



Application Form: Health System Strengthening (HSS) Support in 2016

Deadlines for submission of application:

15 January 2017

1 May 2017

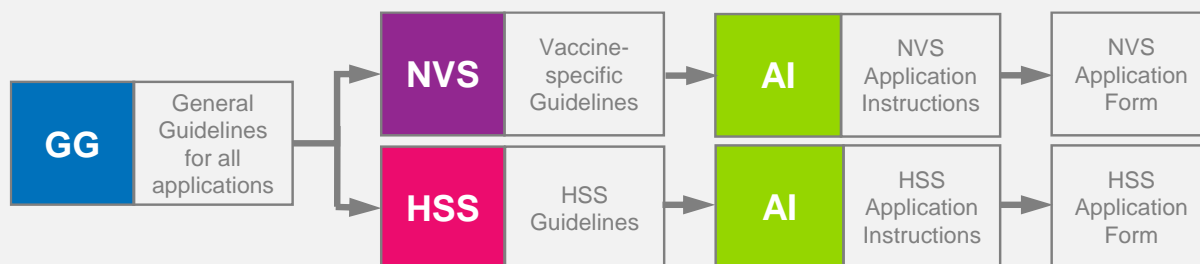
8 September 2017

Document dated: October 2015

(This document replaces all previous versions)

Application documents for 2016:

Countries applying for all types of Gavi support in 2016 are advised to refer to the following documents in the order presented below:



**HSS
Application
Form**

Purpose of this document:

This application form must be completed in order to apply for Gavi's HSS Support. Applicants are required to read the HSS Application Instructions prior to completing this application form and are advised to refer to these instructions whilst completing the application form. Applicants should first read the General Guidelines for all types of support as well as the HSS Guidelines before this document.

The application form, along with any attachments, must be submitted in English, French, Portuguese, Spanish, or Russian.

Weblinks and contact information:

All application documents are available on the Gavi Apply for Support webpage: www.gavi.org/support/apply. For any questions regarding the application guidelines please contact applications@gavi.org or your Gavi Senior Country Manager (SCM).

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PART A: SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION

1. Applicant information	
Total funding requested from Gavi (US \$)	USD 3,149,853
Does your country have a finalised and approved National Health Sector Plan?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
	Indicate the end year of the NHSP 2020 Provide Mandatory Attachment #8: NHSP
Does your country have a finalised and approved comprehensive Multi-Year Plan (cMYP)?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
	Indicate the end year of the cMYP 2020 Provide Mandatory Attachment #11: cMYP
Proposed HSS grant start date:	Indicate the month and year of the planned start date of the grant. July 2018
Proposed HSS grant end date:	Indicate the month and year of the planned end date of the grant. December 2021
Joint appraisal planning:	Indicate when in the year the joint appraisal will be conducted, and which HLRP meeting the joint appraisal report will be submitted to. Q3 and Submitted to October HLRP

2. Application development process (Maximum 2 pages)

Provide an overview of the collaborative and participatory application development process.

Include the following **Mandatory Attachments**:

#4: Minutes of HSCC meeting, at which the HSS application was endorsed;

#5: Last 3 minutes of HSCC meetings; and

#15: TOR of HSCC

The proposal development process started in November 2015 when the Ministry of Health and Medical Services (MHMS) with the support of the World Health Organization Regional Office for the Western Pacific (WPRO) initiated the process of developing a Health System Strengthening (HSS) proposal, submitted in the September 2016 window. Following the IRC recommendation for resubmission, a revised proposal is being submitted taking into account IRC feedback (Ref. 161214_SolomonsI_Re-submission Letter_HSS-CCEOP).

The EPI National Coordinator and the Director of Reproductive and Child Health were closely engaged in developing the methodology of the proposal development. Key stakeholders and essential documents were identified. Information from stakeholders, documents, site visits, and national conferences and events were collected, reviewed, and triangulated to identify key priority needs.

A comprehensive approach was taken to developing the proposal with multiple modalities to collect and

review information:

Stakeholder Consultations: Consultations with the MHMS, Development Partners, and Civil Society Organizations were held.

Consultations with key MHMS offices and officials identified challenges, gaps and bottlenecks describing current initiatives. Key informants included the Permanent Secretary, EPI Unit, Reproductive and Child Health Director, National Medical Stores, Policy and Planning, Finance Division, Health Promotion, Health Information/ Statistics Unit, Human Resources and the National Director of Nursing. Discussions were also held with a provincial director (Guadalcanal Province) and province level child health coordinators who were in charge of EPI implementation (Guadalcanal and HCC Provinces).

Development partners consulted were WHO (health information, EPI and RCH), UNICEF, Australian Department of Foreign Affairs and Trade (DFAT) and the World Bank. The Solomon Islands Christian Association, World Vision and Red Cross represented civil society, churches and NGOs. They described their current child health initiatives, previous and current partnerships with government particularly MHMS, partnership mechanisms and current challenges experienced in communities.

Technical Assistance: TA was provided to the MHMS across the November 2015-January 2016 period by a short-term consultant through WPRO with additional assistance in September 2016 by the TO-HSS in WPRO. Proposal revisions were carried out in Honiara during July and August 2017 by a WPRO sourced consultant.

Site Visits: Site visits were conducted to the Guadalcanal Provincial Health Office, Honiara City Council Pikinini (Children's) Clinic, the Good Samaritan Hospital (a large Area Health Centre), and the National Medical Stores. These visits allowed the rapid assessment of programme implementation, the health information system from health facilities to the national level, vaccines supply distribution, cold chain equipment (CCE) procurement, storage, stock and inventory management, distribution to provinces/ health facilities and their maintenance.

National Events: Attendance to the National Health Conference 2015 benefited the proposal writers as development partners and MHMS reviewed the health system progress, challenges, and future plans. This conference provided a comprehensive overview of the issues faced by programs, including EPI. The team was also able to attend Immunization Week activities in Guadalcanal Province, and the official launch of the Joint UN Programme on Maternal, Neonatal and Child Health.

Document Review

Essential reports and documents were collected and reviewed. These included:

The National Health Strategic Plan 2016-2020, the Reproductive, Child Health and Nutrition (RCHN) Strategy 2016-2020 (draft), expected to be finalised in Q4, 2017, the Role Delineation Policy 2017, the Solomon Islands Demographic Health Survey 2015, the National Immunization Plan (cMYP) 2011-2015, the comprehensive Multi-year Plan for Immunization (cMYP) 2016-2020, the National EPI Policy 2015 and the National Vaccine Cold Chain Policy 2016.

Recent reviews, assessment and missions including the Joint Appraisal Report (2015), the Graduation Mission Report (2015), the Strategic Review on Strengthening Development Partner Support to Immunisation Programs in the Pacific (2015), the draft transition plan, (2017), the Effective Vaccines Management (EVM) Report (2017), the International EPI Review (2012), the Solomon Islands Immunization Status (June 2015, MS PowerPoint).

Operational reports such as the Cold Chain Inventory, the Health Information Status information, the Gavi Annual Performance Reviews and the WHO/UNICEF Joint reporting forms (JRFs) provided updated information.

Findings

Four broad areas were identified based on gaps and current challenges and activities were subsequently developed to address immunisation limitations. The areas are aligned to the NHSP, the cMYP, the Independent performance assessments (2015-2017) and the findings from the SIDHS:

1. Strengthening service delivery and programme management capacity at the national and provincial levels to ensure both operational and financial sustainability post 2021;
2. Improving vaccine supply and cold chain planning, capacity, infrastructure and management system for sustainability;
3. Ensuring good quality and timely routine information and regular surveillance systems; and
4. Optimizing demand-generation and community engagement through development of partnerships.

To strengthen the above four strategies, human resource capacity must be reinforced. Consultations and reports emphasized gaps and challenges in the area of health workforce supply, accountability, multi-tasking, capacity and skills. The proposal integrates health workforce capacity building activities in each of the four objectives.

Initial consultation with the EPI team (19 November 2015), RCH Director, development partners, and NGOs endorsed these broad directions which continue to be a key priority for MHMS for this HSS2 application.

The current HSS1 grant is being implemented in three (3) provinces- Guadalcanal, Malaita and Western Province. This new proposal plans to expand the rollout of HSS activities to five (5) additional provinces, Makira, Central Island, Temotu, Renbel and Choiseul. These five Provinces were selected due to low performance in achieving health and immunisation outcomes, challenges and gaps in inputs (information and cold chain management) and population (size and geographical access). Makira, Central Island and Choiseul are also priority provinces for support in the NHSP 2016-2020 (Attachments # 8 NHSP and #26 coverage in target zones). The goal, objectives and activities of this proposal were initially presented to the Inter-Agency Coordinating Committee for Family Health (ICC) on 7 December 2015. The proposal was subsequently approved and endorsed for submission. After the WHO pre-review processes in January and September 2016, the proposal was updated to reflect the most recent data and plans, and presented to the ICC on 11th October 2016. The revised proposal fully addresses the IRC feedback including sustainability and transition interventions. The human resource requested in the proposal (3 full time positions) are budgeted until the end of 2019 as the Government is committed to absorb these positions by then. Also the budget was tapered to allow for the SIG to absorb 60% of the recurring costs in 2020 and take a further 10% in 2021. At the end of the grant period, SIG would be absorbing the remaining 30% of the activities thus managing the transition in a step wise manner.

During the proposal revision the Programme Capacity Assessment (PCA) was undertaken and their initial findings are considered in the report. Further, as the HSS2 proposal revision was winding down, a data quality assessment (DQA) took place. Whilst the proposal includes data quality improvement activities aligned to the DQA findings, these may not sufficiently be addressing the findings of the DQA as recommendations are yet to be received. The HSS2 proposal was endorsed by the HSCC on 1st September 2017 and presented in Manila in the Peer Review on 10 and 11th August 2017 prior to submission to Gavi.

3. Signatures

3a. Government endorsement

Include Minister of Health and Minister of Finance endorsement of the HSS proposal – **Mandatory Attachment #2.**

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 Ministry of Health.

Minister of Health (or delegated authority)

Name: Honourable Dr Tautai Angikimoana Kaituú

Signature:

Minister of Finance (or delegated authority)

Name: Honourable Syder Rini

Signature:

Date:

Date:

3b. Health Sector Coordinating Committee (HSCC) endorsement

Include HSCC official endorsement of the HSS proposal – **Mandatory Attachment #3**

Include a signature of each committee member in attendance and date.

Mandatory Attachment #3: HSCC Endorsement of HSS Proposal

*We the members of the HSCC, or equivalent committee met on the **1st of September 2017** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached to this application.*

Please list all HSCC members	Title / Organisation	Name	Sign below to confirm:	
			Attendance at the meeting where the proposal was endorsed	Endorsement of the minutes where the proposal was discussed
Chair	Undersecretary Health Improvement- MOH	Dr Nemia Bainivalu		
Secretary	RMNACH Coordinator- WHO	Simon Burgruff		
MOH member- Vice Chair	Director Reproductive and childhealth	Dr Divinal Ogaoga		
	Drector Planning	Ian Ghemu		
	National EPI Program Coodinator-MOH	Jennifer C Anga		
	Program Manager(Supervising)- MOH	Nancy Pego		

	Director National Pharmacy	Timmy Manea		
	Manager National Medical Store	Willie Horoto		
	Director Planning and Policy	Ivan Chemu		
	Head of Paediatric	Dr Titus Nasi		
	Head Of Obstetric and Gynae	Dr Leane Panisi		
Development partners				
CSO members	World Vision International -SI	Everlyn Darcy		
WHO	Country Representative	Dr Sevil Huseynova		
UNICEF	Chief of Field Office SI	Dr Zelalem Taffesse		
	EPI Officer	Ibrahim Dadari		
UNFPA	Program Analyst	Pauline McNeil		

4. Executive Summary (Maximum 2 pages)

Provide an executive summary of the application.

Background: Due to constraints including geographical and human resource challenges, the Solomon Islands have experienced a decline in immunisation coverage, with penta3 coverage declining from 99% in 2011 to 77% in 2014, and the occurrence of a measles outbreak in 2014. A Gavi HSS grant was originally planned to start in 2012 but commenced in 2014 due to challenges in finance procedures, grant making delays as well as the impact of the flooding emergency and measles outbreak. Despite these constraints, the first HSS grant has enabled the successful start of immunisation service strengthening in three low performing provinces. Activities included in this application are geared towards long lasting systems sustainability and transition to own government systems.

Bottlenecks: Existing bottlenecks that hindered effective implementation of immunization are well documented. (1) low service coverage and access 25% of the population still has inadequate access to services and correspond to the overall immunization coverage rates (75% children immunised against measles 2015). There is inequity in access and coverage and access is compounded by challenging geographical typography, poor road and transport infrastructure and a tightening fiscal space. (2) Inadequate Vaccines supply and Cold Chain Equipment and Quality & Safety issues. Whilst the national medical stores had continuous supply, stock outs were confirmed in supervisory visits at lower levels. The 2017 EVM concluded there is limited cold storage capacity at health facility level, inadequate maintenance, stock management and other supportive functions nationwide. Distribution of vaccines and cold chain equipment is constrained by the difficulty to reach mountainous island areas with limited road network and boat availability. (3) Data Availability – Health Information and Surveillance despite recent high reporting levels, challenges include poor data quality, incomplete data, timeliness, accuracy and information management in low performing areas; lack of analysis and use of information for action; need for strengthening the surveillance system for vaccine-preventable

diseases; (4) *Health Workforce* Critical shortages, multiple responsibilities and low provincial capacity in program planning, surveillance and data collection and analysis. (5) *Insufficient Communication and Community Engagement* Gender relations that are heavily male-dominated¹, lack of decision making power for women, and low education rates affect health care seeking behaviour. Churches provide basic health services in communities through their own volunteer workers not institutionalized into the health system and opportunities for community partnerships have not been maximised. The findings of the bottleneck analysis align with the Joint Appraisal Graduation Assessment conducted in 2015 and the annual Joint Appraisal reports for 2015, 2016 and 2017 (Attachment #43 for the JAR 2017).

Objectives of the Proposal: The design of the HSS2 proposal is aligned with the National Health Strategic Plan 2016-2020 (NHSP), the cMYP 2016-2020 and the Role Delineation Policy (Attachment# 39) that defines the roles, capacities and resources in each level of service delivery in order to achieve universal health coverage in a decentralising context. The HSS2 proposal aligns with the NHSP goal, to achieve 90% coverage in immunization by 2021 (the NHSP timeframe is to 2020).

Objective 1: Increase immunization coverage rates through sustainable service delivery and programme management: By the end of 2021, all priority zones will attain and sustain DTP3/Penta3 coverage greater than 90% through effective national and provincial management systems with a focus on low coverage zones. Micro-planning will shift focus to community level focus through Reaching Every Child Strategy (REC). *Major activities* include expanding outreach, training for immunizers, supportive supervision, micro-planning, REC Strategy, performance reviews and planning. Support staff for administration and finance will strengthen programme implementation and monitoring. Technical assistance will support smooth transition to the Health Sector Support Programme finance pool.

Objective 2: Improving vaccine supply and cold chain planning, capacity, infrastructure and management system: By the end of 2021, Essential Vaccines Management (EVM) indicators will show significant improvement at the national and provincial levels through vaccine and cold chain management trainings, procurement, installation, maintenance and replacement of CCE and minimum stock-outs especially in low coverage zones. Key interventions include annual mapping/ inventory, strengthen implementation of guidelines and protocols, human resource capacity building for stock and CCE management and preventive maintenance, monitoring and supervision, support for distribution of vaccines and contribution to the CCEOP.

Objective 3: Ensuring good quality and timely routine information and regular surveillance systems: By the end of 2021, the immunization programme aims at quality and timely routine information and regular surveillance, adequately disaggregated, and regularly used for national and local planning for action. Activities include strengthening health information, analysis and disaggregation; support for DHIS2; national EPI survey; data quality assessment; strengthening data review system; provision of monitoring tools; expanding surveillance sentinel sites to all provinces; and provision of computers and radio systems to strengthen communication. An end of grant evaluation is also planned.

Objective 4: Optimizing demand-generation and community engagement through development of partnerships: By the end of 2021, local partnerships with civil society (CSOs), churches, NGOs and community groups in specific low performing provinces and zones to enhance community engagement and increase utilization of immunization and PHC through grants managed through UNICEF. Activities include dissemination and implementation of the National Communication Strategy for RMNCAH; advocacy for immunization; Immunization Week activities; strengthening partnership and coordination systems in provinces and zones; and capacity building for communication, community engagement, equity and gender relevant to immunization and primary health care.

Implementation in low-performing areas: The HSS2 Grant will be implemented in eight of the ten provinces

¹ Asian Development Bank, 2015, Solomon Islands Country Gender Assessment.

including the three provinces from the existing grant (Malaita, Western Province and Guadalcanal) as well as five additional provinces (Makira, Choiseul, Temotu, Renbel and Central Province). These provinces were selected based on poor health and immunization outcomes, high population and poor system performance in terms of information collection and cold chain management and in addition Renbel was selected due to its low immunisation coverage and remoteness. From DHIS2, immunisation coverage reports from August 2017 for the focused provinces showed the zones with low immunisation coverage (Attachment #26).

M&E and information strengthening activities: includes support to integrate EPI in DHIS2 and ensure adequate disaggregation, a nation-wide EPI survey, data reviews and analysis, surveillance of vaccine-preventable diseases and strengthening information infrastructure through two-way radios and computers. Supportive supervision, monitoring and field visits will be conducted as part of programme management. Monitoring of activities are based on the NHSP M&E and the annual immunisation work plan.

Funds management: The HSS2 grant will form part of the Health Sector Support Programme (HSSP) and will be monitored by the Finance Division of MHMS and the Ministry of Finance adhering to the Solomon Islands Government's procedures as directed by the Ministry of Finance and Treasury. The HSS2 proposal includes a contribution to the Cold Chain Equipment Optimization Platform (CCEOP).

Program Management and Implementation: The EPI Unit, under the Reproductive and Child Health Division (RCHD), is in charge of planning, implementation, monitoring and coordination of all immunization activities. The National Inter-Agency Coordinating Committee for Family Health composed of MHMS and National Referral Hospital officials and development partners provides oversight. UNICEF and WHO provide technical guidance and supports implementation particularly in areas of vaccine procurement, cold chain management, health information and surveillance of vaccine preventable diseases. UNICEF has the additional task of managing grants to CSOs/NGOs/Faith based organisations under HSS2.

Coordination: includes other MHMS units and divisions (e.g. NMS, Statistics, Finance, HR and Health Promotion) as well as with development partners (UNICEF, WHO and DFAT) and CSOs (NGOs and churches). The National Medical Stores (NMS) is in charge of planning, procurement, storage, inventory management and distribution of vaccines and cold chain equipment, including CCE maintenance. The Provincial Child Health (EPI) Coordinator will ensure capacity building in activities related to immunization in the prioritised provinces. Church groups are the main organizations that MHMS can partner with to implement immunization activities in the community. UNICEF supports the government with an in-country EPI technical officer who provides assistance in cold chain management, while WHO supports other EPI programme activities and programme management including planning. The Australian Government (DFAT) is the major development partner supporting the health sector through budget support and specific technical assistance posts including procurement and financial controls.

5. Acronyms

Provide a full list of all acronyms used in this application.

Acronym	Acronym meaning
AHC	<i>Area Health Centre</i>
CCE	<i>Cold Chain Equipment</i>
CHC	<i>Community Health Centre (future designation of Nurse Aid Posts)</i>
CIS	<i>National Core Indicator Set</i>
cMYP	<i>Comprehensive Multi-Year Plan for Immunization, or the National Immunization Plan</i>
CSO	<i>Civil Society Organization</i>

DFAT	<i>Department of Foreign Affairs and Trade, Government of Australia</i>
DHIS2	<i>District Health Information System 2</i>
DQA	<i>Data Quality Assessment</i>
EPI	<i>Expanded Programme for Immunization</i>
EVM	<i>Essential Vaccines Management</i>
GAVI	<i>Global Alliance for Vaccines and Immunization</i>
HSSP	<i>Health Sector Support Programme</i>
KRA	<i>Key Result Area</i>
MHMS	<i>Ministry of Health and Medical Services</i>
MOFT	<i>Ministry of Foreign Affairs and Trade</i>
NAP	<i>Nurse Aid Post</i>
NHSP	<i>National Health Strategic Plan</i>
NMS	<i>National Medical Stores</i>
NGO	<i>Non-Government Organization</i>
NRH	<i>National Referral Hospital</i>
PHC	<i>Primary Health Care</i>
RCHD	<i>Reproductive and Child Health Division</i>
RCHN	<i>Reproductive, Child Health and Nutrition (usually refers to the Strategy)</i>
RDP	<i>Role Delineation Policy</i>
REC	<i>Reaching Every Child Strategy</i>
RHC	<i>Rural Health Clinic</i>
RMNCAH	<i>Reproductive, Maternal, Newborn, Child and Adolescent Health</i>
RWASH	<i>Rural Water, Sanitation and Hygiene Programme</i>
SA	<i>Strategic Area</i>
SSEC	<i>South Seas Evangelical Church</i>
SICA	<i>Solomon Islands Christian Association</i>
SIG	<i>Solomon Islands Government</i>
SWAp	<i>Sector-Wide Approach</i>
UNICEF	<i>United Nations Children's Fund</i>
VII	<i>Vaccine Independent Initiative</i>
VHW	<i>Volunteer Health Workers</i>
VPD	<i>Vaccine-Preventable Diseases</i>
WHO	<i>World Health Organization</i>

PART B: BACKGROUND INFORMATION

6. Description of the National Health Sector (Maximum 1 page)

Provide **Attachment #8**: NHSP or equivalent and reference which sections describe the national health sector. If no existing approved national document describes the national health sector, provide a concise overview of the national health sector.

The Solomon Islands Health System Overview

The Solomon Islands consists of nearly 1,000 islands that together make up a land area of approximately 30,400 square kilometres (km²) within a sea area of roughly 1.5 million square kilometers. The country's six major islands are Choiseul, New Georgia, Isabel, Guadalcanal, Malaita and Makira. The majority of people live along the coast, but there are substantial population pockets in inland areas of Guadalcanal and Malaita. Approximately 84% of the population live in rural areas, including some very remote areas.

The geographical location of communities and villages means that many parents living in more remote areas have to walk long distances or travel by boat to access immunization services and costs of transportation by boat or land can be high and not affordable for many. Cultural practices in the Solomon Islands can also lead to barriers. An example is that there may be fewer or possibly no deliveries in remote clinics in which male nurses are posted because of objections to them providing care for women in labour. Gender inequality is a major obstacle in the Solomon Islands, with high rates of violence against women and slow progress in empowering women with economic and political leadership.

The MHSM functions as policy maker, funder, regulator and provider of nearly all services. NGOs and faith-based organisations also make significant contributions in additional funding and service delivery. The MHMS is involved in the co-financing of some of the Churches health services (e.g. Good Samaritan Hospital). The Private Sector plays a minimal role within the health sector and mostly in Honiara City.

The Solomon Islands health system is based on a public health model that is nurse-led (50% of all health workers are nurses) and delivers three types of services: curative and preventative services through fixed facilities and outreach which includes EPI services, community-based preventative activities and non-individualised services (e.g. mass media). This is delivered through five different levels of services consisting of 187 Nurse Aid Posts (Level 1), 102 Rural Health Centres (Level 2), 38 Area Health Centres (Level 3), Provincial Hospitals (Level 4), and the National Referral Hospital (Level 5). The health system is financed through general government revenue (55-65%) and external donor resources (30-40%), with minimal out-of-pocket spending (~3%). All vaccines are procured through UNICEF and funded from government (through the Vaccines Independence Initiative) or the Gavi Alliance.

The Sector Wide Approach (SWAp), introduced in 2007, has all development partners as signatories to the Partnership Agreement and sees aid financing flow through the Solomon Islands system. Under the SWAp's umbrella, the MHMS has embarked on a rolling programme of reform and analytical work. One of the current major health sector reforms is the development of the Role Delineation Policy, developed to deliver Universal Health Coverage. It defines the range and level of services – or packages of care – to be delivered to given populations across the country and aims at improving both quality and efficiency of services and health outcomes in a fiscal environment that is expected to have limited growth over the next few years.

The progress against the NHSP 2016-2020 is monitored by the Health Statistics Unit of the MHMS which receives, collates and analyses monthly reports from primary health facilities. Outcome data is also collected through routine surveys such as the DHS. The rollout of the District Health Information System (DHIS2) has nearly been completed, with nine out of ten provinces (except Rennell-Bellona) now connected. The migration of several public health programmes (malaria, tuberculosis, EPI and MCH) into DHIS2 has recently been completed and the new monthly report forms reflecting the new EPI schedule have been disseminated. The integration between logistics data through mSupply and DHIS is being currently explored.

The National Medical Store (NMS), a unit under the MHMS manages the national medicine and medicine

supply procurement. On behalf of the country, UNICEF procures vaccines and related devices through the Vaccine independent Initiative (VII) revolving fund mechanism. According to the Health Core Indicator Report (2016), NMS had 98% stock availability in 2016 at central level though significantly less at provincial level. Cold chain equipment procurement is being supported by UNICEF and Gavi. The NMS uses an electronic inventory system *mSupply* that has been hailed as a best practice in the Pacific and the mapping out of all facilities linked to mSupply is taking place through a DFAT supported Tupaia project².

The Solomon Islands health system achieves relatively high levels of equity as there are no user fees; however, access still remains a challenge for rural and remote populations. Approximately, one quarter of the population live more than one hour travel time from the nearest AHC or a RHC, and referral time from health facilities to hospitals varies widely (SIDHS 2015). According to the Health Core Indicator Descriptive Report (2016), on average, visits to health facilities are twice per year. Children living in rural areas and those living in the lowest and fourth wealth quintiles are more likely to be disadvantaged in terms of accessing all basic vaccination according to the SIDHS 2015.

7. National Health Sector Plan (NHSP) and relationship with cMYP (*Maximum 2 pages*)

Describe the relationship of the cMYP to the national health strategy.

*Provide: **Mandatory Attachment #8:** NHSP and **#11:** cMYP; and if available: **Attachment #18:** Joint Assessment of National Health Strategy (JANS); and **Attachment #19:** Response to JANS.*

The **National Health Strategic Plan (NHSP) 2016-2020** provides the agenda for the Solomon Islands health sector for five years and focuses on implementation, prioritising child and maternal health, communicable and non-communicable diseases. The four Key Result Areas (KRAs) are:

- Improve Service Coverage giving priority to the most underserved areas and populations, to the most effective interventions and to the diseases that causes more deaths and illnesses
- Build Strong Partnerships with people, government, donors, churches, NGOs and the private sector
- Improve Service Quality to be safe, efficient, people centred, timely and equitable
- Lay the Foundations for the Future by building health infrastructure, developing sustainable financing mechanisms, information systems and prepare for disaster and climate change.

Under KRA 1 six priority interventions for full coverage have been identified. Immunisation is top priority, followed by family planning, WASH, supervised deliveries, malaria and TB control.

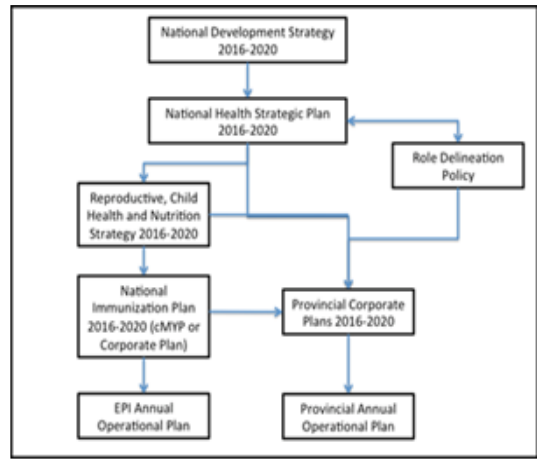
The NHSP 2016-2020 aim is to achieve better health outcomes by improving service coverage. To this purpose, the plan prioritises the most underserved provinces and zones, acknowledging that service coverage varies between and within provinces with some (Honiara) achieving 100% immunisation coverage and nearly 100% supervised births. Of the 10 provinces, Makira, Choiseul, Central and Malaita have been identified in the NHSP as provinces with low levels of service provision across several programmes (including EPI) and Rennell and Bellona as the most remote. The NHSP 2016-2020 emphasizes the role of provinces in terms of planning, management, monitoring and utilization of funds. This direction was reiterated at the 2015 National Health Conference. Given the country's direction towards decentralization, health programmes including EPI are expected to design their activities to strengthen provinces in an integrated manner. The NHSP also highlights the importance of partnerships at all levels especially in communities.

The NHSP M&E Plan 2016-2020 is still under development, and is expected to be finalised in Q1 2018. Progress against the NHSP is reviewed annually through the Annual Joint Performance Review process in which

² Tupaia.org

the SIG, including Provinces and zones and development partners review performance against the strategy. This process supports annual operational planning cycles and takes into account recommendations, priorities and addresses gaps identified as part of the Annual Joint Performance Review. As part of the overall health sector planning process, programmes and provinces are expected to produce their Corporate Plans describing how their programmes and activities are linked with the NHSP 2016-2020. Annual Operational Plans are prepared in line with the NHSP and Corporate Plans and approved every fourth quarter outlining every office activities and expenditure. The 2018 annual operational plans are in the process of being developed.

Figure 2. Solomon Islands policy and planning mechanisms for Reproductive, Maternal, New-born, Child and Adolescent Health and EPI



The 2018 annual operational plans are in the process of being developed.

The Reproductive, Child Health and Nutrition Strategy (RCHN) 2016-2020 (Attachment #41) is currently being finalized along with its overall set of RCHN indicators.³The draft RCHN Strategy emphasizes the strong immunization services that has been developed over years and sustained despite the recent civil conflict.

Specifically, under the *KRA 3 Prevention and care for sick children* the RCHN Strategy aims to ensure the availability of child health services including EPI in all health facilities. It sets a national target to ensure >95% of children (1 year) are immunized against measles/rubella (MR). The RMCH Strategy also aims to increase the proportion of under-1 year old receiving

pneumococcal vaccine.

The **Comprehensive Multi-Year Plan (cMYP) for Immunization 2016-2020** (Attachment #11) is aligned to both of these key documents. The cMYP builds on the achievements of the previous years, and sets new milestones and targets for 2016-2020. The cMYP is also aligned to the draft **National EPI Policy** revised and updated in 2015 (in process for endorsement expected in Q4 2017), which states the aim of the EPI in the Solomon Islands remains to improve infant, child and maternal survival and health by preventing, controlling or eliminating targeted vaccine-preventable diseases. The current cMYP identifies 16 priority areas including immunization coverage, new vaccines, human resources, capacity building, supportive supervision, financial sustainability, cold chain equipment and immunisation data quality. Personnel costs (59%), other routine recurrent costs (19%), vaccine and injection supplies with the new vaccines (HPV, Rota) (7%) and traditional vaccines (8%) are the main costs identified in the cMYP.

Finally, the **Role Delineation Policy (RDP)** (Attachment #39) is a policy is a tool for better defining the range and level of services – or packages of care – to be delivered to given populations across Solomon Islands. The Role Delineation Policy aims to inform the standard requirements for health facilities across the country including EPI and RMNCAH. Primarily the policy:

- Defines the different levels of service in the Solomon Islands Health System
- Developed based on the principles of Primary Health Care
- Acts as a catalyst for health sector reform to strengthen quality service delivery
- Lays the service delivery foundations for future development of the Solomon Islands Health System.
- Provides guidance on types of services (service delivery packages) to be provided at each of the six (6) levels of service to inform service planning and improve service quality
- Defines the referral pathway- linking the health sector to the community as part of the referral system with a strong continuity of care.

In the RDP, nurses have a crucial role in providing primary health care services and knowing their communities.

³ MHMS (2015). Solomon Islands Reproductive Child Health and Nutrition Strategy 2016-2020. (Unofficial draft) Solomon Islands Ministry of Health and Medical Services. Honiara.

This is expected to result in effective engagement and to increase local demand.

8. Monitoring and Evaluation Plan for the National Health Plan (Maximum 2 pages)

Provide background information on the country M&E arrangements.

National M&E Plan and the Health Core Indicator Set

The National Health Strategic Plan 2016-2020 M&E Plan is being drafted expected to be finalised by Q1, 2018. The National M&E plan will be consistent with the National Core Indicator Set (CIS) that was developed to monitor the progress in NHSP priorities. There are 35 indicators in the CIS, covering four key areas: Health Improvement; Health Care; Health Policy and Planning and Administration and Finance. The CIS is a mix of indicators required for international reporting, such as the MDGs and SDGs, as well as country specific indicators that have been adapted to country needs in order to monitor the progress against the NHSP and other sectoral programme plans and strategies. The progress against the CIS is reported annually in the Statistical Health Core Indicator Report of the MHMS (Attachments # 37).

These indicators are reported directly through the District Health Information System Version 2 (DHIS2) and are reviewed every year. The indicators in the CIS related to immunization are:

Number of infant deaths

Number of child deaths

Measles immunization coverage.⁴

The Monthly Report and the DHIS2 include an indicator on the number of days that cold chain is not functional. The indicators on closed health facilities and monthly reporting of health facilities also provide an idea of the availability and monitoring of immunization services.

Data Collection

Information on immunization and other public health indicators is generated from the Area Health Centers (AHCs), Rural Health Clinics (RHCs) and Nurse Aid Posts (NAPs) and consolidated at the Provincial Health Offices. At the AHC and RHC levels, registers for outpatients, child health, maternity care are available. The data is captured in the Monthly Reports and submitted to the province. The Monthly Report includes all health programme indicators including child health and immunization. The tool has been finalised and is aligned with the NHSP and the National Core Indicators set. The DHIS platform already includes planned vaccine introductions such as HPV and Rota and the paper-based forms (daily tally sheets) have already been updated and rolled out to health facilities. Health Information officers are in charge of collecting and consolidating the reports. At the Provincial Health Office, data is encoded into DHIS2 with provinces submit their EPI data to National level through DHIS2.

The National EPI Policy defines data management for immunization including the use of a monitoring tool (coverage charts in health facilities), calculation of dropout rates and immunization coverage based on target populations. The National EPI Policy requires regular planning and implementation of household cluster immunization coverage surveys and national and provincial level programme reviews.¹⁰ Programme reviews are done at the national level. The Health Statistics Division in the MHMS oversees data collection in all provinces. Two-way radio is the main communication link between health facilities and with the province through many need repair or replacement though given high ownership of mobile phones (SIDHS 2015 estimates about 78% of all households own a mobile phone including 97% of urban households) its use is increasing.

⁴ MHMS (2014). National Core Indicators Set. Ministry of Health and Medical Services. Honiara.

Surveillance and Surveys

Sentinel surveillance using syndromic surveillance exist in some provinces and in the National Referral Hospital.⁵ Five sentinel sites for vaccine preventable disease surveillance for Acute Fever Rash (AFR), Acute Flaccid Paralysis (AFP) and Neonatal Sepsis have been established in 2015 through Gavi HSS support⁶. Blood samples and stools are sent to Victorian Infectious Diseases Reference Laboratory (**VIDRL**) (Australia) supported by WHO. The hospital-based and syndromic surveillance systems are currently being linked in terms of monitoring and meetings. Sentinel surveillance trainings for AEFI and VPDs were conducted in three hospitals in 2014. There has not been conducted an EPI coverage survey and one is planned in the 2Q 2020 through this proposal.

Data Quality & Completeness

The District Health Information System (DHIS2) was implemented in 2011. Since 2014, provincial-level health information officers have been able to directly enter data from the HIS Monthly Health Facility Reporting Form into the DHIS (CIS 2015 statistical report). In 2015 the annual reporting return rate (timeliness) was 96%. Two of the focus provinces Makira and Choisul have a completeness rate of 90% and 91% respectively. Whilst above the national target of 80% there are important seasonal variances in reporting rates with completeness reducing considerably in the second half of the year, especially in November and December.

There are issues with data quality for monitoring of immunization coverage. The last population census was undertaken in 2009 and population figures are projected. Provinces like Honiara City Council often show coverage for almost 200% (in 2016, the rate was 196% for Penta1 according to the EPI data) largely due to internal displacement, flooding and children being immunised and reported in Honiara. Reported administrative coverage and DHS estimated coverage are inconsistent, as also reflected in the WUENIC. Data quality issues highlight the need for data quality reviews as well as coverage surveys. To date, there have not been data quality and desk reviews. A data quality survey was conducted in August 2017.

Supportive supervision is conducted at provincial and zone levels. Staff involved in the supportive supervision activities have been trained in the EPI standard monitoring tools. This proposal includes further supportive supervision to improve EPI programme performance.

*Provide **Mandatory Attachment #9:** National M&E Plan (for the health sector/ strategy), as well as any sub-national plans, as relevant. If this does not exist, explain how the National Health Plan is currently monitored and provide a timeline for developing an M&E Plan.*

*If available, provide **Attachment #16:** Data quality assessment report; and **Attachment #17:** Data quality improvement plan.*

***Pooled fund** applicants are required to attach the National M&E Plan and any documentation on the joint review process, including terms of reference, schedule etc.*

Both the National M&E Plan 2016-2020 and the RCHN Strategy 2016-2020 will have an associated M&E plan with a set of indicators. Both M&E plans and indicators are designed to be consistent with the National Core Indicator Set (CIS) submitted with this proposal. The Health Sector Support Programme (HSSP) will follow these M&E frameworks. The HSSP has a joint annual review process as part of the Annual Joint Performance Review with Provinces, Zones and Development Partners as described in Section 7.

9. Alignment with existing results based financing (RBF) programmes (where relevant) (Maximum 1 page)

Indicate whether your country will align HSS support with existing results based financing (RBF)

⁵ Tyson S and Clements J (2015). Strengthening Development Partner Support to Immunisation Programs in the Pacific – Strategic Review. Mott MacDonald. October 2015.

⁶ The five sites are : In Malaita Province : Atoifi Hospital and Kiluúfi Hospital ; in Western Province : Gizo and Goldie Hospital and in Honiara the National Referral Hospital.

programmes.

If yes, provide **Attachment #30: Concept Note/ Programme design of relevant RBF programme, including Results Framework and Budget.**

PART C: APPLICATION DETAILS

10. Health System Bottlenecks to Achieving Immunisation Outcomes (Maximum 3 pages)

Provide a description of the main health system bottlenecks. If such analysis has recently been conducted, attach **Optional Attachment 33: Health system bottleneck analysis.**

Bottlenecks affecting the Solomon Islands Health System Performance for improved Immunisation Outcomes

Seventy three percent of children aged 18–29 months were fully vaccinated based on SIDHS 2015 results, a decline from about 83% reported in the SIDHS 2006–2007 among children aged 12-23 months.

Furthermore, the proportion of children that were fully vaccinated at exactly age 18 months was 71% in the SIDHS 2015, indicating a drop from 77% reported in the SIDHS 2006–2007. In the last five years, reported immunization rates have

plateaued with a dip between 2012 and 2014 and an eventual improvement in 2015-2016 for DTP3 figures. DTP3-containing vaccine rate was 88% in 2011 dipping to 77% in 2014 and increasing to 87% in 2015 (ref EPI data) and 94% in 2016 which has a promising trend. WUENIC reflect the same trend over time, however the point estimates are higher, as they account for discrepancy between reported coverage and DHS estimates: WUENIC is 98% in 2015. The number of children immunized against measles is a key indicator to MHMS. Measles coverage has experienced slow improvements from 73% in 2011 to 75% in 2015, with a sudden increase to 82% in 2016. According to the SIDHS 2015, about 85% of children aged 18 to 29 months received measles or measles rubella vaccine prior to the survey, a decrease from the 87% reported in the previous 2006-2007 SIDHS among children aged 12-23 months. The average number of children (12-59 months) who have received one dose of measles-containing vaccine in a given year was 84% (between 2014 and 2016); immunisation rates for measles appear to be fluctuating between 70% - 95% and this is mainly due to catch-up campaigns which boost the coverage in years they are carried out (Attachment #38 CIS 2016 Descriptive Report).

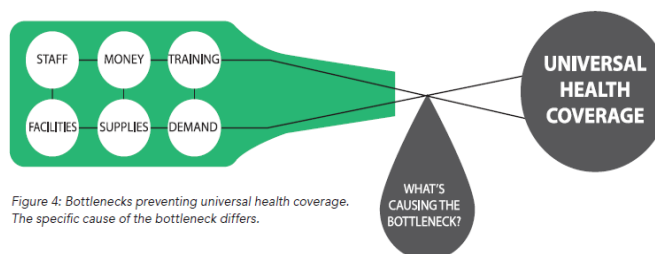


Figure 4: Bottlenecks preventing universal health coverage. The specific cause of the bottleneck differs.

Bottleneck 1: Low Service Coverage and Access

Despite relatively high levels of access to primary health care services (approximately three-quarter of the population are within one-hour to a RHC or AHC (National Health Development Plan), one quarter of the population still has inadequate access to services⁷. Overall immunization coverage rates (85% children immunized against measles in 2015 SIDHS2015 and 84% in the CIS 2016 Descriptive Report but 75% according to 2015 EPI data) appear to correspond with the percentage of population having access to health facilities. The Household and Income Expenditure Survey (HIES) 2012/2013 shows that in rural areas, main facilities accessed are Rural Health Clinics (46%) and Nurse Aid Posts (30%). More than 39% of rural households take more than one hour to travel to a health care facility. Dropout rates are also a cause for concern; Penta 1 and Penta 3 rates in 2014 were 95% and 77% respectively.

According to the SIDHS 2015 (Attachment #36), there is no significant difference between female and male

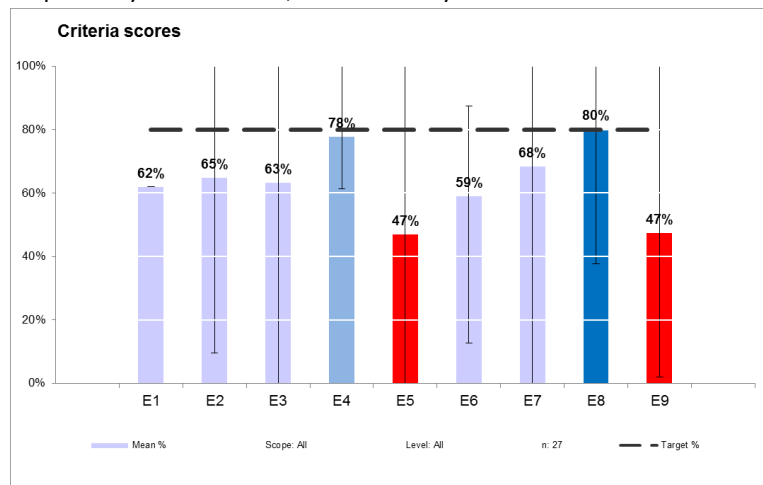
⁷ Asia Pacific Observatory. 2015. Health Systems in Transition Solomon Islands Health System Review.

babies in terms of vaccination coverage rate for all basic vaccinations (coverage being respectively 74% and 73%). Children who are birth order six and higher are less likely to receive all vaccinations. Children living in rural areas, children living in the lowest and fourth wealth quintiles are more likely to be disadvantaged with regard to receiving all basic vaccinations though wealth does not seem to be an indicator of equity in immunisation. The DHS also indicates that 7.5% of all rural children in the survey (631) had no vaccinations at all in contrast with 4.7% (137) in urban settings. The education of the mother also results in lack of immunisation in children (13.1% of children of mothers with no education were not immunised against 2.3% of children from mothers with more than secondary education).

Issues of access to services related inequity is reflected in indicators such as the number of outpatient visits, which remains static and low (1.5 visits per person per year), and the occurrence of large-scale outbreaks; measles in 2014, and rubella in 2012. Combined these, signal that coverage and access to services is falling short of national and universal health coverage targets⁸. Coverage of and access to immunization services are further compounded by the challenging geographical topography, poor road and transport infrastructure, and the below mentioned vaccine supply chain and health workforce issues. Fiscal constraints are also important consideration; the dip in coverage during 2014 and reflects the funding temporary hiatus in funding in 2013 while a major fraud was investigated. This has since been rectified with additional fiscal and financial management support to implement SIG systems and to ensure compliance with the Public Financial Management Directive and with SIG financial regulations with DFAT support.

Bottleneck 2: Inadequate Vaccines Supply & Cold Chain Equipment and Quality & Safety Issues

The NHSP 2016-2020 identified that resources, particularly pharmaceuticals and supplies, were not flowing to the periphery of the health system, and impacted on the Solomon Islands health system’s ability to delivery services. Furthermore, the recent 2017 EVM assessment (Attachment #12) found that consistently maintenance (E5) and IMS, supportive functions (E9), scored the lowest of the 9 criteria. E4 building, equipment and transport and E8 vaccine management reached the acceptable 78% and 80% performance respectively. In addition, health facility scores were also low on storage capacity E3 (not available or fully



operating CCE), hence the accompanying CCEOP application to equip health facilities with CCE and stock management E6 (see EVM 2017 criteria scores figure). The cold chain management system has improved from the previous 2012 EVM assessment in which three criteria E1 Vaccine arrival process, E3 storage capacity and E4 building, equipment and transport all attained a 71% performance rating. In fact, E8 Vaccine management practices criteria has substantially improved from a mean score of 36% in 2012 to 80% in 2017. Storage capacity (E4) dropped nationally form 71% to 63%. The E) supporting functions criteria has consistently being low performing. In 2012 it received a mean score of 21% whilst it has improved somewhat to 47% in the 2017 EVM.

Storage capacity (E4) dropped nationally form 71% to 63%. The E) supporting functions criteria has consistently being low performing. In 2012 it received a mean score of 21% whilst it has improved somewhat to 47% in the 2017 EVM.

According to the 2017 EVM, there are 366 facilities in the country which could provide immunization services. 140 facilities (38%) do not have any active cold chain equipment. The highest number of facilities without any cold chain equipment is Central Region (54%). In terms of number of facilities without any active cold chain equipment is Malaita with 35 facilities (41% of total facilities). The Role Delineation Policy is likely to impact on the number of health facilities that require CCE as it is planned to increase access to services where these

⁸ NHSP 2016-2020, Government of Solomon Islands.

currently are absent based on a number of criteria including coverage level and distance to facilities.

Stock outs in health facilities have been reported in various assessments and confirmed during supervision visits. Effective distribution is made more challenging due to the difficult geographical context; limited road access and many islands in which transport by sea and foot are the only options. Limited road access makes difficult mountainous areas hard to reach such as in Guadalcanal Province, and in other places, refrigerators for example need to be carried by sea and by foot through mountains. In mountain deliveries, it can take 2 to 3 days, with requiring many volunteers. Other recurrent challenges in cold chain management include monitoring, maintenance and repairs.

Bottleneck 3: Data Availability- Health Information and Surveillance

Health information is an essential support structure to enhance micro-planning, implementation and coverage. The Solomon Islands has made substantial progress in the rollout of the DHIS2 and the immunization data has recently been added to the system. Within the health system, even though reporting rates are high, the quality of the data is poor. There is limited analysis and information not used for strategically. Problems such as timeliness, quality, completeness, reliability, and validity of the data need to be addressed. In low performing areas, completeness and quality of the data and its use for management and planning remains poor.

The surveillance system whilst established needs to be further rolled-out for vaccine-preventable diseases and expansion in high-risk zones. As of November 2015, ten cases of Acute Flaccid Paralysis have already been detected reflecting the integrity and value of the surveillance system. Further investment is critical for improving timely data availability.

Additionally, whilst there is a high level of penetration of mobile phone across the Solomon Islands, there is only 6% access the internet⁹. The well-established National Health HF Radio Network remains an important communication network, especially during natural disasters and emergencies.

Bottleneck 4: Health Workforce

The Solomon Islands is classified one the 57 countries deemed to have a critical shortage of health workers, and has limited implementation capacity of EPI and all other public health programmes. Solomon Islands has a smaller physician to population ratio (1:321) compared to Fiji, Samoa and Tonga. There were about 1.5 nurses/nurse aids per 1000 population, which is lower than in Fiji and Vanuatu. Many health facilities are closed because there is no staff. Although most of government health expenditure is allocated for the health workforce (70%), it is challenging to recruit staff especially for remote areas with poor road access. The challenge is both supply-side (limited production of health workforce) and demand-side e.g. difficulty to increase posts for health workforce. There is no institutionalized pool of Volunteer Health Workers.

At provincial level, human resource constraints and low capacity acts as significant bottleneck. Health workers have multiple responsibilities e.g. provincial child health coordinators or EPI program officers are also clinicians, having to manage time between public health management and patient care obligations. Clinical work is prioritized and results in reduced time for essential public health functions. Given the Solomon Islands vulnerability to natural disasters health workers also need to respond to emergencies, impacting on routine service delivery, including immunization.

Low program planning surveillance, data collection and analysis skills capacity impact upon the performance of the health system and immunization service delivery. A knowledge gap exists in routine EPI among health workers according to the cMYP 2016-2020.

At central level restructuring has improved Central staffing capacities. However, there are still problems in terms of financial management and the ability to utilize available resources and funding, and delays in funds reaching implementers.

Bottleneck 5: Insufficient Communication and Community Engagement – Equity, Gender and Access by population sub-groups.

⁹ Jessica Noske-Turner , Jo Tacchi , Evangelia Papoutsaki. 2014. Locating disaster communication in changing communicative ecologies across the Pacific. Australian Journal of Telecommunications and the Digital Economy, Vol 2, No 4, Article 66. <http://doi.org/10.7790/ajtde.v2n4.66>

Gender relations in Solomon Islands are heavily male-dominated, and this perpetuates discrimination against women and girls. Inequalities in control of decision making, economic resources, and access to health care, education, and leisure time restrict the rights and freedoms of girls and women, resulting in unequal benefits for them from the development process.

The SIDHS 2015 found that vaccination rates were similar for boys and girls, 73% and 74% respectively. There is also an insignificant variation in breastfeeding and provision of oral rehydration therapy (for diarrhea) in boys and girls. This is a marked departure from the findings of the previous SIDHS 2007 where discrepancies were marked (vaccination rates for boys 90% than girls 75%). The level of literacy is higher among men (15 to 49) with 90% of men and 82% of women literate.

The SIDHS15 showed that 66% of married women participate on decisions regarding their own healthcare, making household purchases and visiting relatives. This is a positive change from 57% in the SIDHS07. There has also been a slight increase on women taking own health care decisions from 28% in the SIDHS07 to 29.3% in 2015. Husbands making health care decisions on their behalf has also dropped from 17% in the 2007 DHS to 12.1% in the SIDHS15. This lack of decision-making power coupled with lack of access to economic resources further reduces women's ability to maintain their own health or ensure their children's access to health services though this is also linked to education levels.

Immunisation coverage for children increases with mothers who have a secondary level education, with coverage at 79% compared with 70% for children whose mother had only a primary school education (SIDHS15). In the Solomon Islands, it has been found that mother's education and wealth shows a greater impact on children's health outcomes, particularly for skilled care, suggesting the importance of women's education in improving the health status of women and their children. Importantly, women's education (more than secondary education 97%) and wealth (highest quintile, 96%) were closely associated with the type of care women chose. The higher the level of women's education, the more likely they were to give birth with skilled attendance or in health facilities

The activities in objective 4, including the activities related to the National EPI Communication Strategy, will support addressing both communication and community engagement bottlenecks as per below:

Communication bottlenecks

Gender is also an important factor in the effectiveness of mass media communications campaigns aimed to increase demand generation and health seeking behaviour. The SIDHS07 found that the proportion of the population that has access to all three media types (i.e. radio, newspaper and television) at least once a week is generally lower for women (4.4%) than men (9%). About 74% of women and 60% of men (SIDHS15) have no exposure to any media. This is further compounded by low levels of functional literacy. It not only inhibits individuals from finding employment, but makes it difficult for women and men to take advantage of written health and education promotion campaigns or support their children's studies. Lack of literacy can also isolate women, prevent them from seeking services in case of domestic violence, and restrict their participation in community decision making.

Community engagement bottlenecks

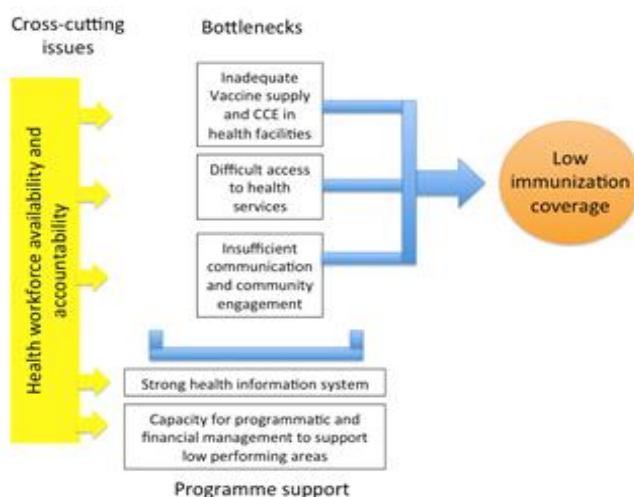
The limited number of health workers and the difficult geography in rural Solomon Islands, mean that opportunities for community engagement has not been maximized. Lack of outreach services, reduces opportunities for health care workers to be more engaged at the community level. The Churches are active in providing basic health services in some Areas and communities and they have their own volunteer workers who assist in health, particularly community mobilization and education. However they are not institutionalized into the health system and their roles are not standardized. There are no clear models yet but their role to support immunization may further be explored. There are only a small number of NGOs.

Pooled fund applicants are required to provide a reference to the relevant section and pages in the NHSP which outline how lessons learned from the previous NHSP have been incorporated into the current NHSP plan. If available, attach documentation on lessons learned implementation of the pooled funding mechanism, including relevant sections from joint annual reviews (JAR), mid-term evaluations etc.

11. Health system bottlenecks to be targeted through Gavi HSS support (Maximum 2 pages)

Identify which of the bottlenecks identified in Question 10 above will be targeted through Gavi HSS support.

Diagram 2: Immunisation Bottlenecks



The bottleneck analysis demonstrated a wide range of issues that affect the performance of the Solomon Islands health system performance for improved immunisation outcomes. The big issues such as overall health workforce constraints transport and infrastructure investments, and improving the education completion rates for women are beyond the scope of this proposal.

However, this HSS proposal can contribute to the improvement of several constraints and elements as identified in Diagram 3. The proposal focuses on four broad areas namely: 1) low service coverage and insufficient capacity for programmatic and financial management to ensure both operational and financial sustainability post 2021; 2)

inadequate supply of vaccines and CCE in health facilities; 3) need for complete, timely and quality health information and surveillance of VPDs; and 4) insufficient communication and community engagement. Equity and gender are integrated in several areas and activities in the proposal including planning, capacity building, awareness raising, information disaggregation and community engagement.

Bottleneck 1 & 4: Low Service Coverage and insufficient capacity for programmatic and financial management

The current grant is implemented in three provinces; Malaita, Western Province and Guadalcanal Province. The NHSP 2016-2020 has also identified 4 priority provinces with low levels of service provision across several programmes: Malaita, Central, Makira and Choiseul. In addition to these four, Temotu Province has the second highest infant mortality rate over the last three years, the second highest CU5 mortality rate in 2015, and the second lowest rate of children vaccinated against measles in 2014 (66%). Renbel province will also be included given their low measles coverage rate (40.6%) and their geographical distance. Honiara City Council (HCC) and Isabel provinces were both excluded from the proposal given their high coverage, well performing and with current government funding and operating sustainability.

The cMYP 2016-2020 identifies that the provision of immunization services at fixed-sites only once a week, and the ad-hoc and inadequate outreach activities as important contributing factors to the falling immunization coverage rates. Together, they represent important missed opportunities to reach the quarter of the population that have the lowest access to health facilities. Outreach services have not been implemented to scale previously and immunization has yet to be fully integrated into RMNCH activities (although this is planned in the draft RMCH Strategy 2016-2020).

This HSS proposal, builds on the current HSS grant will target the gap in outreach and static services the 25% of the population with limited access to health services, and addresses the fiscal constraints to increasing outreach services in these Provinces.

The inclusion of Choiseul, Central and Makira Provinces in addition to Malaita under the current HSS grant ensures that the Gavi HSS proposal will be fully aligned to and supporting the priority provinces identified in the NHSP 2016-2020. Additionally the inclusion of Temotu and Renbel Province, demonstrates that the National EPI programme has considered the latest information from the Strategic Health Core Indicator Report (2015).

Health workforce shortages are a cross-cutting issue that impacts upon the ability to improve access. While the

proposal cannot solve the availability of health workforce, it can strengthen the capacity and motivation of existing staff for effective management and delivery of immunization services especially in low-performance areas through supportive supervision. This HSS proposal will partially target the bottleneck related to low capacity of health care workers in terms of microplanning through training and capacity building. The Reaching Every District (RED) Strategy will be a core part of this capacity development work. This HSS proposal will target programmatic and financial management bottlenecks through capacity development initiatives aimed at addressing the skills gaps in using data, performing data analysis, and financial management to inform EPI program prioritization and planning and ensuring adequate and timely flow and implementation of funds and improve the longer term sustainability of the programme.

Bottleneck 2: Inadequate Vaccine Supply and CCE in Health Facilities

The HSS proposal will target the gaps in vaccine supply and cold chain management including the insufficient implementation of standard operating procedures and protocols for CCE and maintenance that should be standardised across all provinces and zones. The proposal will also target the financial bottlenecks at Provincial level for the distribution of equipment and supplies, installation of equipment and monitoring the management of CCE in health facilities.

Cold Chain integrity is not only hindered by the availability of functional CCE, but also issues related to hygiene and sanitation, poor infection control and poor disposal of health care waste.² Health facility reviews have identified that health care waste management is not conducted according to guidelines. This is in part, according to NMS officials, because there are no incinerators correctly dispose of health care waste (e.g. syringes and needles) in health facilities. The HSS proposal will also target this bottleneck related to CCE integrity.

Bottleneck 3: Data Availability- Health Information and Surveillance

A health programme can only be effective when there is sufficient, timely and quality information that is used for action. This proposal will target specifically HSS bottlenecks that contribute to poor program planning and the ability of the EPI programme at all levels to make informed decisions on coverage improvement strategies and approaches. Particularly addressing the current information gaps related to population denominators, inequities of EPI coverage, rates of dropouts and reasons for non-uptake of immunization services through inclusion of nationwide coverage survey in 2020 and ongoing DQAs.

A data quality assessment (DQA) was conducted on 10-18 August 2017 at central level and in three selected provinces, to identify key issues that could affect the quality of data, mainly with regards to the monitoring of immunization coverage. In fact, discrepancy between routine reporting and 2 consecutive DHS results raise concerns on the representativeness of data.

Main findings from DQA are that Solomon Islands has good foundation for data collection, transmittal and use, through DHIS2 system and standards tools. However, DHIS2 use is hampered by poor internet access, and unclear SOPs for recording of immunization data and for data quality checks, leading to data inconsistencies throughout the system. Use of data from birth notification system and vaccines stock management system is missing, therefore does not contribute to improvement of estimation of target population for immunization and triangulation of data to improve their accuracy.

Based on DQA recommendation a data improvement plan should be developed, including activities aiming to: i) develop comprehensive SOPs for recording, reporting and quality enhancement of immunization data; ii) strengthen capacity of health facility and provincial level staff particularly on use of data, improve supervision and feedback mechanism; iii) support strengthening of DHIS2 system for reporting of and access to data; and iv) enhance availability and quality of data on births and vaccine management, and their use.

This proposal will also focus on continuing to develop and strengthen an effective and timely surveillance system, addressing specific bottlenecks of low-capacity to undertaken surveillance of VPD by province and zone supervisors, and addressing gaps at community-level for early warning monitoring. The timeliness of surveillance data will also include addressing the gap between hospitals and syndromic systems for sentinel sites. Improved data quality data will address the gaps related to vaccine supplies and reduce stock outs.

Bottleneck 5: Insufficient Communication and Community Engagement - Equity, Gender and Access by

population sub-groups.

Addressing insufficient communication and community engagement is a big challenge, given the low rates of access to health information and mass media communication channels in rural and remote areas, as well as the low functional literacy rates. Ensuring that strategies are appropriate for the literacy levels and available communication pathways will be essential.

Consultations with partners showed that knowledge of general population on immunization is still poor. This is mainly due to the lack of or insufficient information campaigns especially in low performing areas. Consultations have shown that civil society including churches, NGOs and the Red Cross can be successful at the community level to enhance communication and information and generate demand for immunization. Such partnerships must be strengthened in low-performing communities. Provincial and zone managers must have stronger capacity to facilitate, guide and monitor these partnerships. Churches and some NGOs also have volunteer community health workers who can disseminate information and identify families and children. Where there are existing facilities, routine immunization should be strengthened. This HSS proposal will target the gaps related to governance and utilisation of partnerships for community engagement and demand generation. The bottleneck related to health seeking behaviours related to RMCH, including immunisation it will be addressed at national, provincial and community level.

There are information gaps on health-seeking behaviour, however, the recent KAP (knowledge, attitudes and practices survey July 2016¹⁰) assessed demand-side issues to health care seeking and factors that affect health care demand. By far, information on immunisation was provided by nurses and health workers (79%), following by messages through the radio (46%) and from family and friends (38%). Community and church leaders (14%) were also found to encourage and support parents to get their children immunised as there were trusted sources of information. As there is high mobile phone coverage and use, all respondents agreed that text messages reminding them when child vaccinations were due would be helpful (95%) given that 59% of the respondents mentioned it took them over an hour to reach the health clinic. Sixty six per cent had radio reception. However 58% mentioned they often forget the age and date they should take children for immunisation. Given that 96% of respondents suggested they would be willing to give their child any vaccines endorsed by the Ministry of Health, 42% said that they felt worried about giving their child a vaccine, the HSS2 proposal supports the implementation of the National EPI Communication Strategy assisting the National EPI program in overcoming communication bottlenecks.

Pooled fund applicants are not required to complete this question.

12. Objectives of the NHSP and application (Maximum 2 pages)

*Present specific objectives to address the identified bottlenecks, explaining how each aligns with objectives in the cMYP and/ or specific health system strengthening policies/ strategies being implemented. These objectives have to be listed in the same order in **Attachment #6 - Detailed workplan, budget and gap analysis**.*

Objectives	Description
Objective 1: Increase immunization coverage rates through sustainable service delivery and programme management By the end of 2021, all	Objective 1 aims to increase immunization coverage through strengthening of existing planning, operational and service delivery mechanisms. It covers activities to ensure that health workers in low performing zones and provinces have the skills to effectively use information, plan, implement, monitor and sustain activities. Immunization activities including outreach must be not only well integrated in annual operational plans and micro-plans, but also better integrated into RMNCH services. Supportive supervision and capacity building through on-the-job training will be done to ensure effective implementation, identify and respond to challenges, and motivate staff to enhance accountability and ensure allocation of adequate financial /human resources.

¹⁰ Improving routine immunisation in Malaita, Solomon Islands. Audience Research Report July 2016.

<p>zones will attain and sustain DTP3/Penta3 coverage greater than 90% through effective national provincial management systems (Reaching Every Child) strategy, on-the-job training, Annual Operational Planning, health facility micro-planning, outreach and supportive supervision) with a focus on low coverage zones.</p>	<p>Linkages to <u>NHSP 2016-2020 (Key Result Areas (KRAs) and Outcomes)</u>:</p> <p>KRA 1: Improve Service Coverage <i>Outcome 1: Improved child survival particularly for disadvantaged, remote, hard to reach.</i> 1.1 Reduce under 5 mortality to 15 per 1000 by 2020 1.2 Immunisation coverage 90% for all children under 2 by 2020 1.4 All health facilities open</p> <p>KRA 2: Build Strong Partnerships <i>Outcome 9: Strengthen Partnerships</i> 9.1 Improved partnership coordination 9.2 Increase multi-sector engagement</p> <p>KRA 3: Improve Service Quality <i>Outcome 11: Achieve Universal Health Coverage</i> 11.1 Role delineation policy implemented</p> <p>KRA 4: Lay the Foundations for the Future <i>Outcome 13: Strengthened Health Systems</i> 13.1 Provincial and Corporate Plans developed (includes EPI) 13.5 HRH workforce and training 13.7 Provincial budgeted fully expended in according to Annual Operational Plans</p> <p>Linkages to the <u>cMYP 2016-2020 (p28-34)</u> <u>Objective 1</u>: Improve Penta 3 and other vaccines coverage >90% in all zones by 2020 <u>Objective 4</u>: Continuously build health worker immunisation capacity annually and orient new health workers on EPI. <u>Objective 5</u>: Ensure at least quarterly supervisory visits by national and provincial <u>Objective 7</u>: Strengthen planning and coordination of immunisation program at national and provincial levels.</p>
<p>Objective 2: Improving vaccine supply and cold chain planning, capacity, infrastructure and management system By the end of 2021, Essential Vaccines Management (EVM) indicators will show significant improvement through vaccine and cold chain management trainings, procurement, installation, maintenance and replacement of CCE and minimum stock-outs especially in low coverage zones.</p>	<p>Objective 2 aims to ensure the availability of vaccines and an effective cold chain management. It covers activities to enhance CC inventory, strengthen cold chain staff capacity and ensure regular maintenance. Ensuring functional cold chain system requires the repair, replacement and installation of CCE. These activities will be implemented in line with the 2017 EVM recommendations The country is also submitting an application to the Cold Chain Equipment Optimization Platform (CCEOP). CCE gaps and projections have been documented in the CCEOP application. The HSS2 grant contributes 50% (US\$ 700, 000) of funding to the CCEOP.</p> <p>Linkages to <u>NHSP 2016-2020 (Key Result Areas (KRAs) and Outcomes)</u>:</p> <p>KRA 3: Improve Service Quality <i>Outcome 11: Achieve Universal Health Coverage</i> 11.1 Role delineation policy implemented</p> <p>KRA 4: Lay the Foundations for the Future <i>Outcome 13: Strengthened Health Systems</i> 13.1 Implement information system to manage stock from secondary level medical store to health facilities.</p> <p>Linkages to the <u>cMYP 2016-2020</u>: <u>Objective 10</u>: Maintain uninterrupted vaccines and supplies at national and provincial levels. <u>Objective 11</u>: Increase cold chain capacity to sufficient levels. <u>Objective 12</u>: Update Vaccine waste management policy and disseminate.</p>
<p>Objective 3: Ensuring good quality and timely routine information and</p>	<p>Objective 3 aims to ensure that the information system for the programme is strong and provincial and zone staff are using the information for analysis and decision-making. Improved data use to inform micro-plans and programme reviews to ensure equity especially among populations with difficult access to health care. It covers data monitoring, DQA and</p>

<p>regular surveillance systems</p> <p>By the end of 2021, the immunization programme will have good quality and timely routine information and regular surveillance, adequately disaggregated, and regularly used for national and local planning for action.</p>	<p>supportive supervisory visits for provincial coordinators and zone supervisors and ensuring that sufficient IT and communication technology is available. The activities also build on the VPD surveillance system that has been started in the HSS1 grant and the DHIS2 investments. A nationwide EPI Coverage Survey planned for Q2 2020 is budgeted. End-of project evaluation is also included in 2021.</p> <p>Linkages to NHSP 2016-2020 (Key Result Areas (KRAs) and Outcomes):</p> <p>KRA 1: Improve Service Coverage</p> <p><i>Outcome 1: Improved child survival particularly for disadvantages, remote and hard to reach.</i></p> <p>1.5 All health facilities births and deaths are notified.</p> <p>KRA 4: Lay the Foundations for the Future</p> <p><i>Outcome 13: Strengthened Health Systems</i></p> <p>13.2 Health Information Systems DHIS2 monthly reporting at 90% for each facility.</p> <p><i>Outcome 15: Solomon Islands health is prepared for disasters, outbreaks and emerging population health issues.</i></p> <p>15.1 Improve preparedness and responsiveness for emergency, disasters and outbreaks</p> <p>Linkages to the cMYP 2016-2020:</p> <p><u>Objective 13</u>: Strengthen and expand VPD surveillance system. <u>Objective 14</u>: Improve data quality and use of data for action. <u>Objective 15</u>: Strengthening AEFI monitoring system</p>
<p>Objective 4: Strengthening demand generation and community engagement through partnerships for communication and health promotion</p> <p>By the end of 2021, parents and care-givers in targeted provinces will seek out immunization at their nearest clinic so that 90% of children can be fully immunized on time.</p>	<p>Objective 4 aims to enhance immunization coverage and community demand by strengthening partnerships for communication and health promotion. The National EPI Communication Strategy developed in 2017 aims to increase demand and uptake of immunization services by parents and care-givers through use of strategic communication so that at least 90% of children are brought to nearest points of service delivery in order to receive routine vaccines. Target Provinces are as per the National EPI Communication Strategy – Western, Malaita and Guadalcanal Provinces. Partnerships for social mobilisation activities will be managed by UNICEF through grants to Civil Society Organisations (e.g. Solomon Islands Red Cross, Solomon Islands Christian Association, Solomon Islands Full Gospel Association, World Vision). The 8 overall priority provinces will also receive funding for health promotion/demand generation and national immunisation week activities.</p> <p>Linkages to NHSP 2016-2020 (Key Result Areas (KRAs) and Outcomes):</p> <p>KRA 2: Build Strong Partnerships</p> <p><i>Outcome 9: Strengthen Partnerships</i></p> <p>9.1 Improved partnership coordination</p> <p>9.2 Increase multi-sector engagement</p> <p><i>Outcome 10: Strengthen Healthy Families and Villages</i></p> <p>10.1 Health village policy reviewed and implemented in each village</p> <p>KRA 3: Improve Service Quality</p> <p><i>Outcome 12: Establish a culture of quality improvement</i></p> <p>12.2 Establish patient feedback mechanism at each hospital and health centre.</p> <p>KRA 4: Lay the Foundations for the Future</p> <p><i>Outcome 16: Strengthen and maintain health research</i></p> <p>16.2 Hold annual health research symposium</p> <p>Linkages to the cMYP 2016-2020:</p> <p>Objective 1: Improve Penta3 and other vaccines coverage >90% in all zones by 2020</p> <p>Objective 16: Increase demand and community ownership of immunisation services</p>

13. Description of activities (Maximum 3 pages)

Describe the key activities which will lead to achievement of objectives set out in Question 12. Please ensure that the activities described align with the activities that are included in **Attachment #6 - Detailed budget, gap analysis and work plan.**

Objective / Activity	Explanation of link to improving immunisation outcomes
<p>Objective 1: Increase immunization coverage rates through sustainable service delivery and programme management</p>	
<p>Activity 1.1: Ensuring high immunization coverage in low performing areas by strengthening outreach activities</p> <p>1.1.a Ensuring high coverage through support for outreach activities</p> <p>Advancing rural outreach teams into villages supported by appropriate logistics has been identified a crucial activity for rural health facilities in decentralised systems in the Pacific to close the gaps in child health¹¹. Outreach is particularly important in the Solomon Island context where there is no institutionalised pool of Volunteer Health Workers, as identified under bottleneck 4 health workforce. Whilst no specific equity study for immunisation has been conducted, the 2015 DHS provides the most up-to-date data on equity in the Solomons Islands currently, and will be used in combination with routine reporting to support this activity.</p> <p>1.1.b Conduct on-the-job training (OJT) for immunizers in low performing zones.</p>	<p>This activity will contribute to addressing the Low Service Coverage Bottleneck. In order to reach the 25% of the population with limited access to health services, provinces will be allocated budgets to support the logistics required for quarterly outreach activities.</p> <p>Outreach visits are planned through the Provincial micro-planning process and included in the Annual Operational Plans of each Province. In 2021, outreach funding will be phased out, and only allocated for use in Q1 and Q2 with Provinces taking on responsibility for Q3, and Q4 funding from their operational budgets. Outreach is conducted monthly, and the costs provide through the Gavi HSS is additional to the Provincial Operations Budget.</p> <p>Training across the 8 priority Provinces (low performing zones that conduct outreach to improve the quality and effectiveness of services in remote health facilities.</p> <p>Since the Solomon Islands have entered an accelerated transition stage, to sustainably manage the transition, the budget has been tapered in 2020 and 2021. At the end of the grant period the country would have absorbed 70% of the recurrent costs and the human resources partly funded by this grant, increasing government budget allocation to immunisation thus improving overall system sustainability.</p>
<p>Activity 1.2: Enhancing accountability through supportive supervision systems at provincial and zonal levels</p> <p>1.2a Conduct supportive supervision to improve EPI program performance with emphasis on hard to reach areas and low performing zones (National).</p> <p>1.2b Conduct supportive supervision to improve EPI program performance with emphasis on hard to reach areas and low performing zone (Provincial)</p>	<p>This activity will contribute to address Bottleneck 4 health workforce - insufficient capacity for programmatic and financial management. The 2015 JA emphasized the importance of supportive supervision from the National level to the Provincial level, building work undertaken in HSS1 Integrated visits with EPI, Child Health, and RMNCAH and Community or Environmental Health will be encouraged and planned where possible. Quarterly supportive supervision from the Provincial to Zone or health facility in hard to reach areas. Contributes to improved DHIS2 reporting.</p>
<p>Activity 1.3: Improving service delivery through EPI micro-planning with a focus on hard to reach provinces and low-performing zones</p> <p>1.3a Conduct annual micro-planning exercises at the provincial and zonal levels (Roll out of REC strategy). A total of 18 micro-planning activities are planned.</p>	<p>This activity will support bottleneck 1 low service coverage through improving and building on the micro-planning achievements in the current HSS grant and as noted in the 2015 JA. Planned in Q1/Q2 of every year as a lead in activity to the annual operational planning in July/August. Micro-planning will be based on updated information from zones to highlight service coverage issues in relation to gender and socio-economic status. Intensive focus will leave behind</p>

¹¹ Duke et al, 2015. Closing the gaps in child health in the Pacific: An achievable goal in the next 20 years. Journal of Paediatrics and Child Health, 51, pp.54-60

<p>Activity 1.4: Strengthening planning and management capacity at national and provincial levels</p> <p>1.4a Conduct biennial National EPI Programme Performance Review</p> <p>1.4b On the job training to build capacity for updates, implementation, supervision and monitoring in low performing provinces and zones. (Linked 1.4g, 2.2a & 3.2a).</p> <p>1.4c & 1.4.d Support staff for the EPI unit in the areas of finance and monitoring/ supportive supervision.</p> <p>1.4e Annual audit by external firm</p> <p>1.4f Technical assistance to guide transition to HSSP fund mechanism and ensure that funds are transferred from HSSP account to the programme and provinces for implementation.</p> <p>1.4.g –WHO TA for RDP and sustainable resilient systems for health.</p>	<p>adequate capacity for continued microplanning beyond 2021.</p> <p>This activity will contribute to <i>Bottleneck 1 & 4: Low Service Coverage and insufficient capacity for programmatic and financial management.</i></p> <p>This activity is planned for Q2 2020 building on the successful national level EPI programme reviews and bringing together the Provincial Child Health, CC and Health Promotion Officers with inclusion of non-government providers including World Vision, the Churches, and development partners.</p> <p>Training is provided to the Provincial Child Health, Cold Chain and Health Promotion Officers. On the job training will target the use of data for planning, monitoring and supervision, and DHIS2.</p> <p>Staffing budget is requested for the following: 1 x Finance Officer, 1 x Hospital based active surveillance Officer, 1 x Monitoring and Supportive Supervision Officer.</p> <p>Included in the transition plan budget for WHO TA: a position focusing on support to the National EPI programme to implement actions under the transition plan, such as supporting budget allocation increase (policy briefing packages, collaborating with WB on costing packages, cost-benefit analysis, strengthening AOP planning at provincial levels, looking a RDP and prioritisation of service delivery based on RDP etc.</p>
<p>Objective 2: Improving vaccine supply and cold chain planning, capacity, infrastructure and management system</p>	
<p>Activity 2.1: Strengthening assessment, planning, policy and financing system for vaccines distribution and CCE management</p> <p>2.1a Conduct annual cold chain inventory update linked with HF and RDPs.</p> <p>2.1b Review of guidelines for procurement and development of SOPs at provincial levels and health facilities for CCE, including dissemination of immunization and CCE handbook (TA); including guidelines and protocols for data management.</p> <p>2.1.c Staff – National EPI Logistics and Cold Chain Officer and Cold Chain Technical Officer (TA).</p> <p>2.1.d Vaccine wastage assessment and temperature mapping study (to the last mile).</p>	<p>This activity will support <i>the Inadequate Vaccine Supply and CCE in Health Facilities bottleneck</i> through strengthening provincial capacity for vaccine distribution and CCE management.</p> <p>Support the annual cold chain inventory by National EPI Logistics and CC Officer coordinating with the Province. These activities will target the development of standardised policies and SOPs and protocols for CCE, mapping and monitoring aligned to the 2016 National CC Policy.</p> <p>The logistics/cold chain technical officer (TA) for the EPI unit will support the implementation of the EVM recommendations and support the overall logistics management of the EPI programme. This position has been identified in the National EPI Unit structure and will be absorbed into the government. Funding is requested until the end of 2019 for this position. This will include working with the National Medicine Stores (NMS) to use the logistics management information system mSupply to its full capacity (mSupply is used down to the second level medical stores). Currently it is being used for stock on hand data, but the officer will work with the NMS to define the parameters and to design the report for the EPI programme. The NMS will also discuss with the software designer whether it is possible to include VVM status for vaccines in mSupply.</p> <p>There is a project (funded by GF/DFAT) in place to expand mSupply to the AHCs for some stock management and collect certain data through the mSupply mobile application.</p>

	Discussions are ongoing with DHIS2 and Sustainable Solutions for integration of mSupply/DHIS for certain functions. To ensure a strong CC system support in place for the EPI at time of transition, additional activities such as the vaccine wastage assessment (undertaken by UNICEF) is budgeted in the SI transition plan. The HHS2 includes a UNICEF TA coordination role for CCE and EVM implementation support.
<p>Activity 2.2: Enhancing capacity of provinces and zones for vaccine supply chain and CCE management</p> <p>2.2a Roll out of capacity building for vaccine supply, stock management and CCE management in low performing provinces and zones.</p> <p>2.2b Support for national and provincial staff to conduct monitoring and supervision of CCE management and vaccine supplies.</p>	<p>This activity will support the <i>Inadequate Vaccine Supply and CCE in Health Facilities bottleneck</i> by building on Activity 2.1.</p> <p>Training provincial staff, cold chain officers and zone supervisors in the guidelines and SOPs for vaccine delivery and cold chain management. On-going supportive supervision must be conducted to enhance workforce capacity and accountability in their respective zones and health facilities.</p>
<p>Activity 2.3: Strengthening cold chain infrastructure in high risk and low coverage areas</p> <p>2.3a Implementation of EVM recommendations.</p> <p>2.3b Ensuring integrity of cold chain through procurement of backup generators at province stores.</p> <p>2.3c Provision of high-temperature incinerator in provinces to improve health care waste management.</p> <p>2.3d Replacement, repair, distribution and installation and of broken down CCEs (freezers and refrigerators) in low performance areas.</p> <p>2.3.e Maintenance of CCE.</p> <p>2.3f Strengthen cold chain and service delivery through procurement of boats and out-board motors.</p>	<p>This activity will support the <i>Inadequate Vaccine Supply and CCE in Health Facilities bottleneck</i> by addressing several gaps identified through the recent cold chain inventory exercise.</p> <p>Procurement and installation of 7 generators on Q2 2019 for second line medical stores in 7 of the 8 priority provinces. N.B. Guadalcanal Province is supported by the KOICA project.</p> <p>Procurement and installation of a high temperature incinerator to ensure vaccine waste is returned to the supply point and disposed according to international waste disposal standards.</p> <p>US\$ 700,000 from the HSS2 budget is allocated to the CCEOP application with detailed breakdown of costs and activities.</p> <p>Procure 8 boats in Q2 2019 and outboard motors for the 8 priority provinces.</p>
Objective 3: Ensuring good quality and timely routine information and regular surveillance systems	
<p>Activity 3.1: Strengthening availability of data and information in low performance and high risk areas</p> <p>3.1a Strengthening collection, provincial level analysis, disaggregation (equity, gender, SES) and use of EPI data in low performance areas through DHIS2 support.</p> <p>3.1b Conduct nation-wide EPI coverage survey in 2020, with disaggregation on geography, SES and gender.</p> <p>3.1c Conduct of data quality assessment in low coverage zones (in terms of data completeness and data quality issues).</p>	<p>These activities focus on addressing the <i>data availability bottleneck</i> through activities that will support data collection, completion and timeliness.</p> <p>At national level, the EPI programme data from DHIS2 will be analysed by the EPI and the statistics unit, to identify not or under/over reporting facilities, zones and or provinces but also data quality issues (ex. negative drop-out, coverage >100%, inconsistency between vaccine doses administered at the same time.</p> <p>WHO to conduct a nation-wide EPI Coverage Survey. The survey is timed to capture the coverage of the new vaccine introduction for HPV and MR2 in 2018/2019 and to inform future planning for transition in December 2021.</p> <p>One DQA, will be conducted in Q3 in 2019 (not budgeted in the HSS as it will be paid internally) and a Q3/Q4 2020 in low coverage zones with WHO TA.</p>
<p>Activity 3.2: Strengthening capacity for data analysis, coordination and use among staff at provincial level and facilities as prescribed by the RDP</p> <p>3.2a Regular EPI data review and updates to support micro-planning at provincial level with participants from provinces, zones and health facilities.</p>	<p>Activities in 3.2 focuses on the capacity gaps of health workers in provinces, zones and health facilities to use and analyse data for planning and management, as identified under the <i>data availability bottleneck</i>.</p> <p>Support integrated biannual meetings between Provincial and Zonal staff to review program performance in line with AOPs</p>

3.2b Printing and distribution of monitoring tools	and micro-plans to improve performance and equity.
<p>Activity 3.3: Strengthening surveillance of vaccine-preventable diseases (VPDs) in hospitals and sentinel sites as directed in the RDP</p> <p>3.3a Training of Trainers for surveillance of vaccine-preventable diseases (national level).</p> <p>3.3b Training on surveillance with linkages between hospital and syndromic systems, for sentinel sites (province/ hospital level).</p> <p>3.3c Community level training for disease surveillance, rumour response, early warning.</p> <p>3.3d Supportive supervision for sentinel sites</p> <p>3.3e Support for expansion in number of sentinel sites</p>	<p>These activities contribute to addressing the data availability bottleneck and build on the success of the VPD surveillance system through hospitals and sentinel sites initiated under the current HSS grant.</p> <p>These activities will strengthen the current system by improving surveillance technical capacities, as well as further expanding the network from five sentinel sites to another five (as per cMYP) in the next three to five years (starting with Makira and Temotu provinces). It also contributes to addressing the community engagement bottleneck by supporting and delivering training for vulnerable communities in underserved areas to recognise potential outbreaks and support a community-led early warning system. WHO Technical Assistance will support the implementation of these activities and strengthening laboratory confirmation of cases (essential for VOSs targeted for elimination).</p>
<p>Activity 3.4: Development of improved communication systems in remote and high risk areas (procurement)</p> <p>3.4a & 3.4b Communication infrastructure: Computers and HF radios in low performance provinces and zones.</p>	<p>These activities contribute to addressing the data availability bottleneck, specifically it will support the procurement of essential ICT infrastructure that will strengthen and improve the timeliness of data and VPD surveillance.</p> <p>There exists a well-established National Health HF Radio Network throughout the country, which is a life-line during emergencies and outbreaks, but also for rural and remote facilities. It is critical to the referral pathway as well. Whilst mobile phone coverage is high (78% DHS, 2015) internet penetration remains very low (6% internet penetration). The NHRN is solar powered, so even in disasters the radio network still operates. Budget for the procurement and installation of 4 HF radios as well as 10 computers for each of the Provincial Child Health Officers. Provinces will finance internet costs, maintenance from their own operational funds.</p>
<p>Activity 3.5: Learning from GAVI HSS2 project implementation to improve EPI, vaccine supply and CCE management</p> <p>3.5a End of grant evaluation</p>	<p>End-of project evaluation will ensure that overall implementation and experiences are documented to strengthen the EPI programme and will used to inform programme planning post-Gavi transition.</p>
Objective 4: Optimizing demand-generation and community engagement through development of partnerships	
<p>Activity 4.1: Strengthening demand generation and community engagement through partnerships for communication and health promotion</p> <p>4.1a Implementation and rollout of the National EPI communication strategy (2017) by Provinces and Zone for advocacy and demand generation for immunisation activities in low performing zones, including immunisation week activities.</p> <p>4.1.b Development of standards, guidelines and monitoring tools to strengthen partnership mechanisms/ protocols between government providers and CSOs/churches to support activities in high risk/hard to access areas.</p>	<p>These activities will contribute to addressing some of the issues identified under Bottleneck 5 insufficient communication and community engagement and Bottleneck 1 low service coverage.</p> <p>To roll out and implement advocacy and demand generation activities. Develop messages to be delivered through SMS campaigns (78% of households have access to a mobile phone), interpersonal communication, and other health promotion activities facilitated by the Health Promotion Officers in the Provinces. Central to the implementation is improving messaging in a locally appropriate and a targeted way that addresses the equity issues related to the socio-economic and education levels of the care-givers (targeting families with caregivers with primary only education, and female caregivers in rural areas that are less literate (literacy rate: 79.8% rural women vs. 88.3% rural men, DHS, 2015)).</p>

<p>4.1.c Supporting community engagement through systems of coordination network/ system between government and civil society partners in low performing provinces and zones. <i>(This is considered a one-time opportunity to engage with CSOs in a more effective way. Post-Gavi, relationships and modus operandi will remain).</i></p>	<p>Communication materials will include low-literacy tools including simple counselling cards with illustrations, community theatre/drama, flip charts and Church announcements etc. in line with the Communication Strategy. Implementation of the communication strategy will support women and men, girls and boys to improve health seeking behaviour and support demand generation.</p> <p>A grant to NGOs and Churches (e.g. SI Red Cross, SI Christian Association, SI Full Gospel Association, World Vision) through UNICEF to utilise their volunteer out-reach workers, social mobilizers, Health Service Providers for demand generation activities and interpersonal communication for immunisation in low performing zones. Activities also include capacity building on interpersonal communication, social mobilisation, advocacy, media engagement, community engagement, equity and gender for health workers on matters relating to immunisation/RCH and community health. The budget starts in 2019, as 2018 activities are funded by UNICEF/KOICA projects.</p>
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14. Results chain *(Maximum 4 pages)*

Complete the **Results Chain** using the template provided below. For each objective defined in Question 12, provide information on: (i) activities (as noted in Question 13); (ii) intermediate results; (iii) immunisation outcomes; (iv) impact; and (v) assumptions for the achievement of results.

Once the Results Chain has been developed, the next step is to complete the **Performance Framework** (for all HSS applications i.e. including for applications for pooled fund support). This can be accessed through the Gavi country portal: www.gavi.org

Pooled fund applicants are not required to complete this template, but must provide a summary of how Gavi HSS funds will contribute to improve immunisation outcomes in the context of the NHSP

Results chain

Objective 1: Increase immunization coverage rates through sustainable service delivery and programme management

<p>Key Activities:</p> <p>Activity 1.1: Ensuring high immunization coverage in low performing areas by strengthening outreach activities</p> <p>Activity 1.2: Enhancing accountability through supportive supervision systems at provincial and zonal levels</p> <p>Activity 1.3: Improving service delivery through EPI micro-planning with a focus on hard to reach provinces and low-performing zones</p>	<p>Intermediate Results:</p> <ul style="list-style-type: none"> ▪ Immunization outreach conducted in low-performing provinces and zones (rate of planned to conducted outreach). ▪ Supportive supervision implemented especially in facilities in low-performing zones (rate of planned to conducted supportive supervision visits). ▪ Availability of micro-plans in health facilities that outline routine and outreach immunizations as well as supplementary activities. ▪ Two Gavi funded EPI staff positions absorbed into Government by end of 2019. 	<p>Immunisation Outcomes:</p> <p>% of surviving infants receiving 3 doses of DTP-containing vaccine nationwide</p> <p>% of surviving infants receiving first dose of measles containing vaccine nationwide</p> <p>% of districts with ≥90% DTP3 coverage</p> <p>Difference in DTP3 coverage between lowest and highest wealth quintile</p> <p>% point drop out between DTP1 and DTP3 coverage</p>
<p>Related Key Activities Indicators:</p> <p>PR-C 1.0 Percent utilisation of Gavi HSS budget</p> <ul style="list-style-type: none"> ▪ Number of EPI/MCH managers trained on supportive supervision ▪ Number & % of supportive supervision conducted in identified High risk areas ▪ Number of zones receiving at least one SS visit from provincial supervisors ▪ % of health facilities with micro plans ▪ Number of provincial teams having quarterly EPI reviews ▪ % increase of government budget allocated to the National EPI Programme. 	<p>Related Intermediate Results Indicators:</p> <p>IR-C 1.1.1. Number of surviving infants who received the first recommended dose of pentavalent vaccine (Penta1).</p> <p>IR-C 1.1.2 Number of surviving infants who received the third recommended dose of pentavalent vaccine (Penta3).</p> <p>IR-C 1.4.1 Number of surviving infants who received the first recommended dose of measles containing vaccine (MCV1)</p> <p>Percentage of facilities offering immunisation services as per the revised micro-plan guidelines.</p> <p>Number and percent of planned outreach immunisation activities conducted in identified high risk areas.</p> <p>Proportion of zones with micro-plans having delivered outreach vaccinations in disadvantaged areas at least four times per year.</p>	

Objective 2: Improving vaccine supply and cold chain planning, capacity, infrastructure and management system		
<p>Key Activities:</p> <p>2.1 Strengthening assessment, planning, information management, policy and financing system for vaccines distribution and CCE management</p> <p>2.2 Enhancing capacity of provinces and zones for vaccine supply chain and CCE management</p> <p>2.3 Strengthening cold chain infrastructure in high risk and low coverage areas</p>	<p>Intermediate Results:</p> <ul style="list-style-type: none"> ▪ Availability of costed cold chain replacement plan in provinces and at the national level. ▪ CCE in health facilities well maintained and functioning. ▪ Back-up generators, incinerators and radios procured. 	<p>Immunisation Outcomes:</p> <p>Percentage of facilities with CCE availability</p> <p>% of surviving infants receiving 3 doses of DTP-containing vaccine nationwide</p> <p>% of surviving infants receiving first dose of measles containing vaccine nationwide</p> <p>% of districts with ≥90% DTP3 coverage</p>
<p>Related Key Activities Indicators:# of EPI/CH staff trained on vaccine supply and CCE maintenance</p> <p>Number of EPI/ CH staff trained on surveillance</p> <p>Number of CCE procured and installed</p>	<p>Related Intermediate Results Indicators:</p> <p>IR-C 3.0 Effective Vaccine Management Score (composite score) improved across all levels and EVM criteria.</p> <p>Stock outs reported at the national and provincial levels.</p> <p>Number of days cold chain not functioning (based on DHIS2).</p>	<p>Difference in DTP3 coverage between lowest and highest wealth quintile</p> <p>% point drop out between DTP1 and DTP3 coverage</p>
Objective 3: Ensuring good quality and timely routine information and regular surveillance systems		
<p>Key Activities:</p> <p>3.1 Strengthening availability of data and information in low performance and high risk areas</p> <p>3.2 Strengthening capacity for data analysis, coordination and use among staff at provincial level and facilities as prescribed by the RDP</p> <p>3.3 Strengthening surveillance of VPDs in hospitals and sentinel sites as directed in the RDP</p>	<p>Intermediate Results:</p> <p>Available EPI data through DHIS2, disaggregated by location, in low performance and high risk areas.</p> <p>Annual updates at national- and provincial- levels synthesized and compiled.</p> <p>National EPI coverage survey completed.</p> <p>Data Audit in 2020 completed in low performing provinces/zones.</p>	<p>Immunisation Outcomes:</p> <p>% of surviving infants receiving 3 doses of DTP-containing vaccine nationwide</p> <p>% of surviving infants receiving first dose of measles containing vaccine nationwide</p> <p>% of districts with ≥90% DTP3 coverage</p>
<p>Related Key Activities Indicators:</p> <p>Number of DQA conducted</p> <p># of supportive supervision conducted by each level (National + Provinces + Districts)</p>	<p>Related Intermediate Results Indicators:</p> <p>IR-C 4.1 Percentage point difference between Penta3 national administrative coverage and survey point estimate.</p>	<p>Difference in DTP3 coverage between lowest and highest wealth quintile</p> <p>% point drop out between DTP1 and DTP3 coverage</p>

<p>Number of staff at NRH and provincial hospitals trained and conducted sentinel surveillance</p> <p># of data review conducted at province level</p> <p># of total sentinel sites established</p>	<p>Completeness of reporting after two months (DHIS2 indicator)</p> <p>Quarterly submission of provincial report from DHIS2</p> <p>Country has reached set AFP surveillance target. At 4 cases per year</p> <p>Absorption of 60% of HSS costs by end 2020</p> <p>Absorption of a further 10% of HSS costs by end of 2021</p>	
Objective 4: Optimizing demand-generation and community engagement through development of partnerships		
<p>Key Activities:</p> <p>4.1 Strengthening demand generation and community engagement through partnerships for communication and health promotion</p>	<p>Intermediate Results:</p> <ul style="list-style-type: none"> • Communication Strategy for EPI disseminated to provinces and zones • Advocacy activities conducted in priority provinces and zones • Immunization week with catch up activities conducted in provinces • Available guidelines/ protocols for partnerships between government and CSOs/ churches • Partnerships implemented at province and zone levels in low performing areas • Enhanced capacity of coordinators and health workers to engage with local partners • Grants managed by UNICEF enabled greater community involvement and improved immunisation coverage in hard to reach/low performing zones. 	<p>Immunisation Outcomes:</p> <p>% of surviving infants receiving 3 doses of DTP-containing vaccine nationwide</p> <p>% of surviving infants receiving first dose of measles containing vaccine nationwide</p> <p>% of districts with ≥90% DTP3 coverage</p> <p>Difference in DTP3 coverage between lowest and highest wealth quintile</p> <p>% point drop out between DTP1 and DTP3 coverage</p>
<p>Related Key Activities Indicators:</p> <p>PR-C 2.0 Total expenditure for the reporting period used by CSO partners.</p> <p># and or % of social mobilization activity per villages implemented</p> <p># and or % staff trained on communication and community engagement</p> <p># of provinces and zones that launched Immunization week with catch-up campaigns</p>	<p>Related Intermediate Results Indicators:</p> <ul style="list-style-type: none"> • Number and or Percentage of formal and semi-formal partnerships at province and zone levels. • Number of grants provided through UNICEF. • Number of children immunised during immunisation weeks and catch up campaigns. 	

IMPACT

Provide an impact statement and indicator(s):

Improved availability, access, quality of and demand for immunisation, Primary Health Care and maternal, newborn and child health services, within a functional and sustainable health system, leading to reduction in morbidity and mortality of children from vaccine preventable diseases in Solomon Islands which will be measured using Under-5 Mortality Ratio, Infant Mortality Ratio and Maternal Mortality Ratio. VPD incidence, prevalence and hospitalisations.

ASSUMPTIONS

List any assumptions: Some indicators outlined in the monitoring framework/ DHIS2 are available on routine basis as monthly reports of immunisation coverage. Other indicators are only available (especially the impact and outcome indicators) through the conduct of surveys such as DHS. Many indicators for key activities and intermediate results will be monitored as part of the programme through systems of quarterly reviews, supportive supervision and development and implementation of the partnership mechanisms. Also special studies (EVM, coverage surveys, data quality assessments and HSS evaluations) will provide additional sources of information for monitoring and evaluation purposes. It is expected that the HSS2 grant in combination with the government commitment and financial support, activities will sustainably transition post 2021.

15. Monitoring and Evaluation (M&E) (Maximum 2 pages)

Provide a description of how HSS grant performance will be monitored.

Immunization coverage is monitored as part of the routine M & E process of the 35 national core indicators. Immunization programme data is collected from all health facilities through routine reporting forms on a monthly basis and transferred to the provincial health office where HIS coordinators enter the data into the national integrated HIS platform which is DHIS2. Data is analysed quarterly, biannually and annually at national level. Apart from routine immunization data, information on cold chain functionality is also collected monthly from every health facility. Cold chain “not working days” are reported and are tracked and followed up when necessary. The EPI unit conducts weekly programme review meetings at which information is discussed along with follow-up actions to be taken. All this data is routinely analysed nationally, by province, health zone and/or by individual health facility in DHIS2 at the Health Information Unit of the Ministry of Health and Medical Services and shared with the EPI unit and other stakeholders.

The country also has an annual performance review mechanism in place along with all developing partners working in health where all data on core indicators are reviewed as a measure of annual performance. An annual core indicator report is produced with the support of WHO. The latest year for which this report is available is 2015. Another important source for data on immunization coverage is through Demographic and Health Surveys conducted every five years. The most recent DHS is 2015 and was published recently.

Supply chain information is monitored through mSupply at the national and provincial medical stores. There is also availability of a list of essential medicines including vaccines and cold chain functionality at health facility level is to be monitored quarterly through the routine HIS system on DHIS2 platform.

A data quality assessment exercise has been undertaken in August 2017 to review and improve data quality from the health facilities and address denominator issues.

Currently, a process of developing an M & E framework for the NHSP 2016 – 2020 is underway. Institutional arrangements for an M & E unit within the MHMS is also being formulated.

M&E is also to be guided in Year 1 with by means of assessments, i.e. the National EPI Survey, baseline assessment through supportive supervision and cold chain mapping/ inventory. It will be monitored through supportive supervision, annual EPI performance reviews and provincial reports. In addition to routine collection of information for monitoring, other avenues to monitor project implementation will include supportive supervision and data and performance reviews at the national and provincial level. Year 1 surveys (National EPI Survey) will provide baseline values of inputs and processes.

Data such as Fully Immunized Child, is difficult to collect. This is because monitoring charts/ patient records are not easily transferrable from one facility to another and thus, FIC is monitored through surveys. Only Penta and measles rates are well collected. Explore possibility to implement an electronic immunization registry, leveraging DHIS resources.

The proposal emphasizes considerations that are important in the area of monitoring and information. Zones and provinces will be trained to enhance their capacity in analysing and using their own data. Data collection will be on low performing areas identified as priority project sites. Collaboration among data managers and programme managers/ implementers should be strong. Provincial level reviews will be scheduled at least twice a year.

In summary, the main activities to strengthen monitoring and evaluation of EPI that will be undertaken as part of this health system strengthening proposal will include the following:

Enhanced supportive supervision systems in hard to reach areas

Capacity building programs of EPI middle level managers on monitoring

Establishment of community partnership mechanisms at provinces and in zones to improve monitoring in low coverage areas

Development of data quality assessment guidance

Implementation of Nationwide Coverage Survey

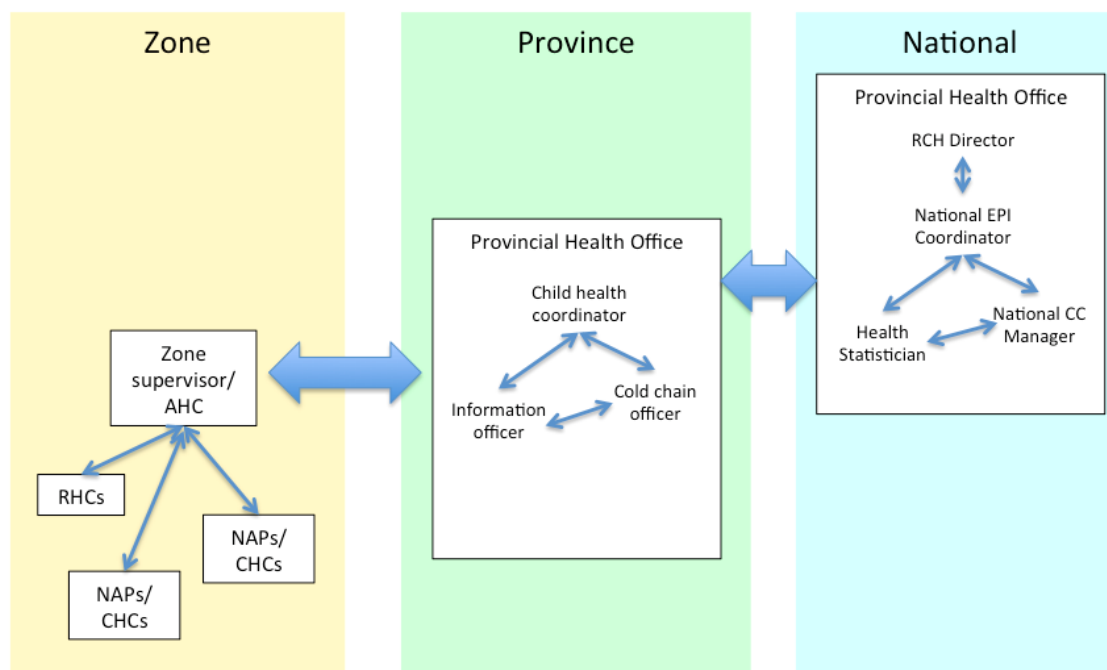
Technically assisting managers (through REC micro-planning guidelines and training) to improve use of data for planning in low coverage areas

Use of community partnership mechanisms (local NGO/CSO research) to better understand gender barriers to

health service access

Improved geographic and gender disaggregated data collection and analysis through implementation of more regular survey methodologies (DHS and EPI Coverage surveys).

Figure 4. Monitoring system of the grant



16. PBF Data verification option

Choose which data verification option to be used for calculating the performance payments.

Data verification option	Select ONE
Use of country administrative data	<input type="checkbox"/>
Use of WHO/ UNICEF estimates	<input checked="" type="checkbox"/>
Use of surveys	<input type="checkbox"/>

PART D: WORKPLAN, BUDGET AND GAP ANALYSIS

17. Detailed workplan, budget narrative and gap analysis (Maximum 3 pages)

Complete **Mandatory Attachment #6: Detailed workplan, budget and gap analysis**, which can be accessed at the online country portal.

Detailed instructions to fill in the budget template are available in the first worksheet of the Excel template.

Once the budget template and financial gap analysis has been completed, provide a **budget and gap analysis narrative** here

Financial Gap Analysis for Immunization Budget

According to the cMYP 2016-2020, for routine immunisation and SIAS, SIG is the largest contributor to immunisation, contributing over 53% of the overall funding in 2014. The support is mainly for staff costs and

financing traditional vaccines and co-financing contributions to Gavi. The cMYP Table 17 (p. 43), shows secured funding up to 2020 with gaps of consistently 50% for each of the years. As Government pays for new vaccines and human resources, operational costs are derived from contributions from the UN and largely from the Gavi HSS grant.

According to the EPI AOP 2016, the total EPI operational budget for 2016 is US\$ 1,126,911.84. Seventy-four per cent (74%, US\$ 838,438) is funded by Gavi through the HSS and New Vaccines Introduction grant. The remainder comes from UNICEF, WHO and the Joint UN fund. This calculation does not include human resources and infrastructure that is funded by Solomon Islands Government. Procurement of vaccines is included in the NMS operational budget and is not itemized in the 2017 AOP.¹² Rather, it is included under the category of “medicines, vaccines and medical supplies” amounting to US\$ 4,763,000.

Financial gap analysis (GAVI Work Plan) shows that resource requirement for immunization for five years is estimated at US\$ 6.28m. GAVI HSS will be supporting around 50% (US\$ 3.15m) mostly for cold chain/ supply chain and information capacity which require large capital. The SI Government’s funding is directed to Service Delivery and Community Engagement, increasing towards the latter part of the 3.5-year duration in transition to post-grant operations. The nearly USD\$3.150 million budget include a \$700,000 contribution towards the CCEOP application.

UNICEF’s commitment is assured for both cold chain and communications. Its support for immunization during the grant period will continue as will be the support by WHO not only as technical but also as implementing partners. The largest donor partner in health is DFAT who provides budget support directly to the government and health ministry. The health budget support between 2016 to 2020 is 47.84 million (AUD) representing USD\$37,888,200 allocated as per government requirements with a number of conditions that need to be met. Whilst DFAT is not planning to stop support to the Solomon Islands, their annual budget allocation decreases year on year by approximately 6%. In 2017, their allocation was USD\$10,351,200 but in 2020 will be USD\$8,592,960. KOICA (Korean aid agency) is currently funding the Guadalcanal cold chain refurbishment whose contribution is reflected in the current CCEOP application.

Budget and Work Plan

The proposal is budgeted at **US\$ 3,149,853 for 3.5 years (July 2018 to December 2021)**. Its four objectives incur the following costs:

Objective 1: Increase immunization coverage rates through sustainable service delivery and programme management US\$ 1,101,099 (35%)

Objective 2: Improving vaccine supply and cold chain planning, capacity, infrastructure and management systems US\$ 1,093,761 (35%)

Objective 3: Ensuring good quality and timely routine information and regular surveillance systems US\$ 594,093 (19%)

Objective 4: Optimizing demand-generation and community engagement through development of partnerships US\$ 360,900 (11%).

NOTE: Costs in the Solomon Islands are high. 1.5 litres of water costs US\$1.30, and the average cost of a domestic airfare return is US\$ 590. Domestic travel is more expensive than international airfares to and from the SI mostly due to no local manufacturing, a small and widely dispersed population size and limited supply of manufactured goods.

In addition to Attachment #6 Detailed work plan, budget and gap analysis, a unit cost spread sheet (Attachment #40) is included with calculations for each of the activities in the budget. Where appropriate, it includes for workshops the number of participants, the length of the workshop/meeting, per diem, transport costs etc. Supervisory and on the job training activities include the number of people visiting, the length of the visit, transport costs and where appropriate, per diem and accommodation.

¹² Annual Operations Plan 2017. EPI Unit, Reproductive and Child Health Division, Ministry of Health and Medical Services.

The major cost driver of this application is the US\$700,000 or 22% of the total of the HSS2 proposal value. Only a couple of other activities attracted a budget line of or around US\$ 150,000 or 5% of the budget. The grants to CSOs managed by UNICEF have a cost estimate of US\$210,900 or seven per cent.

The Gavi grant category procurement and supply chain management carried the largest budget allocation (30.5%) given the CCEOP contribution from this proposal (Objective 2), including activities for the implementation of the EVM plan and for maintenance of the new cold chain equipment. Workforce and Human Resources follows with an allocation of 22.8% or US\$719,723. Health information systems. The US\$212,570 or 6.7% of the total is listed as project management. This includes the end of grant evaluation US\$50,000 and annual financial audits (US\$80,000 in total).

Service delivery is budgeted at US\$351,397 or 11.2% of the total budget. As the country is in an accelerated transition phase, the country will be taking on recurring costs in year 3 and 4 (2020 and 2021) hence the budget is modest for all of the activities proposed in Objective 1. These include outreach (1.1.a), on the job training and supportive supervision (1.1.b, 1.2.a, 1.2.b, 1.4b) and biennial performance review (1.4.a).

Supportive supervision at national and provincial levels (1.2.a and 1.2.b, respectively) represents a total of US\$123,456 or 4% of the total budget. This will ensure that there are at a minimum 100 days of supportive supervision being provided over the year, from Provinces to Zones and Zones to Health Facilities.

Training and capacity building

Activities for “Workforce and Human Resources” are training and capacity building to enhance implementation, performance, technical skills and monitoring. Training and capacity building represents 22.8% of the budget or US\$719,723. Training have been implemented as one-week activities where programmatic and technical updates are combined. Trainings will include:

On the job training for immunizers in low performing areas (1.1.b)

Health worker capacity building to review and develop micro-plans at the provincial and zonal levels (Roll out of REC strategy) (1.3.a)

On the job training to build capacity for updates, implementation, supervision and monitoring in low performing provinces and zones (1.4.b)

Roll out of capacity building for vaccine supply, stock management and CCE management in low performing provinces and zones (2.2.a)

Support for national and provincial staff to conduct monitoring and supervision of CCE management and vaccine supplies (2.2.b)

Community level training for disease surveillance, rumor response, early warning (3.3.c)

Guideline development and capacity building on interpersonal communication, community engagement, equity and gender for health workers on matters relating to immunization/PHC (4.1.b).

Procurement and supply chain management

Most activities in this category are under Objective 2 on vaccines and cold chain equipment incurring US\$ 961,180 or 30.5% of the budget. The large budget allocation includes the US\$700,000 CCEOP contribution (see CCEOP application for further details), in addition to EVM recommended activities and CCE maintenance. It also includes the procurement and installation of seven generators and a high temperature incinerator to ensure vaccine waste is returned to the supply point and disposed according to international waste disposal standards. However to determine the size of the incinerator, there needs to be knowledge of waste volumes and composition, the wrong technology for the waste composition will result in dangerous emissions, high fuel costs, and premature failure of the incinerator. Transport, construction materials and labour, training, M&E, sharps safety, waste segregation, waste collection, final disposal will attract extra costs, some already considered under the transition plan and others such as transportation, waste segregation etc will be covered by provincial budgets.

Eight boats and outboard motors for the identified health facility or zone in line with the Provincial service delivery assessment in the 8 priority provinces will also be procured. The country has traditionally procured its cold chain equipment through UNICEF Supply Division and this case will not be an exception. All CCEs will be procured in line with Gavi recommendations of PQS equipment. Cold chain procurement and installation will be managed centrally by national EPI team with no provincial grants except for maintenance costs captured in the maintenance plan.

Health information systems

Health information systems strengthening activities are included in objective 3 with a budget line allocation of US\$544,093 or 17.3% of the budget. Activities are tailored to improve the quality of the data and information in low performance and high-risk areas. It includes the identification of low or non-reporting areas (3.1.a). Either the Monitoring and Supportive Supervision Officer or the Hospital based active surveillance officer will travel twice a year with the Child Health Officer or the Data Entry Officer of the targeted Province to the health facilities to provide on-the-job training and supportive supervision for data reporting. The data monitoring visits are 12-days and cover all health facilities in the zone/Province that has been identified through the data analysis. Cost is for one airfare from national level, and travel for 2-3 persons for 12 days including fuel and accommodation to each of the targeted province's health facilities has been budgeted at US\$22,056). A nationwide coverage survey disaggregated by geography, SAS and gender is budgeted in 2020 at US\$100,000 (3.1.b) The survey is timed to capture the coverage of the new vaccine introduction for HPV and MR2 in 2018/2019 and to inform future planning in preparation for transition in December 2021. The inclusion of an EPI Coverage Survey will identify areas of EPI coverage inequities; rates of drop outs and; non-uptake of immunisation services. Whilst the EPI has an imminent data quality visit (August 2017), and one is budgeted for low coverage zones for US\$30,000 in Q3/4 2020 with WHO TA. Surveillance training to harmonize hospital and syndromic systems at province and hospital levels (3.3.b; US\$ 116,000).

Information equipment. The National Health HF Radio Network was established in 2006. As recommended by national and provincial officials, radio replacement, installation and maintenance are budgeted in this proposal with approximate cost coming from Health Communication Division that recently built a few radio sites. Four HF radio units at US\$ 7,500 each (includes HF Radio base station, transmitter and solar panels and installation) will be purchased under activity 3.4.b. cost. Computers and printers (10 sets US\$ 1,000 per set) for provincial health offices to support EPI information collection and DHIS2 are also planned.

Community and other local actors

Activities under this grant category include most activities under Objective 4 (Demand-generation and community engagement) such as development of standards, guidelines and monitoring to strengthen partnership mechanisms (4.1.b) for US\$10,000 and supporting community engagement through systems of coordination between government and civil society partners low performing zones implemented by UNICEF with a total allocation of US\$210,900 (4.1.c). This activity is a grant to World Vision to utilise their community officers for demand generation activities and interpersonal communication for immunisation in low performing zones. Activities also include capacity building on interpersonal communication, community engagement, equity and gender for health workers on matters relating to immunisation/RCH and community health.

Programme management

Activities categorized under programme management have a budget allocation of US\$212,570 or 6.7%. This includes the end of grant evaluation US\$50,000 and annual financial audits (US\$80,000 in total) in addition to the funding of the finance officer as a contract position for the life of the project. The position will not be absorbed under the government organisational structure and will be responsible for the financial closure of the Gavi grants. The other two positions (Monitoring and Supportive Supervision and HBAS Officers), have been included in the MHMS restructure under the EPI unit, and are placed on the list that will be submitted to SIG for consideration for new public service positions. Note in the Solomon Islands, each Ministry has to 'bid' for new positions annually at the time of budget submission when the Ministry of Public Service adjusts the establishment ceiling. The MHMS is positioned well to receive their requested position thus are budgeted until 12/2019. An additional recruitment of a Logistics/Cold Chain Officer for the EPI unit to support the implementation of the EVM recommendations is budgeted but will be absorbed into the government. Funding is only requested until the end of 2019 for this position.

Technical assistance

Technical assistance is shared between the HSS2 proposal and the transition plan which is currently in draft. In the HSS2 proposal TA is planned to transition the grant into the HSP mechanism with an efficient transfer of funds (1.4.f with a US\$13,200) and for provincial level planning and capacity building for programmatic and financial management (1.4.g). There is also TA to disseminate the National Cold Chain Policy and develop a supervisory check-list (2.1.b with a value of US\$6,500) and short TA to support the EVM implementation plan. In addition, the community engagement grant management through UNICEF (4.1.c) and the EI survey which will be conducted by WHO. The transition plan includes all partner technical assistance for the

implementation of the HSS grant and for EPI support.

Budget implementation

The SIG has large budget lines for human resources, office infrastructure, utilities and health facilities, Government expenditure is also dedicated to the purchase of vaccines and related co-financing for Gavi funded vaccines. However, the EPI running costs are donor funded with Gavi taking the lion's share. Funding contributions from Joint UN and UNICEF are managed at the national level and will be distributed to provinces nationwide based on annual requirements. The Government will begin to absorb recurrent costs by year 2020 (10%) and by 60% at the start of 2021. The 30% remaining will be absorbed by the MHMS at the end of the project (further details are found in the Sustainability section).

Implementation of this detailed budget will follow the country's existing systems and processes. The Gavi HSS grant will be part of the Health Sector Support Platform (HSSP) and will be monitored by the MHMS/Finance Division and the Ministry of Finance. Monitoring of activities will be based on the NHSP M&E and the work plan for immunization.

Pooled fund applicants are not required to complete the workplan, budget and gap analysis template. Instead, specific information on the sector wide annual workplan and budget should be provided.

This is not a pooled fund application. Financial implementation mechanisms are described in Section 19. The current GAVI HSS fund uses a separate financing procedure other than the Health Sector Support Programme (HSSP). As recommended in the 2015 Joint Appraisal and as per request of the MHMS, the new GAVI HSS grant will be managed through the HSSP.

18. Sustainability (Maximum 2 pages)

Describe how the government is going to ensure programmatic sustainability of the results achieved by the Gavi grant after its completion.

If the country requests recurrent activities, describe steps to reduce further reliance on Gavi funding for recurrent costs.

Provide a summary of the country's policy and approach to sustainability.

The Solomon Islands have been placed in an accelerated transition phase with a full transition by January 2022. Given that currently Gavi funds 3/4rds of the EPI recurrent budget, in order to achieve self-sufficiency and full ownership of EPI programme is required. A number of strategies have been devised for the transition to occur sustainably and to that end, the EPI, Gavi and partners are still developing a transition plan which include technical assistance by partners during this period.

The MHMS is committed to absorb two positions funded by Joint UN into the government civil service system. As this is a bureaucratic process, the proposal has a budget line for these salaries until the end of 2019 but envisages the MHMS would be able to absorb them earlier. A third position for a cold chain officer to work within EPI and manage the cold chain expansion is proposed to be hired for the first 18 months with GAVI resources and thereafter with Government funds. The NHMS is also looking into shifting budgets to accommodate the EPI running costs following the end of the Gavi HSS2 support. The proposal has a budget decrease of 10% for EPI recurrent costs in Years 2020 and a 60% decrease in 2021. This means that at the end of the grant period, the remainder 30% of recurrent costs will be absorbed by the Government. The finance officer position, will remain included within the Gavi HSS grant, as a project officer responsible for closure of the Gavi grants.

The strategic partnership engagement is aimed at ensuring that beyond the Gavi support, established community engagement and outreach mechanisms are in place for the government to advocate further resources for continued coverage of remote and hard to reach areas.

The EPI programme has been implemented for thirty years. It is currently the first of six priority programmes of MHMS aiming towards 90% coverage. EPI had a long history of wins from its establishment in the early 1980s. Solomon Islands was declared polio-free in 2000 and has remained polio-free; Hib and pentavalent vaccines were introduced and have been sustained in the last 5-7 years.

Programmatic sustainability

Programmatic sustainability in Solomon Islands is enhanced through policy and health system strategies to promote efficiencies and ensure EPI is well integrated within the health system.

Organizational Integration: Implementing EPI requires working together of different agencies in the Ministry along with development partners including Unicef, WHO and CSO agencies. Although the EPI unit is currently small (one programme manager and finance support staff), the unit is placed within the Reproductive and Child Health Division and can take advantage of its networks and programmatic support. In provinces, Child Health Coordination manage concurrently EPI. At the NMS and in provinces, staff is dedicated to vaccine supply and cold chain equipment.

Information and planning integration: An extensive monitoring system for EPI has been developed generated from health facilities to the national level. EPI information is part of monthly reporting required for encoding into the DHIS2. The proposed integration of HSS supported activities into the HSSP project from 2017 will also promote programmatic sustainability, by linking of EPI to broader planning and health sector initiatives to strengthen the service delivery sector.

Service Integration: The new Role Delineation Policy (RDP) aims to ensure more efficient management and delivery of services by clarifying roles and functions of the various agents in the health system, as well as defining the package of services to be provided at each level. Through this policy initiative, it is expected that the country can meet the challenge of delivering services in the most efficient manner, particularly given the on-going challenge of shortage of human resources. The RDP clarifies for the long term the specific roles and functions for EPI at each level of the system, addressing issues of accountability for immunization performance. Closer linkages with churches and NGOs in higher risk areas through this HSS proposal will increase the prospects that services can be sustained in hard to reach areas.

Financial sustainability

The Solomon Islands have a number of financial sustainability challenges. The country is deemed as a fragile, least developed and high-risk small island nation with limited economic prospects. Its expenditure is higher than its revenue and is dependent on foreign aid. Health however is a priority and within it, immunisation is top priority as the government recognises the importance of a healthy population. It is committed nonetheless in increasing the human resources in the EPI programme and at best absorb two positions prior to the start of the HSS2 grant and at worst to absorb them by the end of 2019. The commitment of taking on 70% of running costs prior to the end of the grant will ensure the long term sustainability of the EPI.

Planning for Recurrent Budget Costs: As part of the strengthening of the HSSP, and Annual Operational Planning, the recurrent costs being supported through the HSS grant will be clearly identified in Annual Operational Plans and included in the Medium Term Expenditure Framework. This will ensure visibility of the Gavi contribution to the EPI and HSS activities, and support the MHMS to plan for absorption of the recurrent costs.

Narrowing Fiscal Space: Total government expenditure for the immunization programme was 2.04% in 2013 and 2.05% in 2014 as proportion of general government expenditure for health. This is approximately US\$ 1.27 million and US\$ 2.02 million, respectively. This represents 53.74% of total immunization expenditure in 2014.¹⁵ This expenditure is only for operations since budget for staff are under the Ministry of Public Services and not the Ministry of Health and Medical Services.

Increasing Costs of New Vaccines: Overall expenditure on traditional vaccines, from government and foreign sources, had increased from 0.11 million in 2013 to 0.28 million in 2014. The increase is because of the introduction of the new Measles and Rubella vaccine from GAVI for the measles response campaign in 2014.¹⁵ In 2014, government expenditures primarily covered for personnel costs (84.56%), traditional vaccines (8.21%), and supplementary immunization activities costs (2.76%). Although the government had fully funded traditional vaccines since 2012, other sources of donor funding contribute significantly to this budget. Vaccine costs (for both traditional and new vaccines), from all sources, are approximately 0.39 million USD, representing 19.27% of total EPI program expenditures in 2014. Compared to 2013, this amount has increased although similar in proportionate terms.¹⁵

The response to these financial sustainability challenges will be as follows:

Policy Initiatives: The National EPI policy reflects the importance given to immunization. It was revised in 1995 and 2008 and updated in 2015. It sets basic targets and programme operations mechanisms. Provided in this policy is to ensure funding support for EPI. In addition to the EPI Policy, the Role Delineation Policy will

describe the roles and functions of EPI staff within the health system at each level, and the overall policy framework for services integration.

Resource mobilization and partnerships: As a priority programme, government and development partners are obliged to ensure that EPI is implemented well. In addition to international partnerships, this HSS proposal will also propose closer partnerships with Civil Society Agencies in high risk areas in order to promote more sustainable access for hard to reach populations, and support Provinces and Zones to include these organisations in their AOPs to support service delivery and implementation and funding where possible

Efficiency: As outlined in the above-mentioned section on programmatic sustainability, closer integration of the EPI planning, management, information and delivery system will ensure much closer operational linkages with the wider health system, and will assist to leverage the shared costs of the health care system for sustainably improving immunization activities and results.

Current situation. The government is already paying for traditional vaccines, health workforce and infrastructure related to immunization activities. Gap analysis (revised) projects that government is projected to provide US\$ 408,147.00 for immunization in 2017. This will gradually increase to US\$ US\$ 770,104.00 by 2021. By the end of the grant, projected total budget for immunization will be US\$ 6.28 million, an increase from 2.02 million in 2014. NHMS requires to advocate for additional resources to cover the additional costs of vaccines and for recurrent EPI activities.

Pooled fund applicants are required to provide existing documentation that addresses sustainability. List which documents have been provided and reference the relevant sections.

This is not a pooled fund application. Financial implementation mechanisms are described in Section 19. The Health Sector Support Programme (HSSP) financing procedure follows the procedures of the Solomon Islands Government as directed by the Ministry of Finance and Treasury. Its main objective is to strengthen the country's capacity for planning and finance management, reduce parallel funding and implementation systems, and strengthen sustainability of revenue whether coming from domestic sources or foreign contributions. Currently, agencies that use the mechanism include DFAT, UNICEF, Joint UN, WHO, Global Fund, EU, FP Australia and the London School of Hygiene and Tropical Medicine (LSHTM). GAVI and UNFPA have been requested to implement programmes through this mechanism for purposes of financial management. Government ministries including health have several funding pools including a recurrent SIG pool, support budget and developmental budget.¹³

PART E: IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

19. Implementation arrangements (Maximum 2 pages)

Describe the planned implementation arrangements

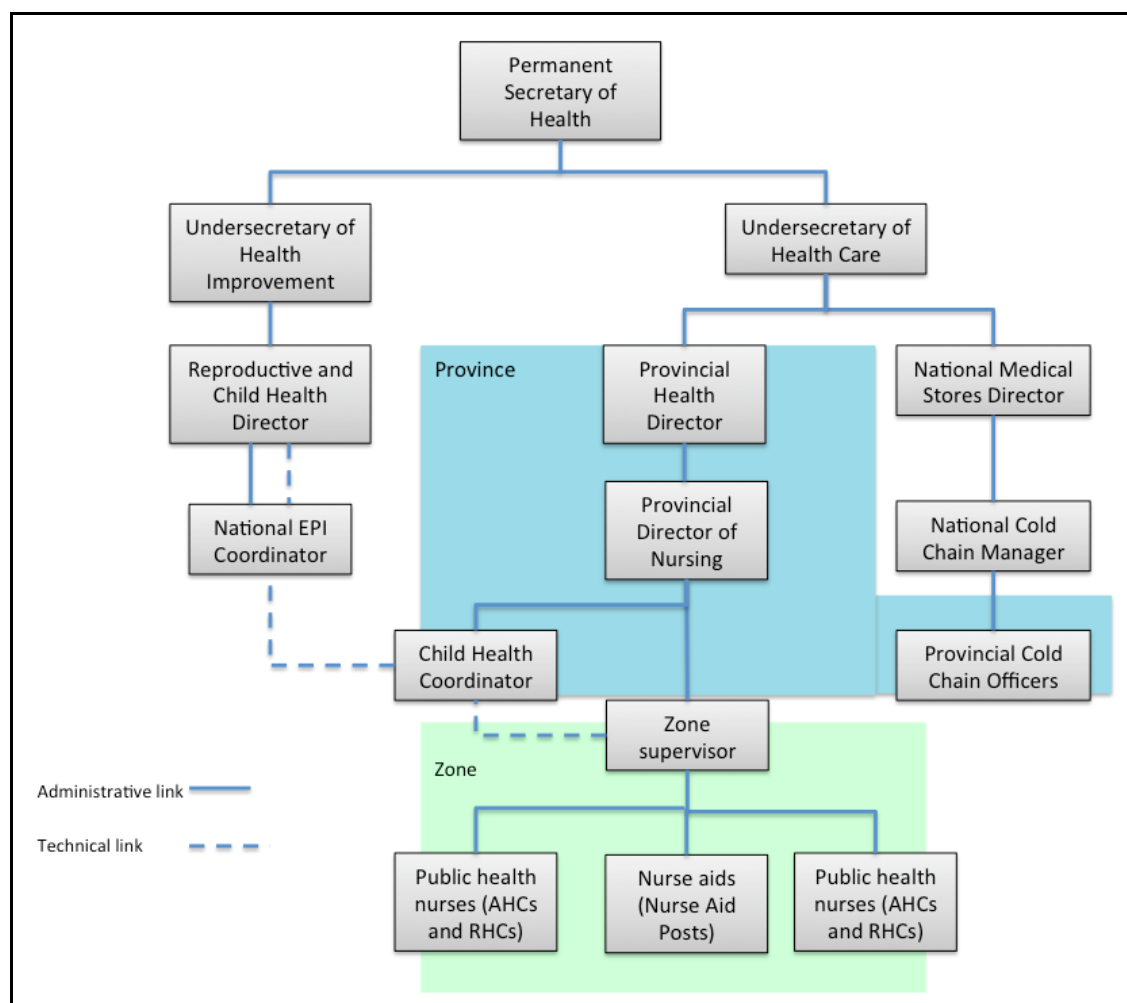
Implementation of this proposal requires collaboration among different offices within the MHMS as well as with partner agencies. As MHMS works in an integrated manner, the EPI does not work in isolation but together with the reproductive health, child health and cold chain among others. Figure 5 illustrates the main offices/ persons within the MHMS who are accountable and responsible for EPI activities. MHMS under the leadership of the Permanent Secretary is the accountable agency for immunization. The Undersecretary for Health Improvement oversees public health programmes including the EPI and supervises priority national health programmes. The Undersecretary for Health Care oversees clinical services and Provincial Health Offices. The Undersecretary for Health Improvement also oversees the Inter-Agency Committee for Family Health that oversees implementation of EPI under Reproductive, Maternal, Newborn, Child and Adolescent Health. It is led by the MHMS along with Development Partners and provides guidance to monitoring of EPI. (See TORs Attachment #42) Quarterly meetings of the Inter-Agency Committee for Family Health include updates on the HSS2 grant. It provides recommendations, coordination and review progress of measurements/ indicators during grant implementation.

¹³ Interview with Accounts Division, Ministry of Health and Medical Services. 2015.

Reproductive and Child Health Division (RCHD) is in charge of family health, maternal, neonatal and child health and nutrition. The RCHD develops, updates, and harmonizes policies, guidelines, protocols, supervisory and monitoring tools across all child health programs including immunization and AEFI surveillance. Functions per level of care and administration will be consistent with the Role Delineation Policy. The national level will also ensure micro-planning using RED/REC Strategy; Cold Chain Management; EPI refresher and AEFI management.⁷

The EPI Unit is in charge of planning, implementation, monitoring and coordination of all immunization activities. Coordination includes that with other MHMS units and divisions (e.g. NMS, Statistics, Finance, HR and Health Promotion) as well as with development partners (UNICEF, WHO and DFAT) and CSOs (NGOs and churches).⁷ The National EPI Coordinator in the EPI Unit will be responsible for implementing the grant with oversight from the RCH Director and technical guidance from UNICEF and WHO. The grant will include additional monitoring and administrative support staff. This team will manage the grant including its implementation, financial management and coordination with MHMS offices and partners.

Figure 5. Main offices and persons accountable and responsible for the implementation of EPI activities in Solomon Islands



The MHMS EPI Unit manages implementation of funds with the approval of the RCH Director. The annual work plan includes the National Medical Stores as implementer of procurement activities and RCH Division (Partnership coordination) and Provincial Health Offices (Community engagement) as implementers too. Activities and funding approval release goes through the EPI Unit and the RCH Director request and approval process.

The draft Health Sector Strategic Plan proposes a Provincial and Programme Planning process including implementation of bottleneck analysis and development of costed annual operational plans (AOPs). The HSS2

inputs will link to this planning process to ensure proposal investments are integrated with the health management and delivery system (NHSP Strategy 2.5.4).⁸

The National Medical Stores (NMS) under the Undersecretary of Health Care, is in charge of planning, procurement, storage, inventory management and distribution of vaccines and cold chain equipment, including CCE maintenance. Cold chain management officers continuously coordinate at national and provincial level managers for immunization logistics needs. The NMS has a warehouse at Honiara. When equipment and logistics are transported from Honiara to provinces through private shipping companies delivering directly to sites.

Provincial Child Health Coordinators handling EPI, report to Provincial Health Directors for management and to the National EPI Coordinator for programmatic and technical concerns. The Provincial Child Health (EPI) Coordinator roles include: capacity building and immunization related activities, plan and conduct outreach immunization including annual Periodic Intensified Routine Immunization (PIRI), quarterly onsite supervisory visits and on-the-job training to use the guidelines, protocols, supervisory and monitoring tools in provincial hospitals, AHCs, RHCs and NAPs.⁷

Health Statistics Unit is in charge of data collection and quality from zones to provinces to the central office through focal points in every province. EPI programme coordinators must regularly communicate with them to improve data quality, analyse data and disseminate them.

UNICEF supports the government with an in-country EPI technical officer who provides assistance in forecasting and procurement of traditional and new vaccines through the Vaccine Independence Initiative programme management, monitoring, training, communications, effective vaccine management, supply and cold chain management. WHO provides technical support for planning and programme management particularly surveillance of adverse effects following immunization. DFAT supports the MHMS through a number of technical assistance advisors such as the financial controller for planning and monitoring the use of funds and the procurement advisor.

Community engagement support will be delivered through NGOs and CSOs through grants provided by UNICEF through this proposal. Engagement with Civil Society and Churches is described in Section 20. Private sector involvement is minor and ad hoc e.g. in the shipping of equipment from Honiara to provincial capital cities/towns when needed and audit firm.

Pooled fund applicants are required to provide documentation of the implementation arrangements of the sector wide mechanism, if appropriate. List which documents have been provided and reference the relevant sections.

This is not a pooled fund application. Funds channelled in to the HSSP 'pooled fund' is only for the financial management purposes, and does not require pooled funding arrangements.

The MHMS Accounts Department is in charge of managing, approving and monitoring funds used for all health programmes. These funds are currently in the ANZ Health Support Account which is separate from the Health Sector Support Platform (HSSP) Account. One of the recommendations of the Joint Appraisal in June 2015 was to implement GAVI HSS grant through the HSSP. Preparatory activities to facilitate this transfer are planned in 2016. Facilitating the new procedure will require technical capacity to ensure that funds are obtained to implement activities up to the province level.

The HSSP follows the financial management procedures of the Solomon Islands Government. Funding for the MHMS comes from three pools: 1) SIG recurrent, 2) Budget support where HSSP falls and 3) Development. HSSP plan follows the MHMS AOP. In 2015, HSSP includes funding from DFAT, WHO, UNICEF, Joint UN, Global Fund, EU, FP Australia and London School of Hygiene and Tropical Medicine.²¹

20. Involvement of Civil Society Organisations (CSOs) (Maximum 2 pages)

Describe how CSOs will be involved in the implementation of the HSS grant.

NGOS, CSOs and Church groups are the main organizations that MHMS can partner with to implement immunization activities. Solomon Islands Christian Association (SICA) is a coordinating agency that included the main church groups in the country. These included the Anglicans, United Church, South Seas Evangelical

Church, Roman Catholics, Seventh Day Adventists and the Salvation Army. In total, these church denominations cover up to 85% of the population. SICA is only a coordinating body and mainly serves for information dissemination e.g. when churches need to announce national campaigns as well as referral to specific churches.¹⁴ During the 2014 Measles Outbreak Response, MHMS partnered with churches for dissemination of information.¹⁵

For specific engagement e.g. service delivery, sharing of resources like venue and more targeted information campaigns, engagement with church groups are best done at the province or zone level. Churches have their own health committees and may run hospitals and clinics. Church-based health committees usually deliver primary care, maternal and child health and advocacy. NGOs e.g. World Vision find it best to partner with churches especially in local communities. Churches also have radio stations where radio announcements and advocacy are done.

The South Seas Evangelical Church (SSEC) is one of the church groups with community health programme. They have 51 project sites. Their activities are focused on leadership and capacity building. They have a pool of community health workers in project sites. Basic health trainings they offer include NCDs, communicable diseases, reproductive health, HIV/ AIDS/ STI, first aid and counselling. Among their plans is to focus activities at the primary care level. They have been a recognized partner by the MHMS and provincial health authorities.¹⁶

World Vision is a potential partner for implementation of EPI activities and already works with MHMS for health promotion, MCH, WASH and disaster response. World Vision previously partnered with MHMS for the training of Traditional Birth Attendants. It already participates in several existing committees led by the MHMS e.g. the Health and Nutrition Cluster, WASH and Health Partners meetings. It is not yet a member of the Family Health Committee.¹⁶

World Vision currently works in around 60 communities in four provinces and has a working staff of more than 120. They also train Volunteer Health Workers (VHWs) whose task is to support MCH activities including health education, identification of mothers and children and referral/ accompaniment of mothers for prenatal care and delivery. Only two VHWs are trained in each community site. Partnership with VHWs for such activities can enhance community engagement. SI does not have recognized institution for VHWs.¹⁶

Another potential partner is the Red Cross of the Solomon Islands. During the 2014 Measles Outbreak Response, the Red Cross was part of the Task Force for advocacy, health education and organization of vaccination sites in Honiara City Council. UNICEF's funding support facilitated Red Cross engagement and they were easily able to generate their trained volunteers.¹⁷

Involvement of CSOs in joint reviews, surveys and assessments is possible although not yet previously done. World Vision and churches may also partner with other government agencies and development partners. The number of local non-church NGOs working in health is very small. The challenge with churches is selecting which groups to partner with. As by World Vision experience, it is a provincial or local level decision since health officials know which churches have wide coverage. Alternating partnerships for specific activities is also possible.

In summary, the following approaches will be used to engage CSOs in the implementation of HSS2. These are consistent with the national Health Plan Strategic Plan Objective 2.3 which seeks to expand partnerships with Churches and NGOs:

- Development of more structured partnerships at province and Zone levels with Churches and NGOs;
- Involvement of Churches and CSOs in joint reviews, surveys and assessments and plans at province and Zone level;
- Implementation of a Task Force for advocacy, health education and organization of vaccination sites in Honiara City Council;
- Partnership with Church supported VHWs for activities to enhance community engagement in high risk areas; and

¹⁴ Interview with Solomon Islands Christian Association, 2015.

¹⁵ Interview with Health Education and Promotion Division, MHMS, 2015.

¹⁶ National Health Conference 2015. Day 3 Presentation. South Seas Evangelical Church.

¹⁷ Interview with Red Cross of Solomon Islands, 2015.

Partnering with Churches and NGOs to implement capacity building activities on EPI for community health workers/volunteers in high-risk areas.

Partnerships with CSOs, churches and NGOs are the focus of Objective 4. These partnerships will include advocacy, communication, education, community mobilization, joint monitoring and other forms of partnerships based on the current work, expertise and capacity of such organizations.

As the MHMS is currently in the process of establishing governance mechanisms, guidelines, processes and tools for Provinces and Zones to effectively engage and enter into contracts with non-state partners, specific partners have not been identified in the budget as such. However, grants to civil actors will be provided through UNICEF.

Engaging CSOs would require capacity building at provincial and zonal levels. Partnerships for health promotion, information dissemination, and distribution of logistics, identification of children, referral and HR support for catch-up immunization are potential collaborations with CSOs. At the national and provincial levels, the MHMS can coordinate with World Vision, Red Cross or church groups for surveys and joint reviews.

Private sector engagement remains minimal though it will be engaged to conduct the financial audits, and there may also be opportunities for vaccine logistics support.

Pooled fund applicants are required to summarise the role of CSOs in the implementation of the sector wide programme.

This is not a pooled fund application. Financial implementation mechanisms are described in Section 19. NGOs such as World Vision and the Red Cross have been involved in the implementation of activities managed through the HSSP. These activities were mainly implemented by MHMS and UNICEF. Currently, churches and CSOs are not yet involved in the planning or review process of the HSSP. The development of corporate plans at provincial level and annual operational plans in zones as proposed by HSSP, in collaboration with development of partnership mechanisms for NGOs/CSOs as part of this HSS proposal, should enable opportunities for joint planning and monitoring activities.

21. Risks and mitigation measures (Maximum 2 pages)

If available, provide Attachment #35: Health Sector Risk Assessment. If such an assessment is not available, provide an analysis of the risks of not achieving the objectives in this application.

Complete the table below for each of the proposed objectives outlined in Question 12. If the risk is categorised as 'high', please provide an explanation as to why it is 'high'.

Description of risk	PROBABILITY (high, medium, low)	IMPACT (high, medium, low)	Mitigation Measures
Objective 1 Capacity for programme and budget management			
Institutional Risks: Change in overall management of the MHMS and structures above EPI e.g. change in the Permanent Secretary, Undersecretaries or RCH Director. Managers at provincial and Zone level not prepared to take on new roles and responsibilities in line with RDP.	Medium	Medium Managers at provincial and Zone level are not prepared to take on new roles and responsibilities in line with RDP.	Prompt communication on officers in charge and signatories. Development of guidelines, procedures, supportive supervision and capacity building programs to support middle level management development.
Fiduciary & Sustainability Risks:	Medium	Medium No access to	Funding predictability over the past eight years of HSSP, has been of significant value to the SIG in planning the management of the health

<p>Difficult access to funds due to new or unclear protocols that may cause delay in implementation. Decline in domestic and foreign sources of revenue for health. No access to funds will result to delayed or slow implementation of the project. Decline in revenue could affect the government's funding for routine vaccines that will lead to the programme being stalled.</p>		<p>funds will result to delayed or slow implementation of the project.</p> <p>Decline in revenue could affect the government's funding for routine vaccines that will lead to the programme being stalled, and ability to progressively absorb the cost of the EPI programme.</p>	<p>sector enabling the MHMS to plan efficiently and effectively.</p> <p>Australia as the main contributor to the SWAP works closely with the SIG in strengthening the financial management of the HSSP including: refining the financial mechanisms both from the disbursement mechanisms. The move towards use of HSSP should assist in joint problem solving of delayed operational funding for the National EPI Programme.</p> <p>In July 2012, ex-ante controls were introduced in all the major Provinces (covering 75 per cent of provincial expenditure). A local accounting firm was contracted with financial support staff now embedded within the smaller Provinces.</p> <p>A financial procedures manual produced and training provided to support provincial officers comply with the new Public Financial Management Act. MHMS has a PFM reform plan that is regularly monitored.</p> <p>The WHO HSS TA will work with the MHMS and the DFAT Advisers to support the budget preparations to include progressive absorption of EPI costs into the SIG budget. The TA will also work with the MHMS to identify how activities can be better integrated for enhance efficiency, and support Provinces to take on more costs related to service delivery. Reporting of progress will be tabled at the XXXX and budget transition is included in the GPF for monitoring.</p>
<p>Operational Risks:</p> <p>Provincial level structures may also change when the director or child health coordinator changes. Similarly, changes in zone and community health staff can delay implementation.</p>	<p>Low</p>	<p>Medium</p>	<p>Prompt identification of acting EPI focal points. Monitoring of hard to reach areas through supportive supervisory systems, outreach REC micro planning (linked to AOPs) and systems of quarterly reviews will provide feedback to national planners of HR capacity gaps and impact operations. Partnership mechanisms will mitigate operational risks through mobilisation of NGO/CSO support for hard to reach areas.</p>
<p>Programmatic and Performance Risks:</p> <p>Changes in programme staff and organizational structure; overhaul of programme design e.g. change types of vaccines confusing coordinators and health staff resulting in implementation and information delays.</p>	<p>Low</p>	<p>Low</p>	<p>For main changes in programme staff and design, EPI Coordinator and RCH Director must evaluate the status and identify immediate actions for response. Prompt communication to provinces and zones.</p>
<p>Other Risks:</p> <p>Cyclones, earthquakes and flooding can happen as evidenced in the last 5 years. Most emergencies are low scale affecting one or a few communities. Emergencies affecting provinces will have greater impact on programme</p>	<p>Medium</p>	<p>Medium to High</p>	<p>As Immunization is an essential public health intervention, it will be prioritised and resumed within two weeks. Catch up immunization campaigns will be done during emergencies e.g. measles vaccination done during the flooding in 2014. Normative programme should be implemented as soon as the situation allows.</p> <p>Strengthened partnership mechanisms and</p>

management. Programmatic operations may be affected for a period of time.			micro-planning processes will enhance the capability of the system to make swift and adequate emergency responses.
Overall Risk Rating for Objective 1	Medium	Medium	
Objective 2 Vaccines supply and cold chain equipment management			
Institutional Risks: Changes in top management and organizational structure. Lack of development of management systems	Medium	Medium	Clarification of roles of vaccine management related staff at all levels of the system aligned with the Role Delineation Policy. The first two years of the grant will procure most of the requirements with subsequent technical support and equipment allocation.
Fiduciary Risks: Delays in preparation of budget for vaccines and closing of annual disbursements	Medium	Medium	TA will be provided to transfer the Gavi account to the HSSP. The finance officer will be retained to the end of the project grant to close all disbursements. Procurement systems as per government guidelines. All procurements over \$100,000 are listed on an Annual Procurement Plan. Provinces are supported through local accounts teams. Preferred supplier arrangements are in place for small value goods, better protecting funds and reducing unit costs.
Operational Risks: Major delays in vaccine and CCE deliveries at the national level leading to delay in immunization activities.	Medium	Medium	Identification of bottlenecks through regular assessments and micro-planning exercises, reinforced by supportive supervision. Implementation of middle level management capacity building programmes for vaccine management. Strengthening use of mSupply (LMIS) in the periphery to improve data management, collection, reporting and analysis for vaccine and cold chain.
Stock out of vaccines.	Low	Low	The ongoing support of UNICEF and the use of the Pacific VII mechanism make this low risk. Risk for stock out at lower levels exist, but supportive supervision, and development of the mSupply mobile function through DFAT, and implementation of the CCEOP and EVM plan will support to minimise the risk.
Close vial wastage of vaccines or delays in implementing the CCEOP plan.	Medium	Medium	UNICEF TA will provide a critical supporting role to the EPI program and the NMS to implement the CCEOP. Additional technical assistance to come annually to follow up on EVM progress is included.
Programmatic and Performance Risks:	Medium	Medium	Regular cold chain assessments and inventory updates to track EVM improvement plan progress through UNICEF TA. Development and implementation of systems for quarterly review at province and zone levels to detect problems and make timely responses
Overall Risk Rating for Objective 2	Medium	Medium	
Objective 3 : Health information system and surveillance			

Institutional Risks: Delayed Implementation of DIHS2 effects or delays program implementation.	Low	Low	
Fiduciary Risks:	Low	Low	
Operational Risks: Poor data quality presents major barriers to effective planning	Medium	Medium	Improved partnership mechanisms and development of supportive supervision systems for low coverage areas will lead to improved listing/identification of high risk areas for low immunisation. Increased use of surveys (DHS and EPI coverage surveys) and data quality assessment will improve managements understanding of data quality and population denominators. Strengthening and supporting the continued development of DHIS2 will result in overall data quality for the sector.
Programmatic and Performance Risks: Disruptive changes in information and monitoring protocols can contribute to confusion among implementing staff.	Low	Medium	Effective communication to provinces and zones. Changes would be communicated at national and provincial meetings to ensure uptake, particularly through supportive supervision, quarterly meetings and partnership mechanisms.
Overall Risk Rating for Objective 3	Low	Medium	
Objective 4 Community engagement and partnerships			
Institutional Risks: Lack of formal linkages between NGOs/CSOs hindering partnership efforts	Medium	Medium	Development of formal partnership mechanisms at national province level, and in low coverage zones supported by the Partnership Coordination Unit. Development of guidelines and tools for Provinces to and enter into partnership arrangements.
Fiduciary Risks: Inadequate funding for operations in remote areas limiting the effectiveness of the partnership mechanisms	Medium	Medium	Integration of EPI into provincial corporate and zonal AOPs will enable cost sharing with other programs and funding sources from other sources The partnership mechanisms will enable opportunities for cost sharing between government and NGOs/CSOs to reach shared goal of reaching hard to reach populations
Operational Risks: Absence of a system of partnership restricts capacity for information sharing and joint planning between civil society and government	Medium	Medium	Establishment of partnership mechanisms will enable the development for exploring joint planning, monitoring and communication activities to reach hard to reach populations.
Programmatic and Performance Risks: NGOs/CSOs may have a limited role in immunization services delivery	Low	Medium	Through partnership mechanisms, HSS and HSSP will engage NGOs/CSOs to expand access to immunisation through communications or operational support in high risk communities through grants managed by UNICEF.
Overall Risk Rating for Objective 4	Medium	Medium	
<i>Pooled fund applicants are required to provide any risk mitigation plan under the sector wide/ pooled</i>			

funding mechanism.

The Health Sector Support Programme (HSSP) financing procedure follows the procedures of the Solomon Islands Government as directed by the Ministry of Finance and Treasury. Its main objective is to strengthen the country's capacity for planning and finance management, reduce parallel funding and implementation systems, and strengthen sustainability of revenue whether coming from domestic sources or foreign contributions. Currently, agencies that use the mechanism include DFAT, UNICEF, Joint UN, WHO, Global Fund, EU, FP Australia and the London School of Hygiene and Tropical Medicine (LSHTM). GAVI and UNFPA have been requested to implement programmes through this mechanism to improve financial management. Government ministries including health have several funding pools including a recurrent SIG pool, budget support and developmental budget.²¹

22. Financial management and procurement arrangements

Describe the proposed budgetary and financial management mechanisms for the grant

The Health Sector Support Platform (HSSP) is a joint funding pool managed by the Finance Division of MHMS on behalf of the Ministry of Finance and Treasury. The pool includes joint UN funds, UNICEF and WHO. This SWAp mechanism was created to enhance the government's mechanism in financial management and monitoring. GAVI funds will be under the HSSP for management purposes only, fully earmarked for HSS activities as proposed.

The current mechanism to receive, hold and disburse funds is parallel to the HSSP. GAVI transfers funds to the Central Bank of Solomon Islands that is transferred to the Health Sector Operating Account in the ANZ Commercial Bank. This account also contains all other funds from GAVI e.g. HPV introduction and MR. Accessing and implementing these funds is cumbersome and takes time and additional resources.

The Ministry of Finance and Treasury and MHMS requested GAVI for the HSS funds to be included in the HSSP account. SI Government and MHMS can manage GAVI funding through HSSP. They will need a letter of concurrence from GAVI approving this arrangement for the HSS2 grant. Funds can then be directly transferred to the HSSP bank account. Monitoring and reporting is done regularly and expenditures are itemized for reporting. As already mentioned, this is in line with the purpose of strengthening government mechanisms and to discourage the proliferation of separate funding streams which weaken the country's capacity.¹⁸ The Finance and Accounting Division is also strengthening HSSP's mechanism by recently adding two auditors to the team. Now, expenses can be traced according to source of funds and type of activity.²¹

Programmatic funds are already being downloaded to the provincial level. Currently, RWASH and Malaria programmes are downloading funds to provinces to activities. EPI Unit has also downloaded funds to provinces for conduct of training and other immunization activities.

Under Objective 1, the proposal provides for technical assistance in the first year to ensure that funds are accessed and utilized at the national and provincial levels. This includes access from HSSP at the national level as well as transfer and recording/ tracking at the provincial level. Financial capacity building – add in here

Planning and financial management procedures will therefore be consistent with the standard operational procedures for planning and management of HSSP supported funds. Operational management for the grant will be managed by EPI unit under the guidance of the RMNCAH Division. Procurement of equipment and supplies will be led by the EPI unit in close partnership with the National Medical Stores. Because the grant will be under the HSSP, all finance disbursements and procurements will have to be approved by the RMNCAH Division Director, the MHMS Financial Controller and the MHMS Permanent Secretary.

Describe the main constraints in the health sector's budgetary and financial management system.

The main challenge in the county's financing system is sustainability because of narrowing fiscal space and the

¹⁸ GAVI (2015). Solomon Islands GAVI Alliance Mission: Graduation assessment report and recommendations. June 2015.

large proportion (30% to 40%) of health budget coming from external aid. Refer to Section 18 for Financial Sustainability issues and alternatives in mitigating their impact. The government is improving financing through centralized management under the Ministry of Finance and Treasury (MOFT). Donors are advised to provide aid through government mechanisms including the Health Sector Support Programme (HSSP). The MHMS has recently increased its staff and auditors to improve finance management in conjunction with the MOFT.

Complete the **Budgetary and Financial Management Arrangements Data Sheet** (below) for each organisation that will directly receive HSS grant finance from Gavi.

Provide **Mandatory Attachment #7: Detailed two-year Procurement Plan**

Pooled fund applicants are required to provide relevant documents for financial management and procurement under the pooled funding arrangement

This is not a pooled funding application. The HSSP follows the financial management procedures of the Solomon Islands Government. Funding for the MHMS comes from three pools: 1) SIG recurrent, 2) Budget support where HSSP falls and 3) Development. HSSP plan follows the MHMS Annual Operations Plan which indicates different funding sources for different programmes. In the case of immunization, other sources of funding include UNICEF and Joint UN fund for 2016.

Budgetary and Financial Management Arrangements Data Sheet	
Any recipient organisation/country proposed to receive direct funding from Gavi must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).	
1. Name and contact information of Focal Point at the Finance Department of the recipient organisation.	Ms Yvonne Lipa, Financial Controller (supervising)
2. Does the recipient organisation have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	YES
3. If YES: <ul style="list-style-type: none"> • Please state the name of the grant, years and grant amount. • For completed or closed Grants of Gavi and other Development Partners: Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. • For on-going Grants of Gavi and other Development Partners: Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion). 	Health Sector Support Platform GAVI HSS current grant (reprogrammed 2014-2017) HPV Current GAVI HSS grant is held in an account partly managed by the Finance Division and EPI. It is not included in a common SWAp pool (HSSP) where joint UN, WHO and UNICEF funds are aligned. The plan is for the next grant to be included in the pool. As the current grant was not implemented in 2012-2013, it is important that monitoring and support to ensure that funds are accessed and mechanisms are well understood.
Oversight, Planning and Budgeting	

4.	Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	Dr Divinald Ogaoga, Director Reproductive and Child Health Division, MHMS Ms Jennifer Anga, EPI Unit under the Reproductive and Child Health Division of the MHMS
5.	Who will be responsible for the annual planning and budgeting in relation to Gavi HSS?	Dr Divinald Ogaoga, Director Reproductive and Child Health Division, MHMS Ms Jennifer Anga, National EPI Coordinator, MHMS
6.	What is the planning & budgeting process and who has the responsibility to approve Gavi HSS annual work plan and budget?	Budgets are planned by unit/ programme in-charge, endorsed by the division director and the Permanent Secretary of MHMS, and finally approved by the Ministry of Finance.
7.	Will the Gavi HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	YES, It is currently submitted as part of the Annual Operational Plan.
Budget Execution (incl. treasury management and funds flow)		
8.	What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request.	Ms Yvonne Lipa, Financial Controller, MHMS Dr Divinald Ogaoga, Director Reproductive and Child Health Division, MHMS Dr Tenneth Dalipanda, Permanent Secretary, MHMS
9.	Will Gavi HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	Gavi HSS funds will be transferred to a Central Bank account managed by the Ministry of Finance and Treasury. Upon approval of AOP, this will be transferred to HSSP Account managed by the Finance Division of MHMS.
10.	Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- "pooled account")?	This is a pooled account used by donor partners.
11.	Within the HSS programme, are funds planned to be transferred from national to sub-national levels (provinces, districts etc.)? If YES, please describe how fund transfers will be executed and controlled, including stating what time of year (month/quarter) funding must be received at the national level in order to disburse to sub-national levels in a timely manner.	YES As in the current grant, funds will be transferred to Provincial Health Offices for specific activities e.g. trainings, meetings, supervisory visits, catch up campaigns and advocacy activities. These transfers will be outlined in the AOP set for the year and approved by the MOFT and Finance Division of MHMS. AOPs should be submitted mid-year prior to the year of implementation for MOFT approval. Advance warrant should be sent every 6 months to cover for 6-months activities. This will be approved by the Finance Division of MHMS and will take 1 month for approval. Requisition for budget release may be submitted two weeks prior to activity for actual release of funds.
Procurement		

12. What procurement system will be used for the Gavi HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)	Procurement for CCE and other CC equipment will be done through UNICEF for WHP pre-qualified equipment. All other procurement will be undertaken by the MHMS and the National Medical Stores following SIG procurement rules.
13. Are all or certain items planned to be procured through the systems of Gavi's in-country partners (UNICEF, WHO)?	Yes, all cold chain equipment will be procured through UNICEF.
14. What is the staffing arrangement of the organisation in procurement?	At MHMS there is a director and programme officer with a new recruit incorporating by the end of August. At NMS, the CC manager who directly reports to the NMS director and coordinates with both the EPI coordinator and the RCH director will be responsible for additional procurements such as boats.
15. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES
16. Is there a functioning complaint mechanism? Please provide a brief description.	YES Complaint mechanism will be through the National Medical Stores focal point.
17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES. Dispute resolution is under the responsibility of the National Medical Stores of the MHMS.
Accounting and financial reporting (incl. fixed asset management)	
18. What is the staffing arrangement of the organisation in accounting, and reporting?	HSSP is managed by the Accounts Department of the MHMS. The Division has TA support from DFAT and two accountants overseeing the funds and monitoring. Annual reporting is done and all reports are submitted to the Ministry of Finance and Treasury.
19. What accounting system is used or will be used for the Gavi HSS Programme? (i.e. Is it a specific accounting software or a manual accounting system?)	Accounts Department of MHMS uses MYOB. Planning with MHMS Departments is done through MS Excel.
20. How often does the implementing entity produce interim financial reports and to whom are those submitted?	Reports are prepared quarterly and annually and are submitted to the Ministry of Finance and Treasury.
Internal control and internal audit	
21. Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	YES. The MHMS follows the Financial Instructions issued by the MOFT in 2011.
22. Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will	YES. An Internal Audit Division (IAD) exists within MHMS and can undertake review of Gavi HSS

be involved in relation to Gavi HSS.	expenditure.
23. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	YES. An Audit and Risk Management Committee within MHMS reviews the audit reports submitted from the IAD
External audit	
24. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)? ¹⁹	YES. Annual external audit of Gavi HSS fund is provided in the proposal. It is also implemented annually in the current grant.
25. Who is responsible for the implementation of audit recommendations?	Accounts Department of MHMS

¹⁹ If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget.