji, which are managed by UNICEF. The quantity of vaccines to be delivered needs to be increased upwards to account for high closed vial wastage.

Unreliable data has an impact on the accuracy of forecasting, planning and development of tailored approaches to reach underserved populations.

3.3. Data

Data quality in the Solomon Islands is improving but remains challenging, as highlighted by the discrepancies between data sources and fluctuations in reported coverage. Nine of the ten provinces have access to DHIS2 – only Renbel does not yet have access due to issues of connectivity – and the system is generating useful reports.

However, data input issues persist, as many facilities are still recording information on paper and sending documents on to more central locations to be uploaded to the system. This creates opportunities for delays and errors, and improved access to communications equipment and internet connectivity would be required to improve data reporting and use. More frequent supervision and feedback on the data generated through DHIS2 could also help to improve data input and use. The EPI team and partners have highlighted the importance of supportive supervision and emphasis on the use of data to try to improve attitudes and practices related to reporting.

Birth registry, and therefore denominator calculation, also remains a challenge. Lack of good census data leads to erroneous interpretation linked to difficulties in clearly identifying the target population. Collection of immunization data is not currently sex-disaggregated.

In addition, two surveillance systems are currently in place. A Public Health and Emergencies Surveillance Unit focuses on identifying and reporting syndromes, with weekly data collected from 10 sentinel sites. At the same time, a Hospital-Based Active Surveillance system focuses on identifying AFP/measles/tetanus, with monthly data collected from 5 of the same 10 sentinel sites serving the first surveillance system. Both surveillance systems are paper-based, and face the same resource constraints – limited personnel, staff are overstretched, staff turnover, and limited funding. Both require further training and equipment, and there may be opportunities to strengthen both through common trainings and approaches.

These issues are being further explored through the ongoing DQA (that will include a communication equipment inventory) and the subsequent DQ Improvement Plan and will be addressed to the extent possible under the HSS2 grant and TCA.

3.4. Role and engagement of different stakeholders in the immunisation system

Coordination:

The Solomon Islands has a committee which fulfils the function of an ICC known as the National Inter-Agency Coordinating Committee for Family Health with representation from the Ministry of Health and Medical Services (MHMS), UN agencies (WHO, UNICEF and UNFPA) and World Vision. Due to the country's small size and limited technical expertise, there is no separate NITAG. Discussions are ongoing on the possibility to create a regional ITAG for the Pacific Islands. An EPI Technical Working Group composed of the MHMS, UNICEF and WHO meets routinely to address technical EPI issues.

Civil society:

As noted above, the MHMS and EPI unit have identified a need to strengthen demand generation, and have identified World Vision as an appropriate partner for this activity. Efforts are currently under way to determine whether and how World Vision can be contracted to undertake this work.

Other donors:

In addition to funding from Gavi and Alliance partners UNICEF and WHO, the MHMS also receives budget support from DFAT, some of which indirectly supports immunisation activities. However as noted earlier, funding from DFAT continues to decline, creating sustainability concerns for health sector and immunisation activities.

The private sector plays a very minimal role within the health sector and immunisation specifically.

4. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

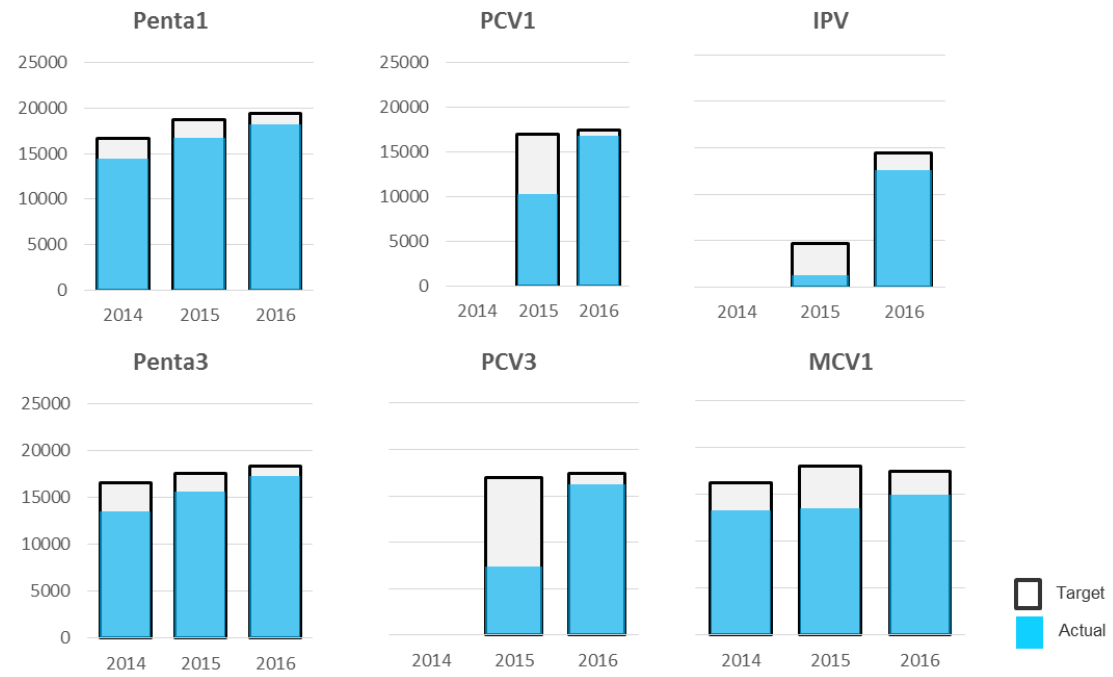
4.1. Programmatic performance

New Vaccine Support: Achievement against targets and implementation progress

Figure 4: Vaccine Coverage (2016 administrative data)

Indicator	Actual
Penta3 Coverage	94%
PCV3 Coverage	89%
IPV Coverage	69%
MCV1 Coverage	82%
% of districts with Penta3 coverage greater than 80%	80%

Figure 5: Target Achievement for NVS 2014-16 (#Vaccinated)



Penta: Coverage remains high, with 99% coverage for the first dose, and 94% coverage for the second dose, with less than 10% drop out rate. This has been largely due sustained efforts by the central EPI team and provinces.

PCV: The Pneumococcal conjugate vaccine was introduced in 2015 with a PCV3 coverage in the first year of 42%. Coverage has improved significantly in the 2nd year of introduction with PCV3 reaching 87% coverage. However, both PCV1 (92%) and PCV3 (87%) lag behind DTP1 (99%) and DTP3 (94%) respectively. Data quality challenges may be behind the different coverage rates reported for Penta and PCV. There may also be higher prioritisation of penta and polio vaccines by health workers in the Solomon Islands, as these vaccines have been in use longer and are better known.

HPV: The Human Papilloma Virus vaccine demonstration project was also launched in 2015 in the two provinces of Isabel and Honiara city targeting girls aged 9-12 years with two doses of the vaccine. In the second year of the demo, a coverage survey conducted in Honiara showed that coverage had dropped from 71% to 51% (no coverage survey conducted in Isabel in year two). Out-of-school girls were more likely to drop out than girls in school. This is reportedly due to the fact that more extensive sensitisation and awareness-raising activities were conducted in year one than in year two.

IPV: The Solomon Islands, in spite of being a low risk country, have been receiving the inactivated polio vaccine IPV without interruption. Due to a delay in introduction in 2015, coverage was only 7%. 2016 saw an impressive increase in coverage to 69% although it still lags behind the target. The country reports that data issues are behind this low coverage rate, as many facilities are still reporting using an earlier version of the report template which does not include IPV vaccine.

MCV: (MSD, measles SIA, MR MCV1) coverage has increased in 2016 to 82% from ~75% in the previous years. MCV2 has been approved for introduction in Q1 2018, and the Solomon Islands will apply for an MR campaign to be conducted from August 2018.

NVS Top 3 Achievements:

- Introduction of new vaccines strengthens implementation of routine programme through trainings and increased outreach and supervision
- Significant increases in PCV and IPV coverage, with opportunities identified to further increase coverage in 2017/2018
- Country secured approval to introduce MCV2

NVS Challenges:

- Medical store in Gizo burned down
- IPV supply constraints in 2016 resulted in reliance on UNICEF buffer stock
- Continued gaps in cold chain (36% of facilities not equipped with necessary equipment)
- Lack of resources dedicated to outreach at the provincial level

NVS Lessons Learned:

- Ongoing on-the-job training was needed to ensure the new vaccines were properly introduced into routine immunisation schedule by health workers
- Intensified focus on micro-planning allowed for improved achievements in coverage
- After unsuccessful submission of HSS and CCEOP applications, the country now has a stronger understanding of requirements, process, need for TA/consultations, and better integration of applications – this will hopefully lead to the successful resubmission of those applications in 2017

HSS: Achievement against targets and implementation progress

Implementation of the current HSS1 grant is ongoing, and is adequately on track to meet its objectives. Spending also advanced considerably throughout 2016 and into 2017.

An HSS2 application was submitted in the autumn of 2016 with the expectation that the new grant would start by mid-2017. The IRC review however resulted in a request for resubmission which will now take place in September 2017. It is likely that the full balance of HSS funds will not be spent by the end of 2017, and given that new HSS funds will not likely be available in-country by the beginning of 2018, the country team and EPI are exploring options for continuing the current HSS grant into the first half of 2018.

Summary of key HSS1 activities and achievements of 2016 and the first half of 2017:

- Significant focus on RED strategy microplanning, including budgeting, for Malaita and Guadalcanal provinces (other provinces covered with support from other donors):

  Trainings were led directly by the EPI team, as the cascade approach (originally proposed) was not achieving the desired outcomes

  Planning done by zone with trainings provided in approximately 100 facilities, resulting in as many microplans which will be updated annually

- Vaccine management incorporated into EVM trainings provided during the year

- Finalised national EPI communication strategy with support from UNICEF

  Social mobilisation and catch-up efforts through outreach in Malaita and Timotu

- OPV switch carried out in April 2016

- Finalised national cold chain policy and installed 14 solar fridges.

- HPV demo conducted in Honiara city council and Isobel:

  Outreach conducted in schools and for out-of-school girls in communities

  Post-introduction evaluation conducted by WHO and shared with Gavi previously

  Coverage survey conducted by PATH

- UNICEF funded and supported a pilot for Hep B vaccine that does not require cold chain, and a training for Hep B sero-survey

Figure 6: 2016 HSS1 performance: Tailored metrics[6]

Metric	2015 actual	2016 actual
By 2015, coverage for MCV1 is above 80% for low performing provinces (NHSP)	44% (4/9 provinces)	30% (3/9 provinces)
By 2015, coverage for DTP3 is above 80% in low performing provinces	55%	80%
% of children immunised against HepB at birth in the 3 targeted provinces	63%	56%
Percent of functioning EPI fridges	64%	68%
Complete recording and reporting for children wards admissions and discharge in three pilot provincial hospitals	Yes	Yes
The methodology for impact of outreach services evaluation in place, utilised and results made available on an annual basis	No	Yes
Number of annual integrated MNCH and EPI review and planning workshops (one annual workshop in each of the three provinces)	1	2

Challenges to HSS implementation:

Ensuring adequate outreach and supervision remains a challenge, with the central EPI team driving many of these activities at all levels. Greater commitment, both in terms of HR and financial resources, is needed at the provincial level and district level.

The EPI team has not yet been able to establish a process for contracting an NGO to engage in community mobilization/demand generation activities. However, an EPI communications strategy has now been developed with support from UNICEF.

Meeting Gavi financial requirements has been a key challenge, resulting in delays and partial disbursement of funds. In 2016 all cash disbursements to the Solomon Islands were put on hold pending compliance with Gavi financial reporting and audit requirements. Following a dialogue between Gavi partners and the EPI team in early 2017, progress was made on financial reporting and a firm was contracted to conduct an audit of Gavi-related expenses. In light of this progress and the collaborative and constructive approaches taken by immunisation stakeholders in the Solomon Islands to overcome the financial issues, a partial disbursement was made in 2017. However, any further disbursements to the country remain suspended, pending the receipt of the required audit reports.

4.2. Financial management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

Financial absorption of HSS grant:

Based on the 2016 end of year financial statement submitted by the Solomon Islands, approximately 50% of the cumulative funds disbursed for HSS had been spent ($505,595 out a total of $1,008,620

[6] No targets were submitted for 2016 (as HSS2 was expected to have started) and therefore the table looks at trends rather than achievement against targets. It should be noted that the metrics initially selected for the HSS1 support were poorly defined and not reflective of the main activities supported by Gavi.

disbursed) corresponding to approximately 31% of the funds committed to HSS. More recent financial reports indicate accelerated implementation and spending in 2017.

In 2016 the country spent $356,688 of HSS funding out of an estimated annual budget of $502,810, a utilisation rate of 71%.

In addition in 2016 the Solomon Islands spent $39,053 and $77,035 on IPV introduction and the second year of the HPV demo respectively, leaving a cumulative cash balance of approximately $130,000.

Figure 7: Cumulative expenditures and cash balances for Gavi cash grants end of 2016

Grant	Start Year	End Year	Grant Amount	Funds recipient	Disbursed USD	Disbursed SBD Received	Expenditure USD	Expenditure SBD	Country cash balance USD	Country cash balance SBD	Source	Comments/Action	Undisbursed
HSS 2	2017	2022		MoH									-
HSS 1	2012	2017	2,049,340	MoH	1,008,620		505,595		503,025			Require **categorised and signed** reports for the following: 1) Jan - Dec 16 Financial Report 2) 2012 - 2016 Audit Report	1,040,720
HPV - Demo	2015	2016	170,000	MoH	145,000		77,035		67,965			Write off remaining. Determine use of balance	25,000
VIG - IPV	2015	2015	100,000	MoH	100,000		39,074		60,926			Determine use of balance	-
OPS - MR	2015	2015	145,000	MoH	145,000		138,587		6,413			Determine use of balance	-
VIG-PNEUMO	2015	2015	100,000	MoH	100,000		108,810		- 8,810			Write off against other grant	-
VIG - Penta	2008	2008	100,000	MoH	100,000								-
													-
									629,518				

Compliance:

The Solomon Islands have not been compliant with Gavi financial reporting and audit requirements leading to a decision in 2016 to suspend disbursements. In 2017, progress has been made on improving the quality and timeliness of financial reporting and an external audit has been conducted allowing a partial release of 2016 committed funding in March 2017. The remainder of the 2016 tranche of funding and PBF will be released on receipt and approval of the final audit report. The approved PBF payment will be disbursed upon receipt and approval of a PBF budget and workplan. A key reason behind these challenges has been the lack of capacity and support available to ensure high quality financial reporting and management. The small EPI team has only one person supporting financial management, and this person could benefit from further training and mentoring.

The EPI team has been using its own bank account to manage Gavi funds, but donors and the MHMS have requested that the EPI begin channeling Gavi funds through a central development partners' health account. In addition, with Gavi support ending in 2021, the EPI team will no longer have Gavi funds available in order to operate through a separate account, and must therefore transition to the central account. Furthermore, the Ministry of Health and Medical Services has noted that the EPI team has not been applying the most up-to-date financial management procedures. The EPI team is seeking guidance from the MHMS' finance team to ensure that they immediately adopt the correct financial procedures.

To support these processes, and to build financial management capacity within the RMNCAH department more broadly, Gavi has therefore agreed to use some of SI's undisbursed HSS funds to contract a firm or individual to provide on-the-ground financial management capacity building to the EPI team for an initial period of six months. This procurement process has been severely delayed but is in progress, and if a firm or consultant can be identified quickly, it may be possible to place someone in this role in Honiara by autumn 2017.

A PCA has also just been conducted in the Solomon Islands, and will provide specific Grant Management Recommendations for further support to SI. The external audit report, to be submitted in August 2017, is also expected to shed light on further areas for strengthening. It should be possible to respond to some of the findings through the HSS and transition grants to be implemented from 2018 onwards.

4.3. Sustainability and (if applicable) transition planning

The Solomon Islands entered into the accelerated transition phase at the beginning of 2017. The country will fully transition from Gavi support by 2022, at which point the expanded program on immunization will have to be fully funded by the MHMS bringing the budget for vaccine procurement, if its applications for rota and HPV introductions in 2018 are successful, to an estimated $ 477,000. . 2017 is the last year in which the Solomon Islands are eligible to apply for vaccine or HSS support.

The Solomon Islands' greatest transition challenge continues to be the lack of financial resources available for the country to sustain a robust immunisation programme beyond Gavi's withdrawal at the end of 2021. Macroeconomic growth is forecasted to be modest (GDP in the range of 3% between 2017 and 2021) and the country is already allocating a substantial share of the budget to health (13% in 2016, domestic only), consistently second largest after the education sector. Real government health expenditure per capita has been constant over last 4 years. As noted above, DFAT has been the single greatest contributor to SI's health sector since 2007, and their contribution has been steadily declining since 2014 with SI's domestic health expenditure not able to keep up pace to fully cover the gaps. Therefore SI is conscious of the need to focus on increasing efficiencies through, among else, greater integration within the health sector and enhanced clarity on the service delivery packages to be provided at each level. The Role Delineation Policy due to be approved later this year is a first step towards a more comprehensive overhaul of the health sector. In addition, since 2011 Provincial Divisions have seen an increase in their funding, while national programmes have seen a drop, which reflects the recognition that provinces are increasingly expected to be responsible for service delivery, while the national programmes should serve as technical support units only. This brings with it the challenge of ensuring the quality and efficiency of spending in the provinces.

The EPI unit's operational costs are fully donor funded, of which 85% of the funding comes from Gavi in 2017. While the position of the EPI Manager is funded by the government, two other staff are funded by the UN Joint Programme due to end at the end of 2017 and one staff by the HSS grant. Solomon Islands has consistently paid for co-financing (except an administrative glitch in 2013) and is procuring non-Gavi vaccines through VII (fully government funded).

A transition assessment was conducted in the Solomon Islands in 2015, and the country has been working closely with the Gavi Alliance partners, including WB, to develop a detailed, costed transition plan. During a transition mission conducted in 2017, Gavi engaged in a series of consultations and workshops were held with the MHMS, Ministry of Finance and Treasury, Procurement and Supply chain experts, to begin identifying ways that the Alliance might support the transition process. Two core areas emerged – enhancing efficiencies and better integration (i.e. improved use of limited resources), and the potential for greater financial contributions from provinces in the context of Gavi phasing out the operational costs funded so far to a large extent through the HSS grant. An additional emphasis was also placed on securing adequate HR funding for the EPI, taking into consideration the ongoing health reform and reorganisation of the Ministry. Discussions also explored issues related to procurement and the need for the establishment of a NITAG or NRA. All stakeholders were in agreement that procurement of vaccines and other commodities should continue through UNICEF to the extent possible, and the MHMS and MoFT indicated their willingness to ensure that this will remain possible. Relevant stakeholders will now determine the best course of action to achieve this outcome. Regarding NITAGs, WHO is exploring the possibility of establishing a regional ITAG and will engage with SI on this issue over the course of the next year. WHO will also plan to support an NRA "Self-assessment" mission to SI to help the country determine whether the establishment of an NRA would be useful, and/or feasible.

The draft Transition Plan has now been developed which outlines the steps different stakeholders may take to make progress in these areas. It is currently being reviewed and costed by the various stakeholders, and is expected to be finalized by the end of August.

Preparing the country for transition from Gavi support will be a key objective of the HSS2 and CCEOP applications currently being drafted for submission to Gavi in September 2017. Key areas of focus include strengthening cold chain capacity, improving the reporting and use of data, building HR capacity both at the central coordination and provincial level and strengthening outreach services.

4.4. Technical Assistance (TA)

WHO and UNICEF, as well as PATH as an extended partner, provide TCA to the Solomon Islands through Gavi funding.

UNICEF employs an EPI Specialist to provide continuous, dedicated support to the EPI team. This support has proven to be invaluable to routine activities such as micro-planning and the development of the communications plan, and through this role, UNICEF has also ensured support for other activities, such as securing a consultant to prepare the cold chain inventory and CCEOP application. UNICEF has reported that activities are on track in their recent PEF reporting.

WHO provides support on demand, and through the general engagement of their in-country and Fiji and Manila-based teams. The recent EVM, planned DQA, and preparation of the HSS, Rota and HPV applications, among other activities, benefitted from considerable support from WHO in 2016/2017. WHO has not yet completed their PEF reporting for Solomon Islands TCA.

The Solomon Islands appear on the list of countries eligible to access additional TCA for 2018 under the recently approved Fragility, Emergencies, and Refugees Policy. These additional funds, if approved, will be provided jointly with a transition grant, once all inputs have been secured. Critical areas for continued TCA in 2017/2018 will include cold chain, EVM improvements, HSS support, vaccine introduction; and transition-related activities such as reviewing options for an NRA and continued access to VII, and increasing domestic financing of immunisation, particularly through engagement with the provinces.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	**Current status**
1. Conduct RED strategy/Micro planning for all low performing zones	RED strategy/Micro planning work conducted in all Gavi-supported targeted locations
2.Support Clinic Outreach programs, in funds and logistics	Outreach supported through both provision of funds and logistical support (procurement of boats in progress)
3. CCE installation, maintenance for Priority Provinces	Planned CCE installed and staff trained in maintenance
4.Conduct monitoring and supervision to poor performing zones	Central EPI team conducted monitoring and supervisory visits across poor performing zones
Additional significant IRC / HLRP recommendations (if applicable)	**Current status**
1. Resubmit HSS Application	In progress
2. Resubmit CCEOP Application	In progress
3. No further disbursements against HSS and PBF until financial reporting/planning requirements met	Annual financial reporting completed, partial disbursement of HSS funds completed, PBF budget and workplan under development, external audit in progress. Disbursement projected for August 2017.

6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for the next year:

- Preparations for introduction of HPV and rota in 2019 (subject to Gavi approval)
- Introduction of MR second dose (approved by Gavi in 2016)
- Implementation of MR follow up campaign (subject to Gavi approval)
- Completion of current HSS grant
- Implementation of HSS2 and preparation for CCEOP implementation (subject to Gavi approval)
- Wastage study
- Formalisation of engagement with NGOs (demand generation, etc)
- Transition preparation and planning
    - Developing clear estimates of immunisation costs to enable the government to include it in their annual and medium-term planning and budgeting
    - Strengthening immunisation budgeting and planning between central and provincial levels
    - Identification of areas for greater efficiencies and integration to reduce health sector/immunisation costs
    - Securing appropriate HR resources for the EPI in view of the reform process and enhance accountability for immunisation–related activities at the provincial level
    - Streamlining processes and guidelines to continue procurement through UNICEF
    - Exploring RITAG option
    - Conducting NRA self-assessment
- Phased scale-up of hepB outside cold chain

Key finding 1	If 2017 applications are successful, 2018 will be a critical year for new vaccine introductions. Significant TA will likely be required to ensure all objectives can be achieved simultaneously.
Agreed country actions	• Secure continued TA from PATH for HPV • Secure continued TA from WHO for Rotavirus • Secure TA from WHO for MCV2 introduction and MR campaign application, implementation, monitoring and evaluation. • Secure TA from UNICEF for micro-planning
Associated timeline	• Contracts to be in place throughout the year as needed
Technical assistance needs	See above
Key finding 2	If the 2017 CCEOP application is successful, important preparations for successful procurement, deployment, instalment etc will need to happen in 2017.
Agreed country actions	• Continued in-country support from UNICEF • Secure intermittent TA from UNICEF to provide targeted cold chain support • Engagement with MHMS' Health Facility Management Team and possibly with Ministry of Infrastructure Development to ensure oversight of CCE installation, maintenance and training • Finalisation of Operational Deployment Plan
Associated timeline	• As soon as the CCEOP proposal is approved (November 2017)

Technical assistance needs	See above
Key finding 3	Vaccine management issues including shortages from very tight dose calculations and broader health system challenges need to be addressed.
Agreed country actions	• Wastage study to be conducted • Continued negotiations with Gavi regarding real wastage rate and improved dose calculations • Conclusions from EVM assessment to be transformed into actions and included in HSS2 grant • TA for EVM improvements to be secured from WHO
Associated timeline	• Wastage study to be conducted once transition plan approved • TA to be secured once HSS approved (under transition budget) • EVM improvements to be implemented over life of HSS2 grant
Technical assistance needs	See above
Key finding 4	Strengthen data systems and surveillance
Agreed country actions	• DQA to be completed in August 2017 • Data quality improvement plan to be developed and elements incorporated into HSS2 • Incorporate position of current surveillance officer into HSS grant to end of 2019 when it will then be absorbed by SIG
Associated timeline	• Over the life of the HSS2 grant
Technical assistance needs	• Secure ongoing support/TA from WHO
Key finding 5	Financial Management challenges and delayed procurement processes need to be addressed.
Agreed country actions	• Adjust financial management approaches based on findings from PCA • Maintain current financial management arrangements, as they are on-plan and on-budget, but shift signatory responsibility to PS with counter-signing Under-Secretary responsible for finance within MHMS • Recruit long-term consultant to strengthen financial planning, reporting and management ○ Gavi Secretariat responsible for this task and have experienced significant delays
Associated timeline	• PCA findings to be applied once report released and actions agreed between Secretariat and country • Immediately shift signatory responsibility for financial sign-offs • Secure consultant by end of September (Secretariat)
Technical assistance needs	See above

7. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

The joint appraisal update was drafted by the SCM, shared with the EPI team and partners for review, edited accordingly, and then shared with the ICC for endorsement by the EPI Manager.

8. ANNEX

Compliance with Gavi reporting requirements

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal.

It is important to note that delayed reporting may impact the decision by Gavi to renew its support.

	Yes	No	Not applicable
Grant Performance Framework (GPF) reporting against all due indicators	X		
Financial Reports			
Periodic financial reports	X		
Annual financial statement	X		
Annual financial audit report		X (audit carried out but report not yet received)	
End of year stock level report	X		
Campaign reports	X		
Immunisation financing and expenditure information	X		
Data quality and survey reporting	X		
Annual desk review		X (DQA in progress)	
Data quality improvement plan (DQIP)	X		
If yes to DQIP, reporting on progress against it			
In-depth data assessment (conducted in the last five years)	X		
Nationally representative coverage survey (conducted in the last five years)	X		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan		X (new EVM carried out in progress 2017)	
Post Introduction Evaluation (PIE)	X		
Measles-rubella 5 year plan	X		
Operational plan for the immunisation program	X		
HSS end of grant evaluation report			X
HPV specific reports	X		
Transition Plan		X (in progress)	