



Reprogramming of Health System Strengthening (HSS) Support Funds in PNG

Country Name:	Papua New Guinea
Date of application:	15 January 2016

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PNG HSS REPROGRAMMING APPLICATION

Mandatory Attachments		X
No.	Attachment	
1	Complete HSS Reprogramming Application Form	
2	Signature sheet for HSCC (or equivalent body)	
3	Signature sheet for the Ministry of Health (or delegated authority)	
4	Minutes of the HSCC meeting endorsing the reprogramming application	
5	Revised work plan, budget and gap analysis, using the Gavi template, for all remaining years of the HSS grant	
6	Detailed procurement plan covering the next two years of programme implementation	
7	National M&E Plan for the health sector/strategy (with actual reported figures for the most recent year available in country)	
8	The most recent interim unaudited financial report (IFR) for use of HSS funds in the current calendar year.	
9	External audit report for HSS funds during the most recent fiscal year	

Additional Attachments – required if document has changed from that submitted with the original HSS proposal		X
No.	Attachment	
10	Latest National Health Sector Plan (NHSP) (or other document/s which highlight strategic HSS interventions), if different from what was submitted with the original proposal	NA (same as previous)
11	Latest cMYP, if different from what was last submitted with the original proposal	NA (same as previous)
12	Sector performance annual review	X
12a	Latest Health Sector Review Report	X
13	Financial statement for HSS grant for the previous calendar year	X
14	EPI Review	X
15	Joint Appraisal 2015	x
16	SIREP Operational Field Guide	x
17	SIREP ten districts	x
18	SIREP Plus	x
19	SIREP budget	x
20	Child Health Policy	x
21	National EPI Report 2014	x
22	National Health Plan	x
23	EVM 2011	x
24	Bottleneck chart	x
25	cMYP	x

Additional Attachments – required if document has changed from that submitted with the original HSS proposal		X
No.	Attachment	
26	DFAT EPI Review of PICTs 2015	x
27	Draft outline of Graduation Grant	x
28	MCH accountability framework	x

1. HSS REPROGRAMMING APPLICATION FORM

PART A: SUMMARY OF ORIGINAL SUPPORT AND APPLICANT INFORMATION

Country name:	Papua New Guinea
Original proposed start date for HSS grant:	1 July 2013
Original proposed end date for HSS grant:	June 2018
Original duration of support:	5 years
Revised new end date for HSS grant, based on this reprogramming application:	30 June 2017
Joint appraisal planning:	<p>In order to align country annual planning and budgeting cycles with Gavi implementation and reporting, applicants are required to:</p> <p>Indicate which HLRP meeting the joint appraisal report will be submitted to: October 2016</p> <p><i>Gavi strongly encourages countries to submit both HSS and NVS for review at the same HLRP.</i></p> <p>A joint appraisal was conducted in PNG in the second half of 2015. The next one will be conducted August 2016.</p>

Original Gavi HSS grant budget (in \$ USD):		
(A) Total grant amount originally approved by Gavi	(B) Amount spent to date (specify DATE):	(C) Amount remaining for reprogramming (C = A – B)
USD 3,072,923	USD 563,718	USD 2,512,205

Please complete the table below for all the remaining programme years of HSS grant implementation included in this reprogramming application. Please include the dates of each programme year (e.g. January 2014 – December 2014). Please add additional programme years as needed.

Annual breakdown for reprogramming application	Current Programme Year	Current Programme Year +1

(in \$ USD): <i>Please detail the dates (month/year – month/year) of each programme year.</i> <i>Please use the total value from column (C) above and allocate for each remaining programme year of the grant.</i>	01/06/2016-31/12/2017	01/01/2017-30/06/2017
	Only one year	Only one year

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PART B: REPROGRAMMING DETAILS

1. Background Information

Since the original Gavi HSS grant was approved, has your country developed a new National Health Sector Plan or any other strategy or plan relevant to immunisation (such as routine immunisation strategy, maternal and child health strategy, etc.)?

NO – The current National Health Plan covers the period of 2011-2020. The Maternal and Child Health Policy is also valid until 2020. The cMYP is valid until the end of 2015, but is scheduled to be renewed in February 2016, with technical support from WHO already planned. The National Department of Health (NDoH) confirms that the objectives of this reprogramming application are in line with those intended for the cMYP 2016-2020. The last EVM was conducted in 2011 and another is planned for early 2016.

The vision for the HSS Reprogramming and Graduation grants

The vision of the National Department of Health (NDoH) is for a nation of healthy individuals, families and communities where self-reliance prepares all for healthy living in a healthy island environment. The ultimate goal is for improving the health of all Papua New Guineans through the development of a health system that is responsive, effective, affordable, acceptable and accessible to the majority of people.

The National Health Plan of Papua New Guinea describes a 'Strengthened Primary Health Care to All and Service Delivery to the rural majority and urban poor'. This is an important element that is reflected in the GAVI Reprogramming Grant, setting the scene for a targeted approach to reaching the unreached in difficult-access rural communities that have, until now, eluded regular access by the health services. This can, to a large extent, be attributed to extremely difficult terrain and a flawed decentralization policy where the provinces and districts have been given the responsibility for running rural health services without ensuring commensurate financial resources and managerial capacity and accountability.

The Government is focusing its efforts on improving maternal and child health and reducing malaria, tuberculosis and HIV/AIDS through specific programmes. There is a heavy burden of communicable diseases, which suggests that huge improvement in health outcomes could be achieved with simple and effective interventions using a primary health care approach. While some hospital services are essential, most health problems can be addressed through effective delivery of primary care that is linked to appropriate referral services. The current poor health status of rural populations points to a weak primary health care system with a lack of essential services that reach rural communities for even basic needs, such as immunization and safe delivery. The increased size and mobility of populations, the growth of larger, denser populations in peri-urban communities, and the relative weakening of health services combine to increase the incidence of communicable diseases.

Papua New Guinea still remains susceptible to outbreaks of vaccine-preventable diseases due to suboptimal immunization coverage. Efforts are also required to strengthen the EPI disease surveillance systems.

Maternal and child morbidity and mortality are not improving in Papua New Guinea. Maternal mortality estimates vary widely, but all are high. The 2006 DHS established a maternal mortality ratio of 733 per 100 000 live births. Around half of pregnant women are cared for by trained health personnel and about 52% of births are in health facilities. Around one quarter of women are using modern family planning methods (2006).

Immunization services in Papua New Guinea are offered as part of public health services through a network of 800 Maternal and Child Health (MCH) clinics, and approximately 30% of the children are reached through outreach services. The rest of the target population is covered through immunization sessions organized at health facilities. Approximately 63% of health facilities are government-owned and the remaining by nongovernmental organizations, religious organizations and private practitioners.

PNG is expected to apply for a HSS Graduation Grant of \$6 million, in addition to this reprogramming application, totalling over \$8 million of vital support. The intention of the use of these funds is to prepare the country for transition by addressing key immediate challenges and laying the groundwork for a sustainable program. Because this reprogramming grant is for a limited amount of funding (in terms of the 7 million population), and its duration is for only one year, the NDoH has determined to select activities for funding that will have the greatest impact on service delivery in the long term, especially for the currently unreached rural areas. The elements will not, in themselves, be expected to raise coverage or reduce cases of vaccine-preventable disease. But they will prepare the ground for the subsequent grant that has more of an implementation focus. Attachment 27 outlines the graduation grant elements.

Thus the main items requested for support are the top two levels of infrastructure (namely refurbishing the cold chain at central cold store and cold rooms in the 22 provincial cold rooms), and training staff (cold chain technicians and regular health facility staff) to install and maintain the new equipment correctly. This will ensure a proper flow of vaccines as far as the provincial level. The next HSS grant (the Graduation Grant) will run for longer (five years) and will focus on refurbishing the cold chain to the more peripheral levels. This will entail mostly solar equipment that requires specialist installation and maintenance/repair.

The other major areas of support are the implementation of SIREP (Special Integrated Routine EPI Strengthening Program) and advocacy and demand generation for immunization. SIREP is PNG's revitalized approach to routine immunization (with an emphasis on outreach), and as such this program is vital. Due to decentralization, SIREP is reliant on strong financial commitment from Province and District levels. Rural areas often complain of under-funding for immunization, but this is often a function of misunderstanding of how to access funds already available. In particular, provinces and MPs have considerable funds available to them, but because of their discretionary basis, do not choose to provide MCH/EPI with these resources.

The grant will address this issue in the expectation that more funds will become available for MCH/EPI in the period of the graduation grant. Advocacy and demand creation are addressed with two TAs that will require outside assistance to complete, but such expertise will provide the proper planning for activities in the next grant.

In the meantime, Gavi funds from both grants will be used to support implementation of SIREP in districts that are most at risk of missing out on services due to their inaccessibility and subsequent high cost. It is envisioned that this support will not only ensure that the hardest to reach are reached, but also that this will set an example for Provincial and District decision makers to see what can happen when the program is well-funded. Included in the Graduation Grant is an increasing government contribution that will lead to the eventual complete funding of SIREP.

In addition to these activities the reprogramming grant includes implementing the Maternal and Child Health Accountability Framework (described in detail in Attachment 28). This strategy collects essential data at the health facility level, helps staff to analyze it, and identifies areas that need extra resources or different strategies to improve coverage of MCH

and immunization services. This will initially be piloted in 3 selected districts in this grant and in other districts in the graduation grant, pending positive evaluation.

The grant also looks to improve capacity of health care workers in basic EPI skills, a weakness identified in the recent Joint Appraisal and Graduation Assessment. Training will also be conducted to increase skills of Provincial Cold Chain and Logistics Officers and appointed district staff in cold chain maintenance to support the major investments being made in cold chain equipment.

In summary, the vision of the reprogramming grant is to initiate various strategies that will allow the graduation grant to implement activities that will raise coverage and correct the imbalance of service provision to the rural poor.

Additional attachments

- Attachment 15. Joint Appraisal
- Attachment 16. SIREP Operational Guide
- Attachment 14. 2013 EPI Review
- Attachment 12. Sector Performance Annual Review 2014

The original Health Systems Strengthening (HSS) proposal was reviewed and recommended for approval by the Independent Review Committee (IRC) in April 2013 for USD 3,072,923 over 5 years. The original application was aimed at intensifying integrated Expanded Programme on Immunization/Maternal and Child Health (EPI/MCH) outreach in 8 low performing provinces. However, since the application submission several key factors have changed immediate priorities for immunization in Papua New Guinea (PNG).

Firstly, the availability of funds for PNG's health budget has decreased significantly, by 20% at latest account, and is expected to drop even further, anecdotally as far as 60% in 2017. This is due to a number of factors including falling commodity prices and the closure of Ok Tedi and Tolukuma Mines and other industries. A foreign exchange cap of \$50,000 has been placed on the purchase of commodities and is likely to affect co-financing payments and procurement of vaccines. Changes in decentralization policy and awarding budget to districts through the political route are also affecting the availability of funds for health. This will have a significant impact on the national EPI budget and has altered immediate priorities in regards to required support for health system strengthening. For example, it was intended that the government would contribute substantial funds towards cold chain improvement, however this no longer appears feasible.

A number of reviews of the EPI and the use of Gavi funds have been conducted since the original grant submission, providing new insight into the program. These include the 2013 EPI Review, the 2014 Graduation Assessment and the 2015 Joint Appraisal. The reviews arrived at similar conclusions concerning the immediate challenges national immunization programme, including:

- Major gaps in the cold chain system and effective vaccine management
- Limited capacity of health staff in EPI specific skills, and a need for training and regular "on-site" supportive supervision, mentoring and coaching
- A continuing lack of vital outreach services
- A need to improve monitoring and evaluation, and review population data
- Challenges in political commitment at the provincial and district levels, leading to a lack of operational funding support
- Weak management of the programme from the central level

In addition to these findings, overall immunization coverage in Papua New Guinea has

stagnated over the past 3 years. In the same period, outreach sessions have been increasingly irregular in every health facility area. Data from the Sector Performance Annual Review 2014 show that the national average of rural outreach clinics per 1000 children <5 years was an average of 35 from 2009-2013 where the target was 50. In 2014 a National EPI Surveillance Consultative Workshop was held where Provincial representatives outlined the need for a new approach to addressing immunization challenges at the facility and community levels. As a result of this, the 'Special Integrated Routine EPI Strengthening Program' (SIREP) was developed. This strategy is aimed at reaching every facility to provide health workers with information and assist them to develop village population based micro plans, which will be implemented on a quarterly basis. SIREP was introduced through an initial campaign stage (SIREP Plus) through 12 of 22 provinces (as of December 2015). The initial rollout of SIREP Plus further demonstrated the need for increased capacity of the cold chain, and highlighted the significant need for increased financial commitment at the Provincial and District levels.

When executed to its full capacity, SIREP will ensure that the entire population receives immunization and integrated maternal and child health services at least once per quarter. However, it requires significant support and financial commitment from the government at all levels. Decentralization of the system has led to widespread responsibility for the rollout of routine immunization, including SIREP. NDoH is responsible for vaccine procurement and the nationwide cold chain while Provincial and District levels are required to allocate funding for all operational costs.

Provinces and districts receive funds through the following means:

- a) Health functional grants: these are to be spent on 3 identified minimum priority activities (infrastructure, medical supply distribution and outreach). T
- b) Funds for the free health care policy.
- c) District Service Improvement Funds: these funds are provided directly to local MPs.

The allocation of these funds is determined by the relevant decision makers at the Provincial and District level and managed by local managers. As such the program is reliant on the commitment of leaders; NDoH can only suggest what the funds are spent on and has limited visibility around expenditure.

Historically Provinces and Districts have committed some funds to EPI but not enough to meet outreach and coverage targets. Commitment varies widely from Province to Province but the recent drops in coverage and outreach indicate that investment may have decreased. It is predicted that Provinces and District levels will contribute between 30-50% of the SIREP budget (variable by province). In order to reduce this gap and prevent any further decrease in investment significant work needs to be done to advocate to relevant decision makers the importance and cost benefit of investment in EPI. This issue needs to be addressed rapidly to ensure that the program is able to, at a minimum, maintain its coverage.

As a result of these collective changing priorities, it was determined by the National Department of Health and the Interagency Coordinating Committee (ICC) that the HSS funds would be better utilized if reprogrammed to meet new objectives. Gavi has agreed in principle to support PNG towards graduation with a grant of \$6 million, and the reprogramming of the original HSS grant is intended to contribute to the overarching objectives of that amount. As such, the reprogramming of the HSS grant is designed to improve the cold chain system, build capacity of health workers, support routine immunization (including outreach through SIREP), generate demand for immunization and integrated MCH services from both decision makers as well as communities, and more effectively manage the programme.

The original grant focused on the integration of maternal and child health services with immunization, and the importance of this is not lost. However, the initial activities from the grant showed that a more comprehensive, evidence-based approach is required to produce results. As such, a portion of the reprogrammed funds will be used to develop a well-thought out, evidence-based strategy for the provision of integrated services that will be absorbed into SIREP. The reprogrammed funds will also integrate MCH in data management through the piloting of an MCH accountability framework. Finally, information, education and communication (IEC) materials produced from the grant will address MCH topics.

The original Gavi HSS grant was for USD 3,072,923 over 5 years. Due to various delays, the total amount of funds disbursed up to December 2015 was only \$1,103,854 (two tranches of \$565,747 + \$538,107). Therefore the unspent balance from this total amount (\$1,969,069) is being consolidated into the reprogramming funds. In addition there is \$543,136 unspent in the NDoH account in country that can be added to the amount for reprogramming. In all, USD 2,512,205 is available for reprogramming.

	USD
Amount nominated in original 5 year HSS grant	3,072,923
Total disbursed to PNG as at December 2015	1,103,854
Amount still to be disbursed	1,969,069
Unspent as at December 2015	543,136
Total not yet disbursed (but available for reprogramming)	2,512,205

Please outline the decision making process for the proposed changes in the HSS grant activities in this reprogramming application. Clearly describe the roles of the HSCC including the government, development partners and CSOs in the decision making process.

Please attach Mandatory Attachment #4 – Minutes of ICC meeting January 15 when this reprogramming was endorsed, as well as any other relevant ICC meeting minutes.

Several key events influenced the decision to reprogram the HSS grant.

In 2014 the National EPI Surveillance Consultative Workshop was held whereby Provincial and District leaders requested a renewed emphasis on routine immunization, resulting in the development of the SIREP strategy.

In the same year, the Gavi Graduation Assessment was conducted, highlighting the need to refocus activities on changing priorities. It recommended increasing cash support (an additional USD 6 million) to address crucial health system issues. Given these changes in priorities it was also recommended to reprogram funds in the current HSS grant. This recommendation was further crystallized in the 2015 Joint Appraisal. During this process NDoH and the Immunization Interagency Coordinating Committee (ICC) agreed that the HSS funds would be better spent towards supporting SIREP and other new priority activities. As such, a final decision was made to reprogram the HSS grant to support the upcoming intended USD 6 million amount.

WHO WPRO provided funding for technical support from two consultants who collectively spent 3 weeks in country working with national officers to develop the proposal for the reprogramming. The drafting of the application was led by a core team composed of the manager of Family Health Services, the manager of PNG's EPI, the cold chain manager,

and the WHO EPI Technical Officer. Technical assistance was also provided by WHO regional office in Manila.

Discussions regarding the reprogramming priorities were held with NDoH (senior management, Family Health Services, EPI, Health Promotion, Health Facilities, Financial Services), Church Health Services, WHO WPRO, WHO PNG, UNICEF EARO, UNICEF PNG, and Australia Department of Foreign Affairs and Trade. One-on-one interviews were conducted and several formal and informal joint meetings were held with NDoH and partners to develop priorities. In addition to this, drafts of the proposal were shared with partners for their feedback to ensure that all activities aligned.

Inter Agency Coordination Committee (ICC) members were engaged through their individual participation in various meetings. They were forwarded the draft of the proposal on 11 January 2016 for their feedback. An ICC meeting was then held on 15 January where all members agreed to the reprogramming application.

Work on the grant proposal started on 30 November 2015 with a meeting of all key stakeholders at the WHO office. The rest of the week was spent working with the core team of Laura Davison (WHO Manila), Assoc. Professor John Clements (University of Melbourne) and Dr Salim Reza (WHO, POM) – see timetable. A meeting of stakeholders was called for 2 December (and the attendance list is posted as Attachment 30). Others involved in the development process are listed below. The draft proposal was shared with the ICC members on 11 January, and a meeting of the ICC was convened on 15 January where members were asked to sign their agreement with the application. It is anticipated to submit the proposal for the graduation grant to GAVI later in the year.

Because of time constraints regarding the January deadline for submission, no attempt was made to involve the staff at sub-national (provincial) level directly in the writing of the proposal. Such consultations can be very expensive, bearing in mind the difficult communications within PNG. However, provinces have been involved in constructing the cold chain inventory and planning the test sites identified in the proposal. SIREP itself was designed based on sub-national consultation through the 2014 National EPI Surveillance Consultative Workshop where Provincial and District representatives outlined the need for a new approach to addressing immunization challenges at the facility and community levels. But there is no single body that is available for consultation that represents the 22 provinces. Officers in DFAT were interviewed individually, and staff in POM UNICEF and WHO offices were in constant communication with the team during the writing.

Timetable

Monday 30 Nov	AM. Briefing with EPI national manager, other NDOH team members, WHO team PNG, WHO/WPRO staff, in WHO Office. Conducted bottleneck analysis PM. UNICEF Rep and team, UNICEF Office
Tuesday 1 Dec	AM. Informal meeting with UNICEF EPI/STC, NDOH CC Officer, WHO Programme Officer to discuss SIREP and cold chain. PM Security briefing
Wednesday 2 Dec	AM. Team work PM. Team meeting to discuss progress to date. Presentation by CJC and LD to NDoH team.
Thursday 3 Dec	AM. Meeting with Secretary of health, meeting with DFAT PM. Meeting with Rosaline (Health Education), and Deputy Sec

	NHP&CS. Team work
Friday 4 Dec	AM. Meet with WHO-WR. Meet with Christian Health Services PM. Team work
Saturday 5 Dec	Depart PNG
December 6-18	Work at distant workstations
Personnel met with	
<p>Mr Pascoe J Kase, Secretary for Health Elva Lionel, Deputy Secretary NHP&CS Christine Sturrock, Counsellor, DFAT Roselyn Melva, Manager Health Promotion Dr Mohamed Salim Reza. WHO Programme Officer PNG Dr Sergay Dioritsa, Coordinator, EPI/WHO/WPRO Paulinus Sikosona, HSS Coordinator, WHO, PNG Dr W Lagani, Manager Family Health Services Branch, NDOH, PNG Dr Sibauk Bieb, Executive Manager Public Health, NDOH, PNG Gerard Pai Sui, EPI Manager, NDOH, PNG Jonnie Arava, Technical Officer Cold Chain, NDOH, PNG Baba Danbappa, UNICEF Representative, PNG Dr Pieter JM van Maaren, WHO/WR PNG Laura Davidson, Programme Officer WHO/WPRO Sukadeo Neupani, EPI Consultant SWITCH, Nepal Peninah Masu, Logistics and Procurement Officer NDOH, PNG Vathinee Jitjaturunt, Dept Rep, UNICEF PNG Dr Justine Nankinga, Paediatrician UNICEF PNG Arnold Calooy. Consultant EPI/UNICEF, PNG Nathan Kili, Christian Health Services.</p>	
<p>The reprogrammed proposal continues to be aligned with the “National Health Plan 2011-2020” and the comprehensive Multi-Year Plan (cMYP) for the period of 2011-2015 for the National Immunization Program. The cMYP will expire prior to the roll out of the reprogrammed activities, however it is planned to be updated in the 1st quarter of 2016 with technical assistance from WHO, and will be in place before the next application for the USD 6 million is produced. This application has been developed in line with the intentions of the upcoming cMYP 2016-2020. In particular, SIREP is intended to form a major role in the plan.</p>	
<p>Although not ready at the time of preparation of this application, an Effective Vaccine Management (EVM) assessment is scheduled to take place in February 2016. This will play a role in informing the implementation of the reprogramming, and will be a major influence on the development of the upcoming Graduation Grant application.</p>	

2. Health system bottlenecks to achieving immunisation outcomes

Please complete this section only if the reprogramming application includes new or revised objectives not included in the original approved Gavi HSS grant.

This section will be used by the IRC to understand the main bottlenecks affecting health system performance. Countries should then demonstrate how the new/revised objectives

and activities in the reprogramming application are designed to address these bottlenecks.

Countries are encouraged to describe the following:

- Health and immunisation systems bottlenecks that impede the improvement of immunisation outcomes, at each health system level.
- Bottlenecks and constraints to providing services to specific population groups, based on geography, gender or socio-economic status. These may include barriers to civil society and community level interventions.
- Bottlenecks identified in any new vaccine applications to Gavi and recent health sector assessments, such as Effective Vaccine Management (EVM) assessment or Post Introduction Evaluations (PIEs).
- Description of efforts underway to address the noted bottlenecks.

In order to keep this question concise, please provide references to the relevant sections in existing bottleneck analyses

Maximum 2 pages:

As a result of the 2013 EPI Review, the 2014 Graduation Assessment, the 2015 Joint Appraisal and the original 2012 HSS grant application many health systems bottlenecks have been revealed and discussed. Below is a recap of the most severe currently affecting the program. A concise table outlining these is available in Attachment 24.

Enabling environment

1. Social norms

- Generally vaccination is seen as a positive experience for the majority of communities. However, there is a lack of active demand for services which in turn affects the decisions of district and provincial leaders in regards to immunization financing.
- There is an on-going heightened security risk in many parts of the country with frequent tribal clashes leading to periods of time where communities are without access to services.
- There is no evidence of a marked gender bias in favour of either sex.

2. Management, coordination, governance, policy and regulations

- There is a lack of strong leadership at central level. This is partly due to the individual staff in post, and partly due to the dynamics of Central government-to-province dynamics resulting from devolution.
- Decentralization with devolution of government to the provinces continues to limit central government's ability to implement policy, including health. Funds go directly to provinces who are not directly accountable to central government including NDOH. Indeed, national policy is oftentimes not implemented, without consequences to the province concerned. There is no transparency regarding accountability of how allocated funds are spent.
- The ICC is working well at central level, with a broad representation of its membership. But strong leadership at central level of government is lacking. There is little systematic accountability process in place.
- Church organizations offer a significant proportion of immunization services. They are represented in the ICC, but their presence is missing in governance at other levels.
- Management capacity at the health facility and provincial levels is very low.

3. Health finance

- Financial flow from central level is stifled. This includes funds from the NDOH that are HSIP (Health Services Improvement Programme – pooled partner funds). As well, the MOF sends funds directly to the provinces, and these funds are difficult for the district and lower levels to access. Funds come from the MOF (Health Functioning Grants) on a quarterly basis, but often do not arrive until near the end of the year and there is a scramble to try and spend them before they are returned to MOF as “unspent”.
- Despite budgeting, each level complains that there are inadequate funds for planned activities. This is probably a mix of a genuine lack of funds and inability to access those funds that are theoretically available.

Procurement and supply chain management

4. Availability of commodities and equipment

- The supply chain for vaccines, including cold chain functioning is a key determinant of an effective immunization programme. The systemic bottlenecks around the cold chain functioning in PNG fall into three areas:
 - lack of refrigerators, as well as existing items that are not functioning
 - poor maintenance of refrigerators. Even simple repair jobs may be left unrepaired for long periods of time due to lack of knowledge of maintenance.
 - poor distribution of vaccines between service delivery points.
- There is an inability to distribute vaccines to the periphery from central locations for various reasons including no fixed cold chain, inability to make ice for vaccine carriers, lack of transport and lack of funds for transport, fuel, lack of cold chain equipment. Difficult terrain and poor weather compound these difficulties throughout the country.

5. Health service delivery

- There is often only one static clinic per week at the health centre level resulting in long waiting time for services as well as a de-motivating factor for bringing the child for follow-up visits. Despite the “*Free Health Care Policy*”, some health facilities require user fees to run the operational costs of the health facility. This discourages attendance at clinics unless the child is actually sick. .
- There is an inability to access funds for routine activities by officers at province and district levels, resulting in a failure to conduct mobile and outreach clinics. There is a lack of accessible funds to purchase fuel and *per diem* for outreach activities.
- At least 40% of the population lives in areas not accessible by road. This figure rises to 60% in areas such as Gulf, Eastern Highlands, Central, Western, East Sepik, West Sepik, Madang, Moreobe, Maritime provinces and Hela Provinces due to their terrain. Approximately 70% of children are reached only through outreach or mobile activities. Tremendously difficult terrain hinders access to remote communities and is compounded by seasonal rains that cut off certain communities for months. Some communities can only be accessed by helicopter for some for the year. All outreach activities are expensive due to terrain and options for reaching remote communities.
- There is a dependency of health workers on SIA programmes or campaigns to raise coverage, resulting in lowered interest to improve routine immunization services. There is also a dependency of health workers on *per diem* from SIAs to supplement their income.
- The difficult terrain ensures that there is marked inequity of service provision in hard-to-reach areas. Even with the service functioning with all resources possible, it would still be difficult to reach remote communities regularly.
- There is a lack of support from central level to the provinces, and from province to lower levels for developing proper microplans for both SIAs and routine immunization services.

- Inadequate plans to catch drop-outs and left-outs following fixed site vaccination. The multi-dose vial policy results in vaccine vials not labelled properly when returned to the refrigerator.
- Adverse events monitoring has been introduced but not yet fully implemented.

6. Health workforce

- Inadequate pre-service and in-service training has led to a lack of basic EPI skills. This is even worse in remote areas.
- At province level, there is no-one with specific responsibility for EPI, except in 8 provinces with specifically funded EPI officers.
- There is a widespread lack of staff and a largely ageing staff, leading to a lack of health workers to conduct regular outreach and mobile clinics even when the funds are available.
- Motivation of staff is low in many areas due to poor pay, poor housing and working conditions, and lack of supportive supervision. Peripheral workers have little chance of promotion.

Community empowerment and demand generation

7. Demand generation

- MPs have other priorities and may not realize they can support EPI with funds at their disposal, or are not aware of the financial benefits. A similar situation applies to provincial and district health administrators.
- There is little or no social mobilization, community participation, advocacy to engage the public and stakeholders.

Data and health information systems

8. Quality of services

- Standards have slipped through a lack of monitoring and supportive supervision from the province to district level and to health posts.
- Insufficient assessment of coverage through rapid coverage assessments monitoring (RCM) and regular feedback for corrective action. This was started in 2015.
- Uncertain validation of vaccine coverage levels due to absence of any form of recent coverage survey.
- Low ability to manage data quality, analyse it and share it with the provinces/districts/health facilities.
- Inaccurate assessment of target population
- Failure to use the child health register and ANC register to update the actual target population, resulting in a lack of knowledge of the correct denominator.
- Inaccurate reporting of the number of children vaccinated against the target.

3. Objectives of the Reprogramming Application *(Maximum 2 pages)*

Please complete this section only if the reprogramming application includes new or revised objectives not included in the original approved Gavi HSS grant. If no new objectives are proposed, please indicate this in the table below, and list the original objectives of the Gavi HSS grant.

This section will be used to assess whether the newly proposed objectives are relevant, appropriate and aligned with the National Health Sector Plan and cMYP, and contribute to improving immunisation outcomes. It will also ensure alignment with the bottleneck analysis

above.

These objectives have to be listed in the same order in the Performance Framework and Attachment #5: Revised work plan, budget and gap analysis.

Applicants are encouraged to describe the following for each objective:

- How the objective will address the targeted bottlenecks identified, in order to improve immunisation outcomes;
- How the objective aligns with the objectives in the cMYP and/ or specific health system strengthening policies/ strategies being implemented;
- Whether and how the objective relates to the identified equity and gender related barriers. *For countries with a high level of immunisation coverage (over 90% DTP3 coverage), equity focus should play a greater role in improving immunisation outcomes. Equally, countries with a lower level of immunisation coverage are more likely to have the greatest inequities;*
- How the objective meets the “SMART” criteria i.e. specific, measurable, achievable, relevant/ results-focused and time-bound.

The proposed objectives described in this section will be assessed in terms of whether they are relevant, appropriate and aligned with the cMYP and contribute to improving immunisation outcomes. They will also be assessed for their alignment with the bottleneck analysis presented in Question 2 above. The original proposal aimed at reaching the unreached population through outreach activities in selected low performing provinces. It also looked to strengthen and reinforce monitoring of activities and put into practice the National Health Plan’s “Back to Basics” strategy to Strengthen Primary Health Care for all and improve service delivery for the rural majority and urban disadvantaged. The reprogramming of funds stays true to these overarching aims, but seeks to address the key bottlenecks that are immediately preventing the effective implementation of EPI in PNG. In doing so, the reprogramming will also support the upcoming \$6 million Graduation Grant intended to be received by putting key supportive factors in place in preparation.

HSS Grant Objective	Is this an original objective or a new/ revised objective ?	Description of objective <i>For new/ revised objectives only</i>
<p><i>Objective 1:</i> Provide immunization and integrated maternal and child healthcare services to women and children.</p>	<p>New</p>	<p>This objective is related to the overarching objectives of the previous application. It addresses bottlenecks in health service delivery through refocusing on outreach and micro-planning at the facility level through SIREP. It addresses equity issues by reaching the hard to reach. Services will be expanded to achieve 95% coverage in 16 high-risk districts based on the inability of services to reach the community, penta-3 coverage, and surveillance. It aims to improve the broader impact of integrated MCH services through the development of a MCH</p>

		strategy and through the piloting of innovative data monitoring.
<i>Objective 2:</i> Improve cold chain capacity and improve EVM scores by 10% by 2018 to ensure effective provision of vaccines	New	A major bottleneck underpinning the entire program is an inadequate cold chain system, without which vaccines cannot reach clients. Initial improvements to the most essential elements of the cold chain will ensure that vaccines pass successfully through it. It will also prepare the system for further upgrades intended to occur through support from the Graduation Grant.
<i>Objective 3:</i> Develop capacity of health care workers and cold chain technicians to provide quality service delivery	New	Quality of EPI and MCH service delivery is not at sufficient levels to provide effective services due to a lack of refresher training for health care workers. Cold chain skills require improvement both on behalf of cold chain technicians and health care workers handling vaccines to ensure proper flow of vaccines to end users. Classroom and on-the-job training sessions will be facilitated to ensure health care workers and cold chain technicians have the level of skills required.
<i>Objective 4.</i> Generate demand for maternal and child health services both from the community and decision makers.	New	Without demand for services the programme will struggle to ensure sustainable funding from Provincial and District decision makers. The grant will be used to develop a demand creation strategy that will encourage care-givers to come for MCH and EPI services, and advocate the need for continued support from MPs.
<i>Objective 5.</i> Manage the programme effectively to achieve outcomes	New	Current management bottlenecks are hindering the programme's ability to reach its targets. No matter what changes are made to the program it cannot function effectively without stronger leadership at the central level and improved management practices. The recruitment of a National Programme Officer will strengthen leadership. An end-of-grant review of fund management, activities undertaken with grant funds, and impact will support the implementation of the Graduation Grant.

These objectives are in line with the National Health Plan, particularly Key Result Area 4 Improve Child Survival and 5 Improve Maternal Health. They are also aligned with the current cMYP. The cMYP expired at the end of 2015, however it will be updated in February 2016 and the objectives are aligned with the planning intentions for the next 5 years.

The policy as stated in the National Health Plan (2011-2020) and the cMYP (2011 to 2015) aims to:

- Achieve high quality immunization services that reach every child and mother
- Make progress towards elimination of measles
- Make progress towards control of hepatitis B
- Maintain PNG's polio-free status

- Eliminate maternal and neonatal tetanus
- Introduce new vaccines against major killers of children, including *Hib*, and when available and affordable, strategies for vaccination against *Streptococcus pneumoniae*, HPV.
- Integrate EPI with other health interventions
- Conduct supplemental immunization activities every 2 years and increase the coverage of routine immunization, including at Community Health Posts

Each of these aims aligns to a greater or lesser extent the aims in the grant proposal.

Reprogrammed HSS/GAVI Proposal Objectives	NHP's Key Result Areas (KRAs) (NHI Plan 2011-2020)
<i>Objective 1:</i> Provide immunization and integrated maternal and child healthcare services to women and children	KRA4 Improve child survival and KRA5 Improve maternal health
<i>Objective 2:</i> Improve cold chain capacity and improve EVM scores by 10% by 2018 to ensure effective provision of vaccines	KRA 3 Strengthen health systems (infrastructure)
<i>Objective 3:</i> Develop capacity of health care workers and cold chain technicians to provide quality service delivery	KRA 3 Strengthen health systems (health workforce)
<i>Objective 4.</i> Generate demand for maternal and child health services both from the community and decision makers.	KRA 7 Promote healthy lifestyles and uptake of services
<i>Objective 5.</i> Manage the programme effectively to achieve outcomes	KRA 3 Strengthen health services (leadership and governance)

4. Description of Activities

Countries are required to include the detailed description of activities, to align directly with that included in Mandatory Attachment #5: Revised work plan, budget and gap analysis template. This description should include:

- A list of all proposed activities for the **remainder** of the grant;
- Explanation of how the proposed activity is linked to improving immunisation outcomes;
- Demonstration of the alignment between HSS grant activities and activities funded through other Gavi direct financial support, including Vaccine Introduction Grants and Operational support for campaigns.

Guidance on the types of activities usually funded through Gavi HSS grants has been provided in Section 1.4 of the guidance above.

Gavi is also continuously working to identify and share insights on activities determined to have a high potential for impact for addressing bottlenecks to improve immunisation outcomes. More details can be found here: www.gavi.org/library/documents/gavi-documents/guidelines-and-forms/guidance-on-investments-with-high-impact-potential/.

Objective / Activity

Explanation of link to improving immunisation outcomes

Objective 1: *Provide immunization and integrated maternal and child healthcare services to women and children*

Activity 1.1: Use supportive supervision and other key strategies of SIREP to achieve 95% routine coverage in 16 high-risk districts and evaluate the impact

National routine immunization coverage levels are around 60% DTP3 but probably much lower in some districts. SIREP is designed to strengthen routine immunization throughout the country and provide integrated MCH services, however until financial support is improved some districts (those with higher operational costs due to inaccessibility) are at significant risk.

16 districts from 10 provinces will receive operational cost to conduct outreach clinics and supportive supervision under GAVI HSS grants. The following factors have been considered in selecting these districts-

- Hard to reach areas
- Large catchment population
- Very Low Penta-3 coverage for the last 3 years
- High operational cost generated by rugged terrain and an absence of a road network. These places are only accessible by charter helicopter/aeroplane/boats
- Receipt of irregular funding support from the province to districts to conduct outreach clinics and supervision

	In the long term, it will help act as a catalyst to encourage funding from Provincial and District stakeholders in these districts and others on-going so that following Gavi transition this challenge is met. Without this element of support, new vaccine introduction (funded by Gavi NVS) will be ineffective.
Activity 1.2: Collect and analyse data using MCH accountability framework in 3 districts	The MCH accountability framework is a new initiative aimed at reducing maternal and child mortality through better management of MCH programs at all levels through the collection and utilization of data on maternal and child health using MCH Accountability Monitoring and Management tools. The Framework is a set of input, output and outcome indicators used to measure different levels of implementation of KRA 4 and 5 of the National Health Plan. The Government is currently in pilot stage of the project, and the grant will support this work in 3 districts.
Activity 1.3: Evaluate MCH Framework pilot	Following the piloting of the MCH Framework an evaluation will be conducted to inform future intended national roll out, which may be supported by the upcoming Graduation Grant.
Activity 1.4: Develop a strategy for an integrated MCH outreach approach	Health services are naturally integrated in PNG due to the limited number of staff at facility level. However, this is not done so strategically or using the best evidence base. A national strategy will be developed to guide the provision of integrated services effectively. This will improve challenges in access to services, quality of services, and equity.
Objective 2: <i>Improve cold chain capacity and improve EVM scores by 10% by 2018 to ensure effective provision of vaccines</i>	
Activity 2.1: Procure essential cold chain equipment for proper functioning of Central cold store in Port Moresby and all 22 Provincial stores	Significant gaps have been revealed in the most recent Effective Vaccine Management assessment (2011) and cold chain inventory (2014). The immediate priorities are ensuring that the Central store and Provincial stores are running effectively to ensure the quality of vaccines at least as far as Provincial level (future HSS grant application will address the cold chain at lower levels). Without this element of support, new vaccine introduction (funded by Gavi NVS) will be ineffective.
Objective 3: <i>Develop capacity of health care workers and cold chain technicians to provide quality service delivery</i>	
Activity 3.1: Train 120 cold chain technicians in maintenance of new	A large amount of cold chain hardware will be installed as a result of this grant, the upcoming

<p>equipment in 10 training sessions.</p>	<p>Graduation Grant, and commitments from the government and partners. This will require on-going maintenance. Current skill level is not adequate for this, particularly in the face of new technology such as solar. UNICEF has already begun training in this area and the provision of tool kits. This grant will enable the training to be rolled out into the remaining provinces. Reprogramming funds will enable 10 training sessions to be conducted with 120 participants (Provincial Cold Chain and Logistics Officers and two representatives from each district). Further training will be conducted through support of the Graduation Grant to reach nationwide coverage. Follow up sessions will be conducted during which subsequent quality improvements will be measured.</p>
<p>Activity 3.2: Train 420 health staff in 10 provinces in basic EPI training, including daily maintenance of cold chain equipment.</p>	<p>Reviews have found that many staff lack the basic skills necessary for EPI and MCH services, or have not received refresher training, thereby decreasing the quality of services provided. Training will be conducted in 10 Provinces participants from each health facility/sub-facility. Provinces with large populations will have two sessions conducted, totalling 14 sessions. This activity will be further supported by the Graduation Grant in order to reach the remaining Provinces. In addition to this, the Graduation Grant will support ongoing supportive supervision through SIREP that will measure quality improvements and follow up on training to ensure that skills remain.</p>
<p>Objective 4:<i>Generate demand for maternal and child health services both from the community and decision makers.</i></p>	
<p>Activity 4.1: Develop advocacy plan for central and provincial levels through TA</p>	<p>Due to the devolution of the PNG health system, Members of Parliament and District health officers have control over significant amount of funds that can be used for health. However, the value of EPI is not always understood and requires advocacy to ensure appropriate support from these resources to routine immunization. A targeted advocacy strategy will ensure that decision makers are aware not only of the value of investment in EPI, but are also clearly guided in the best use of funds. The implementation of the advocacy plan will be supported through the Graduation Grant.</p>
<p>Activity 4.2: Central level event to advocate for MPS through TA</p>	<p>Following the development of the advocacy plan, one central level meeting for MPs will be held within the lifespan of this grant. Further implementation of the plan will take place through support of the Graduation Grant.</p>

Activity 4.3: Develop demand generation strategy through TA	While the community is generally positive in regards to immunization, active demand of services is low. Increased demand from the community would cause decision makers to contribute more funds.
Activity 4.4: Print and distribute EPI/MCH IEC materials	Materials have been developed in support of SIREP but have not been distributed to all districts. Additional printing will allow for this to happen.
Objective 5: <i>Manage the programme effectively to achieve outcomes</i>	
Activity 5.1: Appoint National Programme Officer in support of EPI Programme Manager	The programme currently lacks strong oversight and leadership from the central level. A National Programme Officer will be appointed for 2-3 years in order to mentor and up-skill staff in the role in preparation for graduation. This position will be funded in the next two years from the Graduation Grant, and is not envisioned to last longer than that.
Activity 5.2: Conduct evaluation of grant to inform Graduation Grant activity implementation	An evaluation of this grant will be conducted in Q1 2017. This will be used to identify challenges and inform the implementation of the upcoming Graduation Grant.

5. Results Chain

The results chain or logical framework sets out how the activities described under Question 4 would contribute to the achievement of the objectives set out in Question 3, identifying the casual pathways and linkages in the chain of results.

Countries are requested to complete the results chain using the template provided below. For each objective, information is required on: (i) objectives and activities (as noted in Question 3 and 4 respectively); (ii) intermediate results; (iii) immunisation outcomes; (iv) impact; and (v) assumptions for the achievement of results.

Countries are encouraged to note/ consider the following:

- Complete at most 2-3 indicative activities for each objective; it is not necessary to list all activities.
- Clarify causal pathways and demonstrate how activities contribute to achieving intermediate results and how these intermediate results contribute to achieving immunisation outcomes. The intermediate results should link directly to the targeted HSS bottlenecks identified in Question 2 and should address or contribute to addressing these.
- Include all of the five mandatory outcome indicators, presented in Figure 1 below, which provides an illustrative results chain. Countries are encouraged to also include other relevant immunisation outcome indicators if the bottleneck analysis suggests additional objectives may be appropriate.
- Immunisation outcome indicators do not have to be related to any specific objective,

they are related to the programme as a whole.

- Information should be consistent with the country's Performance Framework.

Figure 1: Illustrative results chain for Gavi HSS grants

Results chain (Maximum 4 pages)

Objective 1: Provide immunization and integrated maternal and child healthcare services to women and children

<p>Key Activities:</p> <ul style="list-style-type: none"> • Use supportive supervision and other key strategies of SIREP to achieve 95% routine coverage in 16 high-risk districts and evaluate the impact • Collect and analyse data using MCH accountability framework in 3 districts 	<p>Intermediate Results:</p> <ul style="list-style-type: none"> • Increased availability of integrated outreach services to the community • Improved management outcomes using data 	<p>Immunisation Outcomes (related to all Objectives):</p> <ul style="list-style-type: none"> • % of infants receiving 3 doses of Penta vaccine • % of surviving infants receiving first dose of measles containing vaccine
<p>Related Key Activities Indicators:</p> <ul style="list-style-type: none"> • SIREP activities carried out in 16 high-risk districts • Maternal and Child Health Accountability Framework introduced in 3 districts 	<p>Related Intermediate Results Indicators:</p> <ul style="list-style-type: none"> • Quarterly coverage target achieved in 16 high-risk districts • Timeliness of data collected, analysed and used by service providers to improve services 	<ul style="list-style-type: none"> • % of districts with ≥80% Penta3 coverage • % point drop out Penta1 to Penta3 • Reduced inequity of service delivery in hard to reach districts by comparing Penta-1 between districts quarterly • Increased levels of demand for integrated EPI/MCH services from the community (anticipated after implementation in Graduation Grant, cannot be measured now) • Increased flow of funds from Province and District mechanisms (anticipated after implementation in Graduation Grant, cannot be measured now)

Objective 2: Improve cold chain capacity and improve EVM scores by 10% by 2018 to ensure effective provision of vaccines

<p>Key Activities:</p> <ul style="list-style-type: none"> • Procure essential cold chain equipment for proper functioning of Central cold store in Port 	<p>Intermediate Results:</p> <ul style="list-style-type: none"> • Effective cold chain equipment in place at Central and Provincial Stores 	
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	Moresby and all 22 Provincial stores	<ul style="list-style-type: none"> Fully functioning cold chain at Central and Provincial levels 	
	Related Key Activities Indicators: <ul style="list-style-type: none"> % of ordered items to arrive in country by the end of grant % of ordered items to be installed and functioning in designated sites 	Related Intermediate Results Indicators: <ul style="list-style-type: none"> No stock outs or wastage due to ineffective cold chain system at Central or selected Provincial levels 	
Objective 3: Develop capacity of health care workers and cold chain technicians to provide quality service delivery			
	Key Activities: <ul style="list-style-type: none"> Train 120 cold chain technicians in maintenance of new equipment in 10 training sessions. Train 420 health staff in 10 provinces in basic EPI training, including daily maintenance of cold chain equipment. 	Intermediate Results: <ul style="list-style-type: none"> Cold chain equipment in selected provinces functions effectively Health care workers are able to provide quality service 	
	Related Key Activities Indicators: <ul style="list-style-type: none"> 120 cold chain technicians and district officers completed UNICEF "Tailored cold chain repair and maintenance" training 420 health workers (at least 1 from each health facility) in 10 provinces receive basic EPI training 	Related Intermediate Results Indicators: <ul style="list-style-type: none"> CC technicians able to maintain and repair cc equipment EPI staff able to ensure proper routine functioning of cc equipment Health care workers able to provide quality service 	
Objective 4: Generate demand for maternal and child health services both from the community and decision makers.			
	Key Activities: <ul style="list-style-type: none"> Develop advocacy plan for central and provincial levels through TA 	Intermediate Results: <ul style="list-style-type: none"> Stakeholder (EPI, Health Promotion, partners etc.) buy in generated for advocacy plan and demand generation strategy and 	

	<ul style="list-style-type: none"> Develop demand generation strategy through TA 	ready for implementation under the Graduation Grant	
	Related Key Activities Indicators: <ul style="list-style-type: none"> Advocacy plan developed and demand generation strategy developed 	Related Intermediate Results Indicators: <ul style="list-style-type: none"> Fully costed and delegated advocacy plan and demand generation strategy ready for implementation under Graduation Grant 	
Objective 5: Manage the programme effectively to achieve outcomes			
	Key Activities: <ul style="list-style-type: none"> Appoint National Programme Officer in support of Programme Manager Conduct evaluation of grant to inform Graduation Grant activity implementation 	Intermediate Results: <ul style="list-style-type: none"> NPO increases effective management of EPI program Evaluation results are used to inform implementation of activities in Graduation Grant 	
	Related Key Activities Indicators: <ul style="list-style-type: none"> National Programme Officer is appointed by Q3 2016 Evaluation of grant conducted 	Related Intermediate Results Indicators: <ul style="list-style-type: none"> Adjusted implementation of Graduation Grant according to findings in HSS evaluation 	
IMPACT <i>Decrease in cases, deaths and outbreaks from vaccine preventable diseases</i>			
ASSUMPTIONS <ul style="list-style-type: none"> <i>Government's ability to fund the healthcare system in 2016 and beyond given the downturn in the economy</i> <i>Stable management and leadership in NDoH headquarters</i> <i>Availability of cold chain equipment and vaccines from manufacturers</i> <i>Adequate numbers of health staff</i> <i>Effects of 2015 drought do not have major impact on the immunization program</i> 			

- *The security context allows the program to be conducted*

6. Performance Framework

Once the Results Chain has been developed, the next step is to complete the **Performance Framework**, which can be accessed through the Gavi country portal: www.gavi.org

When completing the performance framework, applicants are required to:

- Propose relevant indicators in the performance framework, corresponding to the immunisation outcomes and intermediate results for each objective in the results chain presented under Question 5.
- Indicators at the activity, intermediate results and outcome level should align to those proposed in the Results Chain.

More information on the performance framework is available at www.gavi.org/support/performance-frameworks/

7. Monitoring and Evaluation (M&E) of the HSS grant

The proposal will continue with the same monitoring and evaluation process as the previous grant, with new tailored indicators adopted. It will utilize the M&E plan of the National Health Plan 2011-2020 and the National Health Information System in order to avoid duplicating any systems. The M&E Strategic Plan of the National Health Plan (2011-2020) continues to be the core instrument to strengthen the accountability both at health service delivery and health administration in providing high quality information to assess the delivery of health services using this approach.

Core indicators and the JRF will be tracked using this system. In addition to this, several tailored indicators have been developed to track programme activities, and various methods of monitoring will be employed depending on the activity.

As WHO has agreed to manage the programme funds, they will work with the Government to ensure that these monitoring and evaluation requirements are met. A part time position will be recruited to manage the funds of the grant and track them against the indicators.

The previous Gavi application referenced the fact that M&E activities in outreach had been neglected, and aimed to strengthen the system through improved data collection of outreach patrols. This work continues through the SIREP approach. Supervision and monitoring plans from the province to the district levels have been developed in collaboration with the Provincial senior management team, ensuring their support. Recording and reporting forms have been developed and shared with provinces to analyse coverage data and enable actions to reach 90% coverage at the province and district levels.

In addition to this, the grant will help to pilot the MCH Accountability Framework Initiative in an attempt to strengthen monitoring and evaluation systems for the future. The MCH Accountability Initiative was designed to support the reduction of maternal and child mortality in the country through better management of MCH programmes at the national, provincial, district and health facility levels through the collection and utilization of data on maternal and child health using MCH Accountability Monitoring and Management tools. If successful in the application for the reprogramming grant, this work will continue on and be expanded in the Graduation Grant.

Grant evaluation

In the first quarter of 2017 an evaluation of the HSS grant will be conducted. This will aim to identify key challenges presented during the implementation of the grant. The evaluation will be used to ensure that the reprogramming funds have had the intended effect of supporting the Graduation Grant. The Graduation Grant will be applied for by 1 May 2016, and as such, results from the evaluation will not be immediately incorporated into the application, however they will still be used to inform the implementation of programme activities. The evaluation will be conducted with technical assistance from WHO.

8. Detailed work plan, budget narrative and gap analysis

The amount of funds available for reprogramming amounts to \$2,512,205.

Major expenditure: The large majority of the funds (\$1,452,205, 58%) will be used on the procurement of essential cold chain equipment at the central and provincial levels. In 2014 an inventory of the national cold chain was conducted and a list of requirements produced with technical assistance from WHO. The list contains necessary items pre-qualified by WHO under their Performance Quality and Safety (PQS) programme. The complete needs of PNG's cold chain system total to PGK 28 million (\$9,309,768 at 7 January 2016 exchange rate 0.33). The entire need cannot be met by the government or partners in the immediate future. As such the list has been prioritised. \$337,864 has been spent on cold chain from the HSIP, as well as \$195,000 GAVI funds (total of \$532,864) in 2015 on the immediate priorities. Following this, it is now vital to ensure that the Central and Provincial stores are functional. Funds from this grant will be used for this purpose. A detailed breakdown of the equipment to be purchased with this grant is available in Attachment 6. Further equipment will be purchased with the Graduation Grant, targeting lower levels of the health system. All cold chain equipment will be procured directly by UNICEF. Gavi funds will be given directly to the Copenhagen procurement team who will make the purchase according to the list provided in Attachment 6.

The next largest expenditure is training for cold chain technicians and health care workers.. UNICEF has already been conducting cold chain training for Provincial Cold Chain and Logistics Officers and district staff through the "Tailored cold chain repair and maintenance" course. On average each session for 12 technicians costs \$10,000. Reprogramming funds will be used to train 120 participants in order to support the large investment in cold chain procurement. These costs include the provision of tool kits.

In addition to this, 420 health care workers (at least 1 from every health centre/sub-centre to avoid classic challenges faced by cascade style training experience in PNG in the past) from 10 Provinces will receive basic EPI training. Recent program reviews indicated that there were significant gaps in basic EPI skills and this support will go towards improving that challenge. The training will be conducted by UNICEF The forthcoming Graduation Grant will train participants from the remaining Provinces.

\$250,000 is being allocated to support the roll out of SIREP in 16 hard to reach districts. The majority of this amount will go towards the hiring of planes and helicopters for areas that are otherwise unreachable. An average figure of \$15,625 is used to estimate cost per district. Other basic operation costs will continue to be met by current Provincial and District government commitments. It is intended that the total costs for outreach in these districts will be met by Province and District by the end of the upcoming Graduation Grant. Attachment 5 details the

costs for the 16 high risk district. Attachment 19 provides details the budget for annual expenditure for the entire SIREP program (not just high risk districts) to provide context and further understanding.

\$150,000 is allocated to the printing and distribution of information and education communication materials related to SIREP. It allows for 2,000 banners used during community engagement activities and 150,000 posters (50,000 copies of 3 different EPI/MCH posters).

Monitoring and evaluation: \$20,000 is allocated for monitoring and evaluation. Although this is lower than the recommended 5-10% of funds, the period of implementation is quite short and as such monitoring activities will only take place for 12 months. /The grant will be monitored by WHO PNG and costs will be absorbed into their existing systems. \$20,000 will then be used towards an evaluation of the grant towards its end in Q1 2017, and will allow for technical assistance from WHO Regional Office to assist in the evaluation. It is expected that the Graduation Grant will contain a higher portion of funds related to monitoring and evaluation, and will likely contribute towards a comprehensive EPI Review in 2021.

CSO activities: As the Church Health Services are such an integrated part of the health system, funds that are spent on improving service delivery, CSOs will also benefit from them. For example, CSO staff will be trained as part of the cold chain and basic EPI skills training courses and their facilities will receive updated cold chain equipment as part of the procurement process. No funds have been earmarked specifically for CSOs.

Technical assistance: \$120,000 of technical assistance is planned across three areas (\$40,000 each):

1. Development of a national strategy for an integrated EPI/MCH approach; this is designed to ensure that the integration of EPI/MCH services is conducted in a strategic manner based on evidence. PNG has a long history of integrated services yet their provision has been ad hoc and inconsistent. This strategy will be a vital document for the future
2. Development of an advocacy plan aimed at Provincial and District decision makers and
3. Development of a demand generation strategy.

These last two TAs are aimed at addressing the major bottleneck of insufficient fund provision from the Provincial and District levels. Successful implementation of this part of the proposal would go great lengths to ensuring the sustainability of the programme.

Human resources and other institutional costs: A vital part of the proposal is the recruitment of a National Programme Officer at the Central level. Currently leadership at this level is not strong and lacks technical capacity. It is agreed by all partners that a strong leader is required to provide guidance to the programme and mentor the National EPI manager. \$60,000 has been allocated to this role over 12 months, in order to attract a high level candidate, and funding will be extended into the next grant.

Gap Analysis:

a) Cold chain: total required by NDoH for complete refurbishment of the cold chain is 28m PGK (\$9,333,333).

- Total already purchased - \$ 497,340
- Total to be spent by HSS reprogramming - \$ 1,452,205
- Total intended to be covered by Graduation Grant - \$ 2,000,000
- Total remaining - \$ 5,383,788 (16,151,364 PGK)
- Possible funding source – need to explore if HSIP funds can be used as well as

funds from the provinces and districts.

b) SIREP 5 year budget

SIREP is highly reliant on the variable financial commitment from Province and District decision makers. A major element of this grant is the support for the development of an advocacy plan to increase and sustain this commitment at a level appropriate to achieve coverage targets. Support for this activity will be implemented throughout the Graduation Grant and it is intended that this will have a positive effect on the current gap in planned SIREP funding. In the meantime Gavi funds will be used to support SIREP in addressing immediate priorities (high risk districts) until this commitment is met.

Budget for one year for SIREP in all 22 provinces	\$10,213,637 x 5 years = \$51,063,185
To be spent in HSS reprogramming grant	\$ 250,000
Total intended to be covered by Graduation Grant	\$ 1,480,000 (including government estimated contribution of \$590,000)
Total estimated to be covered by Province and District funding (30-50%)	Between \$15,500,000 and \$26,000,000
Total remaining	Between \$33,833,185 and \$ 23,333,185

The following are the HSS programs being implemented in PNG:

1. The Global Fund support has a Health Systems Strengthening component which was submitted in combination with the Tuberculosis proposal. It focuses on

- (i) Strengthening laboratory services
- (ii) Strengthening registration, inspection and licensing of pharmaceutical establishments, legislation review
- (iii) Medicines drugs logistics management information systems (LMIS) application of mSupply
- iv) Building capacity for good manufacturing practices (US\$740,362)

2. DFAT HSS support covers

- (i) Quality control laboratory for medical products
- (ii) product registration systems, inspection and licensing of pharmaceutical facilities
- (iii) building for capacity for monitoring and rational use of medicines and pharmacovigilance
- (iv) forecasting and quantification of medicines needs (AUD 3,997,248 over 3 years).

3. Rural Primary Health Services Delivery Project – financed by DFAT, ADB, Japanese International Cooperation Agency, WHO and UNICEF, OFID and NDoH. The project is being implemented in 16 districts in 8 Provinces. Its purpose is to strengthen rural health system in selected areas by increasing coverage and quality of primary health care. The main components include: (i) National health Policies and Standards (ii) Sustainable Partnerships with Churches, NGOs and private sector (iii) human resources Development in health sector (iv) health infrastructure development (iv) Health promotion. (Estimated cost = US\$81.2 million)

4. The WHO Country Office is implementing HSS as a component of the 4 year WHO –DAFT Partnership financing agreement since 2012. Activities are coterminous with the WCO HSS program of work (US\$10 million over 4 years)

There is no overlap in any of the activities across program with different funding - though program activities may look the same – especially in pharmaceuticals – these are different aspects of the same activity.

9. Procurement Plan

Provide Mandatory Attachment #6: Detailed two-year **Procurement Plan**, including:

- A detailed plan for the acquisition of goods, works and services covering the next two years of programme implementation.
- A schedule of the planned delivery, implementation or completion dates for all goods, works, consultancies and services acquired;
- Estimates of the value of each procurement package of goods, works, consultancies and services;
- Indication of items or sections of the services, consultancies or works that can be aggregated for procurement as a single package;
- Procurement method;
- Timelines for critical stages of the delivery programme; and
- Who will be responsible for this procurement.

A detailed procurement plan is included as Attachment #6. It will be for one year only as the grant period is limited to one year. The cold chain equipment will be ordered as soon as NDoH is notified of a successful grant application. This should be by June 2016. UNICEF PNG will be asked to order the equipment, and payment for the items will be made directly to UNICEF Supply Office, Copenhagen, without those funds needing to pass through PNG. Advance warning to Copenhagen will ensure that as many items as possible are available for immediate shipment. The need to install this equipment in Central and Provincial level facilities is urgent and distribution and installation will begin as soon as the equipment has cleared customs. No tax is due on such items so there will be no hold-up at the docks. UNICEF will provide administrative and technical assistance to the person responsible for this – the National Cold Chain Officer - for these arrangements.

10. Sustainability

GAVI supports the long-term sustainability of health and immunization systems. The reprogramming application is in an unusual situation regarding this element because the funds

will be spent in 12 months (Q3 2016 – Q2 2017). Thus it will not be possible to incorporate a sustainability element in all the components. However, the activities in the reprogramming of this grant are intended to act as a catalyst to support the upcoming Graduation grant of \$6 million, which will aim to increase the sustainability of PNG's immunization programme.

The pilot study in 4 districts regarding data management will be relevant to the Graduating HSS grant (GG) application to be submitted in 2016. Here the rollout of the pilot will be included and a contribution provided by the government that increases by 15% per year until graduation when 100% will be paid for by government. This process will be applied to the remaining elements of the reprogramming grant application.

The bulk of the funds will be used to procure UNICEF cold chain equipment which will be one-off purchases, for which financial sustainability is not relevant. However, the correct on-going use of the equipment is catered for in one of the other main elements, namely the training of the cold chain technicians and general health staff. In addition to this, one objective of the cold chain procurement in this grant is to alleviate some financial pressure on the government so that it is more able to concentrate on ongoing operational costs.

SIREP (routine immunization) will eventually be fully funded by the Government, with contributions made to each service level (central, provincial and district). Currently, money is allocated through various means for EPI (e.g. outreach is designated as a Minimum Priority Activity by the government), however decision makers at the provincial and district level have ultimate control over how the funds are spent and do not always select EPI. The advocacy element of this application and its ongoing implementation through the Graduation Grant is intended to increase the priority of EPI in Provincial and District funding commitments, thereby improving the sustainability of routine immunization. In the meantime, Gavi funds will be used to support SIREP in 16 of the most high-risk districts, which would otherwise be unmet until this commitment improves. It is intended that this will act as an example to decision makers of what a programme can achieve if funds are made available. Combined with the advocacy component, this is the government's approach to working towards sustainability.

11. Implementation Arrangements

This section will be used to determine if the necessary arrangements and responsibilities for management, coordination, and technical assistance inputs of the implementing parties have been put in place to ensure that programme activities will be implemented for the remainder of the grant, as included in this reprogramming application.

Countries are required to describe the planned implementation arrangements, including:

- How grant implementation will be managed, identifying key implementing entities and their responsibilities.
- If implementation delays were experienced with the current HSS grant, please describe how these issues will be addressed in the reprogramming application.
- Describe governance and oversight arrangements, including the mechanisms that will ensure coordination among the implementing entities.
- Financial resources planned to be allocated to grant management and implementation.
- Financial management arrangements planned for the grant – the country is required to confirm if the financial management arrangements included in the original HSS grant and assessed by the most recent Financial Management Audit (FMA) are still valid; or provide

additional details if this is not the case.

- The role of development partners in supporting the country in grant implementation.
- Short term and long term technical assistance included in the reprogramming activities, and how this technical assistance will improve the way health systems and immunisation programme function. If no technical assistance is planned to support implementation of this HSS grant please provide an explanation of why it is not planned.

The implementation of the grant will not deviate greatly from the original grant plan. The technical and managerial Lead Implementer of this proposal will be the NDOH and its selected departments. The responsibility and implementation of services lies with the Health Centres with support, collaboration and supervision of the district and provincial health officers. The Church Health Services play a key role in service delivery, especially in the rural areas. The development partners will play a supportive role when needed and available.

The major change in implementation relates to the financial management of the grant. In an effort to pass the delays and other challenges previously experienced when operating through the HSIP, the Government has agreed for all funds to be channelled directly through Unicef (for cold chain procurement) and WHO (for the remaining activities). This arrangement is intended to continue for the early stages of the Graduation Grant, however the Graduation Grant will include efforts to improve the financial management used by NDoH in order to eventually hand management controls back to the Government by the time of transition.

Previous partner missions have looked at alternative methods of financial management. In the context of this grant, Dr Lagani of NDoH proposed that the financial management for elements of the grant actioned in-country should be handled by WHO. This was because the auditing of all NDoH accounts is approximately two years behind, with no prospect of improvement. Thus it would be difficult to show proper acquittal of GAVI funds in a timely fashion. Independent audit would not be possible in the one-year time frame for the reprogramming grant. Allowing WHO to handle the disbursement would also speed up the flow of cash to the provinces, a process that is currently very slow. UNICEF will receive funds for cold chain procurement directly from GAVI, avoiding these problems. This bypasses the acute problem in PNG regarding foreign exchange, there being a cap in place at the moment. This can make foreign exchange problematic.

The proposed cash flow will be as follows:

1. UNICEF will receive funds directly from GAVI for procurement of cold chain equipment specified in the application. An additional 30% will be channelled through WHO to pay the private logistics company to transport and install the equipment.
2. WHO/PNG office will receive the balance of the grant directly from GAVI
3. WHO/PNG will disburse 25% of the cash destined for the provinces to their designated Health Sector Improvement Programme (HSIP) Trust Account four times a year, on receipt of acquittal of the previous tranche of funds;
4. Provinces will send the funds to the districts and the health centres based on a prepared plans which will identify human resources, transport, days, needed fuel etc. The HSS/GAVI grant will be used for the following purpose: (i) 50% for per diem 35 PGK or 17 US\$; (ii) 50% for transport cost (car, boat, fuel) for the outreach activities.
5. WHO will draw up TA contracts and disburse to the recipients directly.
6. WHO will employ a part time officer to monitor the cash flow.

12. Involvement of Civil Society Organisations (CSOs)

This description will be used to assess the involvement of CSOs in implementation of the new/ revised activities. For additional information, please refer to the CSO Implementation and Results Framework located here on the Gavi website: www.gavi.org/support/cso/.

Countries are required to:

- Describe how CSOs will be involved in the implementation of any new/revised activities, indicating the approximate budget allocated to CSOs.
- If CSOs will not be involved in implementation an explanation is required as to why they are not involved and what steps will be taken to facilitate future involvement of CSOs in Gavi HSS activities.
- Please ensure that any CSO implementation details are reflected within the detailed workplan, budget and gap analysis provided in Question 9.

Maximum 1 page:

CSOs have a proven track record for working in partnership with governments in a number of Gavi-eligible countries to ensure the delivery of vaccines. This is also true in extending health care services to marginalized communities, particularly in remote areas that are difficult to reach. PNG is a particularly good example where CSOs have played a major part in providing health services. The Church Health Services are a consortium of all church-based organizations that provide such services in PNG, consisting predominantly of Catholic churches. They employ local staff who have faith-based work ethics and dedication to the task. They cover more than 40% overall of immunization services and operate approximately half of the rural health centres and sub-centres. They obtain vaccines through the government supply system free of charge, as well as other medical supplies, and NDoH grants them around 150million Kina per year for their services. Representatives from the Church Health Services are members of the ICC. As part of the grant, Church Health Services staff will be involved in the cold chain maintenance and basic EPI training. Church run facilities will be supplied with IEC material that is being printed for promotion of new vaccine introduction and other aspects of promotion of EPI. No specific funds will be earmarked for CSOs as they already benefit from government support and will benefit from this GAVI grant.

PART C: HSCC SIGNATURE PAGE – MANDATORY ATTACHMENT #2

For submission with Gavi HSS Reprogramming Application National Coordinating Body - Health Sector Coordination Committee

Country: Papua New Guinea

Date of Reprogramming Application: 15 January 2016

We the members of the HSCC, or equivalent committee [1] met on 15 January 2016 to review this reprogramming application. At that meeting we endorsed this reprogramming application on the basis of the supporting documentation, which is attached. The minutes of the meeting endorsing this proposal are attached to this application.

[1] Health Sector Coordination Committee or equivalent committee that has the authority to endorse this reprogramming in the country in question. This includes any committee/body responsible for the oversight of the country's National Health Plan. Endorsement from the EPI coordinating committee (ICC) only is not sufficient. Please attach full membership list and meeting minutes.

Name of the Committee in country _____

The **endorsed and signed** minutes of this meeting are provided as **Mandatory Attachment #2**.

Provided as separate pdf file

Please tick the relevant box to indicate whether the signatories above include representation from a broader CSO platform: Yes No

Individual members of the HSCC may wish to send informal comments to: proposals@gavi.org
All comments will be treated confidentially.

PART D: GOVERNMENT ENDORSEMENT – MANDATORY ATTACHMENT #3

For submission with Gavi HSS Reprogramming Application

Signatures: Government endorsement

Please note that this reprogramming application will not be reviewed or approved by Gavi without the signature of the Minister of Health/ National Department of Health or their delegated authority.

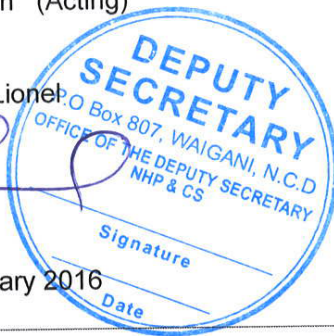
We, the undersigned, affirm that the objectives and activities of the Gavi proposal are fully aligned with the national health strategic plan (or equivalent), and that the funds for implementing all activities, including domestic funds and any needed vaccine co-financing, will be included in the annual budget of the National Department of Health.

Secretary of Health (Acting)

Name: Ms. Elva Lionet

Signature:

Date: 15th January 2016



ANNEX 1: ACRONYMS

CMYP	Comprehensive Multi-Year Plan for Immunisation
CSO	Civil society organisation
DTP	Diphtheria-tetanus-pertussis
EPI	Extended Programme of Immunisation
Gavi	Gavi Alliance (Formerly the Global Alliance for Vaccines and Immunisation)
HSCC	Health Sector Coordinating Committee
HSS	Health system strengthening
ICC	Inter-Agency Coordinating Committee for Immunisation
IRC	Independent Review Committee (Gavi)
KRA	Key Result Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MR	Measles-Rubella vaccine
NDoH	National Department of Health
PBF	Performance based funding
Penta	Pentavalent vaccine
PIE	Post Introduction Evaluation
PFA	Partnership Framework Agreement
PNG	Papua New Guinea
SIREP	Special Integrated Routine Strengthening Program
TA	Technical Assistance
UNICEF	United Nations Children's Fund
WHO	World Health Organization