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GAVI ALLIANCE

Health Systems Funding Platform (HSFP)

Health Systems Strengthening (HSS) Support

COMMON PROPOSAL FORM

This common proposal form is for use by applicants seeking to request Health Systems Strengthening (HSS) Support from GAVI and/or the Global Fund.

HSS Funding requests to the Global Fund using the Common Proposal Form and Guidelines can only be made when the application materials are launched on 15 August 2011

This form is structured in three parts:

- Part A - Summary of Support Requested and Applicant Information
- Part B - Applicant Eligibility
- Part C - Proposal Details

All applicants are required to read and follow the accompanying guidelines in order to correctly fill out this form.

Part A - Summary of Support Requested and Applicant Information

Applicant:	**Ministry of Health and Medical Services (MHMS)**			
Country:	**Solomon Islands**			
WHO region:	**Western Pacific Region**			
Proposal title:	**Strengthening Health and Community Systems to Improve Immunization Outcome and MNCH (Maternal, Neonatal and Child Health)**			
Proposed start date:	**January 2012**			
Duration of support requested:	**4 years**			
Funding request:	**Amount requested from GAVI:**	**2,399,340**	**Amount requested from Global Fund:**	**N/A**
Currency:	☒ USD		☐ EUR	

Contact details	
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Executive Summary
→ Please provide an executive summary of the proposal.

Background:
The Ministry of Health and Medical Services (MHMS) of the Government of Solomon Islands seeks support from the GAVI Alliance for Health Systems Strengthening (HSS) for the total amount of US$ 2,399,340 over a period of fours years for the remainder of the National Health Strategic Plan 2011-2015. The request amount is based on the country allocation as indicated by the GAVI Secretariat for the Health Systems Funding Platform (HSFP) which was US$0.6 million per year.

Funding is being requested to improve "availability, access, quality and demand of immunization services, IMCI and MNCH" in the country, through working on the supply side of the health systems and on the demand side of the community systems, with a special focus on the highly populated three low-performing provinces of Guadalcanal, Western and Malaita. The HSS goal and objectives were guided by the overarching health goals as laid out in the National Health Strategic Plan (NHSP) 2011-2015, and were fully consonant with the programme policies and strategies including the Solomon Island's National Plan for Immunization (cMYP) 2011-2015, Solomon Islands Child Health Strategy 2011-2015, and National Reproductive Health Policy and Strategy 2011-2013. The proposed HSS activities are expected to contribute to the improvement of immunization outcome of the children and contribute thereby to the reduction of child and infant mortalities in the country. The integrated approach with IMCI and MNCH at the primary health care level and in the outreach services aim to contribute to achievement of Millennium Development Goals 4 and 5.

The HSS funding request through the Health Systems Funding Platform (HSFP) by GAVI, the Global Fund (GFATM) and the World Bank was officially launched in August this year. Following the announcement of the HSFP call for application, an in-country briefing and discussion took place with a facilitation of WHO including a gap analysis of HSS. The HSS concept note for the GFATM/GAVI joint application was presented to the CCM including the key ICC members and was endorsed in October 2011. The Technical Working Group (TWG) for coordination of the HSFP proposal developed was established under the leadership of the Director Public Health involving all the key stakeholders. After the announcement on the cancellation of the Round 11 by the GFATM in November, the proposal was adjusted to focus on the GAVI/HSS part of the funding request only, while the support for the remaining part of the GF/HSS will have to be sought from an alternative partner.

The Solomon Islands is a Melanesian archipelago consisting of over 900 islands situated in the South Pacific east of Papua New Guinea, with a population of about 516,000 and GNI per capita at US$910. Progress towards achieving the MDGs 4 and 5 are notable in the past 20 years although the infant mortality and child mortality rates in the Solomon Islands are still among the highest in the Pacific region, with a high neonatal mortality contributing to it. Health services in the Solomon Islands are largely publicly provided and funded by the Ministry of the Health and Medical Services (MHMS) with 15% of the services provided by the community based organizations (CBOs).

The sector wide approach (SWAp) was launched in 2008 and there are various bilateral and multilateral donors supporting different elements and the programmes of the health sector. Major health systems constraints are still observed in the areas such as weak service delivery especially at the primary care level; lack of sufficient EPI cold chain and other basic equipments; lack of sufficient outreach services and provision of integrated package of care; lack of integrated human resources management and training; and lack of effective health information systems. In addition, health seeking behavior in the Solomon Islands in general is rather passive as often discouraged by the prolonged and costly travel to the health facilities. Following the principles in the National Health Strategic Plan, it is the intent of the Government to strengthen primary health care services without a much scale-up in existing facilities, but with also strengthening of the community systems.

HSS Goal, Objectives and Service Delivery Areas (SDA) with Key Activities:

The goal is supported by the two objectives; the first objective to strengthen the supply side (health systems) and the second to strengthen the demand side (community systems). The goal of hierarchy of planning elements in the proposal submitted is as follows:

Goal: **Improved availability, access, quality, and demand of immunization services, IMCI and MNCH**

Objective 1: **Improved availability, access and quality of immunization services, vaccine cold chain capacity, IMCI and MNCH.**

SDA 1: **Procurement and supply chain management** (US$ 669,500)

The three main activities are provisions of ice-lined electrical fridges, solar powered EPI fridges, and solar powered examination lights to be installed in the facilities with the greatest need for improving IMCH, MNCH and EmONC services.

SDA 2. **Routine data collection, analysis and use** (US$ 138,740)

The main activities include pilot for hospital children wards admissions and discharge recording and reporting; establishment of child death reporting within the national health HIS; strengthening hospital based active surveillance of the vaccine preventable disease and AEFI and strengthening of the M&E system for the national

HIS including those activities under the GAVI HSS proposal.

SDA 3. Service delivery (US$ 813,300)

The main activities include: re-assessing the EPI cold chain, waste management, water and sanitation and facility lighting in collaboration with key partners including UNICEF and WHO, and update the maintenance and replacement plan; strengthening infection control; strengthening planning and implementation of the outreach services for immunization and MNCH package following the RED strategy; conduction of regular micro-planning workshops to increase coverage; and supply of boats for outreach activities.

SDA 4. Health workforce (US$ 268,600)

The main activities include: training of health centre staff in Integrated Management of Childhood illnesses (IMCI) in three provincial training centers; provision of WHO middle level management (MLM) training adapted to fit the need for Child Health Coordinators, EPI managers and Maternal and Reproductive Health managers at provincial and zone level; and annual integrated MNCH and EPI review and planning workshops in each target province.

SDA 5. Stewardship and governance (US$ 20,000)

This SDA aims to ensure effective implementation of the GAVI HSS programme by conducting an annual workshop for the provincial MCH programmes representatives and EPI/cold chain managers on the planned activities and the M&E system in the three piloted provinces.

Objective 2: Increased demand of immunization and MNCH services.

SDA 6. Advocacy, communication and social mobilization (US$ 489,200)

The key activities include: community mobilization on EPI and MNCH through various means by PHS, FBO, CBO, village committees, and other stakeholders – three pilot provinces. Activities would cover all aspects of community demands for EPI and MNCH, e.g. timely vaccination, de-worming, vit-A supplementation for children and pregnant women.

Monitoring and Evaluation:

The achievement of the goal of this proposal will be assessed through the impact indicators which are taken directly from the NHSP 2011-2015, together with the baselines and targets:

1. Under-five mortality rate (U5CMR): baseline 2010: 36/1,000 to target 2015: 29/1,000
2. Infant Mortality Rate (IMR): baseline 2010: 30/1,000 to target 2015: 25/1,000

In addition, the following three outcome indicators will be assessed at the objectives level:

1. By 2015, 90% of surviving infants receiving 3 doses of Penta vaccine nationwide, baseline 78% to 90%;
2. By 2015, 90% of children are fully immunized by 15 months with one dose of measles containing vaccine nationwide, baseline 67% to 90%;
3. By 2015, coverage for all vaccinations is above 80% for the three low performing provinces (NHSP)

There are total six output/programmatic indicators under the total of six SDAs. These indicators are output oriented and specific to the individual activities proposed under GAVI.

1. By 2015, at least 90% of functioning EPI fridges (total and by type & facility);
2. Children wards admissions and discharge recording/reporting running in three Pilot provincial hospitals from Jan 2013 on-wards (Yes/No);
3. By Dec 2013, the methodology for impact of outreach services evaluation in place, utilized and results made available on annual basis (Yes/No);
4. Number of annual integrated MNCH and EPI review and planning workshops (one annual workshop in each of the three target provinces);
5. Annual MNCH briefing and evaluation WS conducted at national level (Yes/No);
6. Proportion of children immunized against HepB at birth in the three targeted provinces (data collected through the monthly returns) N.B. Proxy indicator for healthcare seeking behaviour of pregnant women.

Budget, Financial gap analysis and Value for money:

The total budget of the GAVI HSS proposal is US$ 2,399,340 over a period of fours years, i.e. 2012-2015 till the end year of the current national health plan. Among the total amount requested,
US$ 1,910,140 is budgeted under the Objective 1 on the health systems strengthening to work on the supply side

while US$ 489,200 is budgeted under the Objective 2 on the community systems strengthening to work on the demand side of the proposal. The areas where the financial gaps exist have been identified during the process of a concept note development.

The main beneficiaries under this proposal include all children and women in the country. Following the Reaching Every District (RED) strategy, special emphasis will be given to the three most populated provinces (Guadalcanal, Malaita and Western) which are also identified to have a high percentage of women and children living in the poorest households compared to other parts of the country. The proposed HSS activities therefore aim to bring a high impact to improve health of these women and children.

In the SDA 1 (27.9%) on the procurement, the procurement of the EPI cold chain equipment is following the detailed national assessment and the procurement plan. Use of the solar-power equipments will improve cost-effectiveness. In the SDA 2 (5.78%) on the data collection and analysis, the proposed activities will be conducted as an integral part of the ongoing HIS efforts and will strengthen the national HIS rather than creating a parallel structure. The SDA 3 (34.73%) on service delivery is the biggest expenditure SDA in this proposal as it includes the key activities to improve availability, access and quality of services, such as strengthening implementation of the RED strategy. Conduct of various assessments will strengthen the future planning and improve programme performance. In the SDA 4 (11.19%) on health workforce, the value for money and sustainability of the programmes are being sought by ensuring the integrated approach for EPI, MHCH and IMCI. SDA 5 is about strengthening M & E of this GAVI HSS project. In the SDA 6 (20.39%) on social mobilization, it is intended that enhancing the community awareness and demand through the use of CBOs will improve utilization of the services, thereby bringing in the synergistic effect with the HSS components of the proposal.

Implementation arrangement, Technical Assistance and Risk Prevention:

The Ministry of Health and Medical Services (MHMS) will assume a primary responsible role in the implementation and monitoring of HSS activities supported by the GAVI HSFP, in collaboration with other members of the TWG (Technical Working Group) including WHO, JICA and UNICEF. The lead of the TWG is the Director Public Health and the TWG will operate under the guidance of the ICC (Inter-Organization Coordinating Committee) and the NACC (National Advisory Committee to Children). MHMS is the sole lead implementer in the GAVI HSS proposal and there are no sub-implementers. MHMS will however be responsible for coordination and supervision of the Provincial Health Departments, particularly in the three target provinces (Guadalcanal, Western and Malaita) as well as the relevant CBOs, which will implement community strengthening activities under the contracts with the MHMS.

During the proposed period of the GAVI HSS project, three TA (technical assistance) are being proposed to strengthen the implementation capacity of the lead implementer: in the areas of M&E, EPI programme assessment including cold chain assessment, and assessment of waste management, water supply and sanitation.

The Government of the Solomon Islands has a joint financing mechanism for the health sector and the MHMS follows a defined public financial management procedures and guidelines. The overall governance and the oversight of the GAVI HSS project will be ensured through the MHMS Executive Meetings under the leadership of the Under-Secretary Health Improvement.

Certain internal and external risks, as well as unintended consequences of the proposal have been identified in the area of HR management, recurrent cost, use of the procured items, capability of CBOs, as well as the recent bilateral agreement with Vanuatu on export of nursing staff. Mitigating strategies for those risks have been identified.

Part B - Applicant Eligibility

If this application includes a request to the Global Fund, please fill out the eligibility and other requirements section available here.

If this application includes a request to GAVI, please click here to verify the applicant's eligibility for GAVI support.

Part C - Proposal Details

1. Process of developing the proposal

1.1 Summary of the proposal development process

→ Please indicate the roles of the HSCC and CCM in the proposal development process. Also describe the supporting roles of other stakeholder groups, including civil society, the private sector, key populations and currently unreached, marginalised or otherwise disadvantaged populations. Describe the leadership, management, co-ordination, and oversight of the proposal development process.

Following the establishment of the joint Health Systems Funding Platform (HSFP) by GAVI, the Global Fund (GF) and the World Bank, and after the subsequent launch of the Common Proposal Form with other guidelines by GAVI/GF on the 15th August 2011, an in-country briefing on Developing Strategic Proposals was organized in Honiara, Solomon Islands from 5th to 9th September 2011. This in-country briefing was jointly organized by the Ministry of Health and Medical Services (MHMS) and WHO, with facilitation by the WHO Western Pacific Regional Office (WPRO) and Country Liaison Office (CLO) staff members. In consonant with eligibility of the Solomon Islands for both the GF and GAVI grants, it has been decided to develop proposals for the GF Round 11 HIV component, and for Cross-cutting HSS funding under the GAVI/GF Health System Funding Platform.

As a next step, WPRO organized an "Inter-country Workshop on Developing Strategic Global Fund Proposals for Round 11" on the 30th September in Hanoi, Vietnam. The purpose was to brief representatives of the eligible countries in detail on the processes and new features of the GF R11 and HSFP proposals. Dr Tenneth Dalipanda, Director Public Health, MHSP Solomon Islands attended this workshop.
In the meantime, a concept had been developed for both proposals, GF R11 HIV and CcHSS under the HSFP, respectively (Ref 2, 3). The development of these notes has been carried out in a broad participatory process, led by the MHMS with technical assistance from WHO staff including WHO Technical Assistance (TA) for each of the proposals. During the process, gap analysis and priority interventions were discussed and agreed based on the key national health policies, strategies and assessments.

The concept note on the HSFP proposal was presented to the Solomon Islands National Coordination Committee (SINCCM) on the 27th October, which included the key members of the Solomon Islands equivalent to the HSCC, the Inter-Organization Coordinating Committee (ICC). The concept note for the joint GFATM/GAVI application was collectively endorsed without any objection (Ref 13).

The Technical Working Group (TWG) for coordination of the HSFP proposal development had been constituted through invitations by the Director Public Health to all relevant Government, Private sector, NGOs and CBOs partners. The TWG first meeting took place on the 3rd November, chaired by the Director Public Health, MHMS (Ref 15). The timeline for the HSFP proposal development was agreed at the TWG meeting on the 7th Nov 2011 (Ref 16). The TWG with technical assistance of WHO TA continued to develop and elaborate a workplan, a logframe, the detailed budget and the M&E framework based on the directions set forth in the concept notes. The meetings were held on the following dates: 9th, 22nd of November, and the 5th, 8th, 13th of December (Ref 17-20, Attachment No.11).

1.2 Summary of the decision-making process

→ Please summarise how key decisions were reached for the proposal development.

Under the initiative of the MHMS, the HSS objectives and the key activities have been discussed and agreed during the initial phase of the concept note development. The country's SINCCM and the ICC had agreed that the Solomon Islands would pursue a joint application to both the Global Fund and GAVI using the common HSFP

proposal form. The TWG has been working on the gap analysis in the health and community systems strengthening for addressing MDGs 4, 5 and 6. The overall focus of the original joint application was on rationalization of vertical services in four priority HSS areas including health information, human resources, medical products & vaccines and technologies, and service delivery, with a focus on the integration of HIV/TB/ malaria, EPI and MNCH programmes through the Area Health Centers, Rural Health Clinics, and Aid posts, with community involvement. The HSFP funding request needs to have a delineation of the funding request to GAVI and the GF. Following the GF Board meeting's decision on the cancellation of the Round 11 at the end of November 2011, however, the TWG decided at its meeting on the 22nd November to split the GF CcHSS proposal from the HSFP joint application and continued with the development of the GAVI submission to be prepared with all the necessary requirements before 30 December 2011.

The membership of the TWG had been adjusted to reflect the focus on the GAVI HSFP. It was decided by the TWG that the GAVI HSFP proposal would follow the original overall HSS objectives, but keep its strong focus on the strengthening health systems at the primary health care level for improving immunization coverage and bringing in a broader impact on MCH. The GFATM funding request part of the HSFP proposal would be revisited in 2012 to seek for other potential donors. The last TWG meeting was held on 13th December to finalize the proposals and the required annex (Ref 20). The final set of the draft proposal documents including the narrative parts were circulated to stakeholders involved including UNICEF and JICA and it was endorsed by the ICC meeting on the 14th of December.

The proposal document was also presented by Dr Divinol Ogaoga (MHMS) and discussed at the Special Meeting of the National Advisory Committee to Children (NACC), which is an advisory body to represent the Government, non-governmental and church organizations in the areas of child health (Pls see Attachment 13 - NACC TOR). The special NACC meeting took place on 20 Dec 2011 and recorded its full support to and endorsement of the GAVI HSFP submission (Ref 63 and Attachment 14 – NACC Endorsement).

Ministers of Health and Finance endorsed and signed on 14 and 20 December 2011, respectively (Attachment 6.1).

The final set of the proposal documents was submitted to the GAVI Secretariat on the 28 December 2011.

2. National Health System Context

2.1 a) National Health Sector

→ Please provide a concise overview of the national health sector, covering both the public and private sectors at the national, sub-national and community levels.

2.1 b) National Health Strategy or Plan

→ Please highlight the goals and objectives of the National Health Strategy or Plan.

2.1 c) Health Systems Strengthening Policies and Strategies

→ Please describe policies or strategies that focus on strengthening specific components of the health system that are relevant to this proposal (e.g. human resources for health, procurement and supply management systems, health infrastructure development, health management information systems, health financing, donor coordination, community systems strengthening, etc.)

2.1 a) National Health Sector

Country Background

The Solomon Islands is a Melanesian archipelago consisting of over 900 islands situated in the South Pacific east of Papua New Guinea and north of Vanuatu. It has a land area of about 28,000 square kilometers which has been inhabited by Melanesian people for thousands of years. Solomon Islands is sparsely populated (about 80% rural) with a population density of 13 persons per km2 although parts of the country are relatively densely populated. Gross National Income (GNI) per capita is US$ 910 in 2010 and around 22 % of the population is living below the national poverty line (Ref 47).
Solomon Islands has recently undergone years of major unrest (1998-2003) where much of the infrastructure, including primary and secondary health services were disrupted or destroyed. For more than two years the country was marred by violence between the militants, during which there was serious social and economic decline. Solomon Islands began a process of rebuilding its infrastructure and services, but with fewer resources than ever before. Currently, with assistance of its development partners, Solomon Islands is taking steps to address the underlying problems. Literacy rates among women are lower than for men, due to less access to secondary and tertiary education. Women's access to health and family planning services is particularly poor in rural areas, and infant mortality and child mortality rates are among the highest in the Pacific region, although they have fallen since 1990. Recently major partners have begun supporting the health sector and it is expected further improvements in health indicators will follow (Ref 30).

Selected key background information and health indicators are summarized in the Table 1 below:

<table>
<tr><th colspan="7">Table 1: Country Background Statistics</th></tr>
<tr><td rowspan="4">Population (thousands)</td><td>[Total]</td><td></td><td>515.87 (2009)</td><td rowspan="3">Life expectancy at birth (years)</td><td>[Both]</td><td>67 (2009)</td></tr>
<tr><td>[0-15 years]</td><td>40.6 %</td><td>209.46 (2009)</td><td>[Male]</td><td>67 (2009)</td></tr>
<tr><td>[0-5 years]</td><td>14.8 %</td><td>76.51 (2009)</td><td>[Female]</td><td>69 (2009)</td></tr>
<tr><td></td><td colspan="2"></td><td>Birth registration</td><td colspan="2">80% (2007)</td></tr>
<tr><td>Annual population growth rate</td><td colspan="3">2.3% (2009)</td><td>Total fertility rate</td><td colspan="2">4.6 (2007)
3.4 (Urban)
4.8 (Rural)</td></tr>
<tr><td>Under-five mortality rate (per 1 000 live births)</td><td colspan="3">36 (2010)</td><td>GNI per capita (US$)</td><td colspan="2">910 (2009)</td></tr>
<tr><td>Infant mortality rate (per 1 000 live births)</td><td colspan="3">30 (2010)</td><td>Penta 3 coverage</td><td colspan="2">78% (2010)</td></tr>
</table>

Maternal mortality rate (per 100 000 live births)	143 (2007)	Contraceptive prevalence rate	27.3% (2010)
Annual birth cohort	18,309 (2010)	Surviving infants	17,759 (2010)

(Sources: Solomon Islands Child Health Situational Analysis 2011 (Ref 45), WHO Country Health Information Profile 2011 (Ref 30), WHO/UNICEF Joint Report Form 2010 (Ref 11), WHO EPI Country Poster 2010 (Ref 5)

Epidemiological Profile

The Solomon Islands is in a phase of epidemiological transition. The country is also dealing the “double burden of disease” while the communicable diseases is still prevalent (malaria, ARI, diarrhoea, TB, STI, etc) and the increasing incidence of noncommunicable diseases and risk factors, with limited resources for health, poses a major challenge for the country. Disease burden in terms of DALY score is 20,053/100 000 population; and DALY per person of 0.20. (Ref 29, 30)

Progress has been made in malaria control in the recent years. Malaria incidence rate was reduced to 77 cases /1000 population in 2009 but with still regional variations. The National TB Programme is progressing well with its implementation at both provincial and national levels. TB incidence rate 180/100 000 in 2009 and has achieved the cure rate of 82%, while the detection rate still remains 46%. As regards HIV/AIDS, Solomon Island has had 17 diagnosed HIV/AIDS cases since 1994, although considerable underreporting is suspected. WHO estimates the number of HIV positive people in country could be as high as 350. There is a high incidence of Sexually transmitted infections (STIs), coupled with consistently low rates of condom use, which is regarded as a potent combination of biological and behavioral factors that contribute to HIV transmission.
Although infectious diseases are still the major causes of morbidity and mortality, there is some evidence that noncommunicable diseases (NCDs) such as cancer (cervical and breast cancers are reported to be the most common, followed by lung cancer), cardiovascular diseases, diabetes mellitus, hypertension, tobacco-related diseases and mental illness are increasing. High rate of overweight and obesity are also one of the major risk factors for NCDs. Other major public health concerns include: alcohol and substance abuse; adolescent pregnancies, injuries and trauma caused by gender based violence (GBV) (Ref 30).

Progress in achieving MDGs 4 and 5

Infant mortality and child mortality rates in the Solomon Islands are among the highest in the Pacific region with a high neonatal mortality, although they have fallen since the 1990 benchmark. Measuring progress towards achieving the Millennium Development Goals (MDGs) in Solomon Islands is very difficult due to a lack of agreed upon MDG health targets for 2015 and reporting issues. Various documents discuss MDG progress and Solomon Islands appear to be slightly off track for meeting MDG 4 (reducing by two thirds the under-five mortality rate, between 1990 and 2015) although will most likely meet the associated infant mortality rate (IMR) target. Nutritional status is intimately linked with child health and it appears that there is good progress in improving child nutritional status with the MDG 1 2015 target already achieved. However, it must be noted that one third of Solomon Island children are stunted (low height/length for age), which is a measure of chronic malnutrition. In addition almost half of children under 5 five are anaemic. It needs to be also highlighted that the neonatal mortality accounts for 41% of all the under-five mortality and 63% of infant mortality. With regard to immunization coverage, the national coverage for pentavalent vaccine, OPV and BCG are generally high, but the reported coverage for TT2, measles and Hep B birth dose are relatively low (See Section 2.3) The current reported coverage for the first dose of measles is around 67%, slightly lower than the 1990 benchmark of 70%, however, data accuracy is a problem and the actual coverage may not be as low as the reported figure (See Section 2.2) (Ref 45)

MDG 4: Reduce child mortality	1990 Benchmark	Most recent available	2015 Target	Progress
Target: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate				
4.1 Under-five mortality rate (per 1,000 live births)	73	36	29	
4.2 Infant mortality rate (per 1,000 live births)	66	30	25	
4.3 Proportion of children under 1 year immunized against measles	70%	67 %	90%	

MDG 5 (Improving maternal health) is on target for MDG 5a (reducing maternal mortality) with a substantial decline in maternal deaths since the early 1990's. Reducing maternal death, however, is very time sensitive. Of the 5 major causes of maternal death, two of them normally require that a mother be transported to emergency obstetric care facilitates. But in light of the country's limited transport infrastructure by boat and its associated high cost, it is predicted that bringing down the MMR faster will be a challenge. The proportion of births attended by a skilled birth attendant is relatively high (85%) although there is a variation among different social, economic and geographic groups (see Section 2.2). (Ref 45)

MDG 5: Improve Maternal Health	1990 Benchmark	Most recent available	2015 Target	Progress
Target 5a: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio				
5a.1 Maternal mortality ratio (per 100,000 live births)	549	143	120	
5a.2 Proportion of births attended by skilled health personnel	85%	85%	90%	

Organization of Health Services

The Ministry of the Health and Medical Services (MHMS) is the major provider of health services in the Solomon Islands. The publicly funded health system operates at the at three administrative and service delivery levels. The central level is the Ministry of Health and Medical Services (MHMS) and the National Referral Hospital, including referral diagnostic services. Below the central level, there are the Provincial Health Departments and nine Provincial Health Hospitals.
The levels of formal health system in Solomon Islands include (Ref 38):

- National: Ministry of Health and Medical Services (includes the National Referral Hospital and National Medical Store);
- Provincial: Honiara City Council (HCC) plus and Provincial Health Departments. The latter run and/or oversee a total of ten hospitals in 9 provinces (Including NRH);
- Area or (Medical) Zone: Area Health Centres (AHC: n=38 including four Urban Health Clinics). AHC is the highest level primary health care clinic, typically staffed by five health workers (registered nurses or nurse Aids) and provide basic outpatient and inpatient care;
- Rural Health Centre (RHC) (n=102) / Nurse Aid Post (NAP) (n=187): RHCs generally have two staff, while NAPs are small clinics staffed by one nurse aid. Officially NAPs are under the supervision of the nearest RHC, however in practice both are often overseen directly by the AHC.

Figure 1. shows the organogram of the Ministry of the Health and Medical Services (MHMS):

The current organogram of the MHMS is shown in the Figure 1 below:

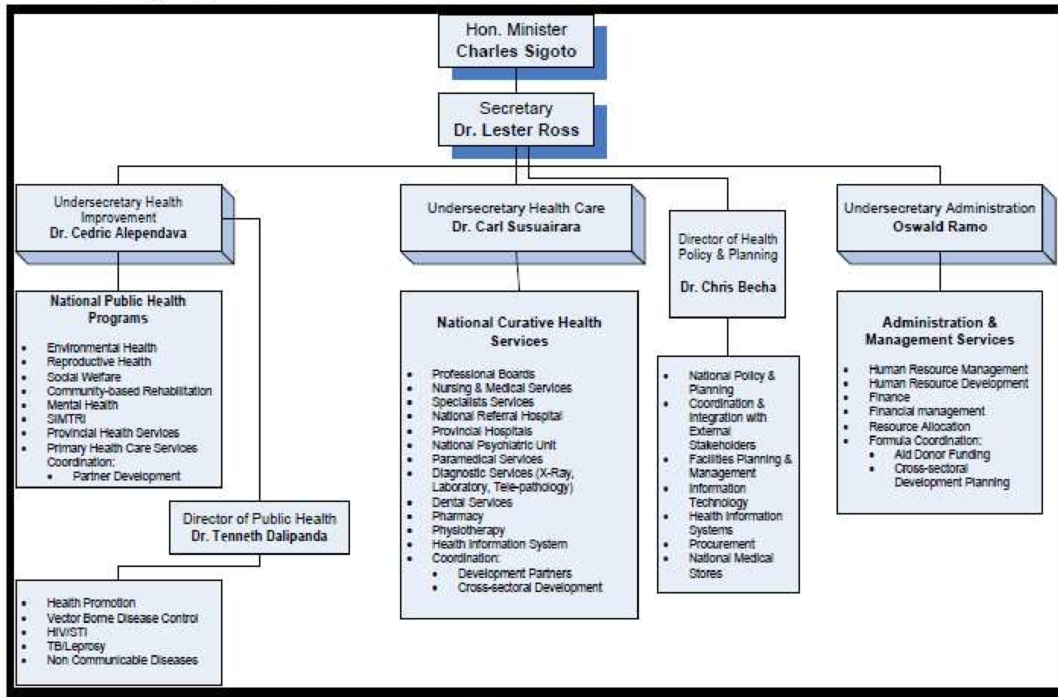


Figure 1

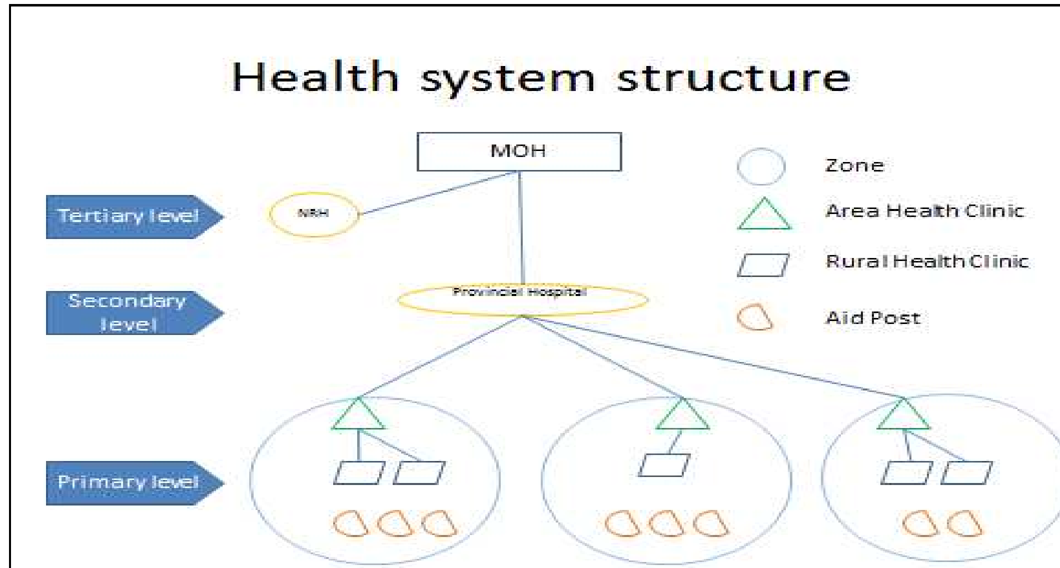
(Source: National Health Strategic Plan 2011–2015, MHMS, Ref 35)

PHC clinics in the public sector are the main providers of health care nationally, apart from small numbers of private practitioners. Private health practice is limited to the capital Honiara and there are total 10 facilities. These facilities have not been included in the national health HIS, so the information about privately provided services is limited. Decentralisation is at an early stage and the Provincial Health Departments have limited control over planning and implementation of provincial health services. This is particularly true for disease specific programs with large external funding such as malaria, TB and HIV programs.

Other faith-based organizations (FBO) and NGO's provide less than 15% of outpatient and inpatient services of the country. Significant proportions of the funding for the services of these FBO's and NGO's is provided by the Government through the MHMS, and the MHMS accounts for these services in their planning and overall management of the health sector. As a result, there is little overlap of FBO and NGO services with the MHMS.

As shown in Figure 2, the primary level constitutes of a network of health clinics with different levels of staffing, equipment and infrastructure according to the services they are expected to deliver. A province is divided administratively into zones which are equivalent districts in generic terminology. Each zone has one or several Area Health Centres (AHC). Below the AHC are the Rural Health Centres (RHC). The most peripheral health facilities in the primary level of the health system are Nurse Aid Posts (NAP). The network of primary health care clinics (AHCs, RHCs, NAPs) are the main providers of immunization services along with other primary health cares services such as acute care outpatient services, maternal care (antenatal visits, births and post natal care) and child health services (growth monitoring), outreach satellite clinics, health education and inpatient services (with the exception of hospital outpatient clinics which would admit directly to the provincial or national hospital). These primary health care clinics are also responsible for organizing outreach activities which include village meetings, school visits and conducting mobile satellite clinics. However, the increasing construction of NAPs has reduced the need for mobile satellite clinics. About three-quarters of the population (74.3%) lives within one hour's travel time from the nearest health facility, which for most is either AHC or RHC.

Figure 2:



There is a proposal for reclassification of the facilities in the primary level of the health system which, if adopted, it would classify AHCs into AHC level 1 (smaller facility without in-patients) and larger AHC level 2 facilities with capacity for admissions and in-hospital care. RHCs and NAPs would be re-classified to RHC Level 1 and RHC Level 2 of which RHC Level 1 would include the NAPs. The government run health facilities are being currently reclassified as follows:

AHC 1: Catchment population 3000-5000. Minimum staffing; 1 MW, 1 RN and 1 NA

AHC 2: Catchment pop. 5000-10 000. Minimum staffing 1 MW, 2-3 RNs and 2 NAs

RHC 1: Catchment population 500-1500, 1 RN or 1 NA

RHC 2: Catchment pop. 1500-3000, 1 RN, 1 NA

Health Care Financing

Health expenditure in the Solomon Islands is predominately paid for by the government, which funds them mainly from general revenues with substantial support from external donors. Total health expenditures (THE) in 2008 was 5.2% of GDP. Out of the THE, the general government health expenditures was 93.4% while the out-of pocket payment consisted 4.4% and other private sources 2.2%. External resources for health were 33.5% of THE- mainly from Australia, Japan and New Zealand. In the Solomon Islands, both general outpatient and inpatient services are provided free of charge. User fees are charged for specific services such as dental care, radiology and laboratory services, speciality outpatient clinic visits, etc. There is a private health insurance scheme but its contribution to the total health expenditures is minimum. (Ref 10) In general, resources are concentrated at the central level including in clinical/curative services. MHMS is known to be "top heavy" with 64% of funding held at the central level in 2010. The health budget per capita in 2010 is about US$ 120 (Ref 10).

Human Resources for Health

To meet the needs of the National Health Strategic Plan 2010 – 2015, a Human Resource and Workforce Plan (2011) (Ref 52) has been created, which concentrates mainly on a "Provincial Staffing Model" linked to role delineation of facilities in the Provinces. The Plan does not address the long term staffing position of the National Referral Hospital or that of the staff based at HQ who provide a National service. The approach adopted for developing the plan was to use a Service Targets approach which seeks to standardise the staffing provision across the Provinces according to the type of facility.

Based on the latest analysis in the Human Resource and Workforce Plan, there is currently 2,734 staff engaged in health in the Solomon Islands. Of these some 2,686 are paid for by the Ministry either as seconded or through the Provincial Grant. Of this some 1,658 are employed in the Provinces. The table 2 below shoes the total numbers and the breakdown of different health staff categories:

TABLE 2 - ANALYSIS OF ALL STAFF WORKING IN HEALTH in the SOLOMON ISLANDS									
	2011 Budget Establishment								
	M & D	**Nurses**	**Nurse Aides**	**Prof**	**Prof Helper**	**Admin**	**ASC**	**TOTAL**	**%**
HQ staff + Mental Health	12	138	27	111	1	46	94	**429**	16%
Donor funded	0	0	0	10	0	5	15	**30**	1.1%
NRH	103	254	86	87	14	18	57	**619**	23%
Provinces - MHMS	35	496	0	290	7	17	4	**849**	31%
Provinces - DWE[1]	3	34	411	70	104	40	127	**789**	29%
NGO's & Private Funded	0	9	8	1	0	0	0	**18**	0.7%
TOTAL	**153**	**931**	**532**	**569**	**126**	**126**	**297**	**2734**	
Staff %	6%	34%	19%	21%	5%	5%	11%		

(Source: Human Resource and Workforce Plan, 2011 (Ref 52) & MHMS 2010 Annual Report (Ref 39)

The Provincial Staffing Model was developed over a four month period between Sept – Dec 2010. This Model seeks to identify each type of staff assigned to the designated facilities or a Province wide and public health function. The comparison between the existing staffing and the Model suggests that there is a current imbalance staffing numbers of some 19 posts which represents 1% of the total staffing in provinces. However within provinces there are differences. Three provinces (Honiara, Guadalcanal and Temotu) stand out as having more funded posts than the Model suggests. Three Provinces are close to their target (Western, Central and Malaita). Four provinces (Isabel, Makira, Choiseul and Renbel) are below the model target. Renbel's position is probably the most anomalous in that were it not a designated Province it would not attract the Province wide health staff numbers (Ref 52).

2.1 b) National Health Strategy or Plan

The Solomon Islands have the basic mechanisms in place for sector planning, resource allocation and coordination following the new National Health Strategic Plan (NHSP) 2011-2015 (Ref 35), which was developed as informed by the National Development Strategy for 2011-2020 (Ref 31). There is clear country ownership of the National Health Strategic Plan, supported by a Medium Term Expenditure Framework (2011) (Ref 42). A formal agreement between the Ministry of Health and Medical Services (MHMS) and its development partners (DPs) is in place. The Ministry leads policy development and implementation. All external support is aligned to a shared national sector policy/strategy. While significant funding is channelled through national systems, only AusAID provides un-earmarked budget support. DPs, including AusAID, also provide earmarked budget support through the 'Sector-wide Approach (SWAp) account' and/or project assistance (Ref 49).

The National Health Strategic Plan 2011-2015 (Ref 35) conforms to the central Government's policy statements for health. The NHSP outlines the current national health problems and the proposed response to these issues through the adoption of one major goal: "The Solomon Islands' population health status will improve overall by between 1 and 2 percent by 2015". To achieve this, the Government has identified a set of eight priority programmatic and fourteen organizational priorities. The first category of priorities is "substantive" – those policies which relate to the programmatic and technical aspects of health and medicine. The second category consists of "organizational" policies, which deal with how the MHMS is structured, its operational processes and procedures, its management, and its functional relationships with other government and non-government organizations. (Ref 35). The National Health Strategic Plan has defined a core set of indicators which cover the entire health system. There is generally one indicator for each major program area or significant disease.

The NHSP recognizes that there are six strategic options: (i) Do altogether new things; (ii) Do more of what you are already started doing; (iii) Do what you are doing better; (iv) Diversify what you are doing; (v) Do less of what you are doing; or finally (vi) Reassign/collaborate to/with other to undertake the function/activity. The primary strategic focus of Ministry of Health and Medical Services (MOHMS) is to "Do Better" – which implies that the policy and a set of activities exist and that they will be qualitatively improved. Given the above, the Government is planning to improve services mostly within existing community services and through existing facilities without a major scale up in the infrastructures or change in the systems.

The operationalization of the NHSP and its realization on the ground is supposed to work through a set of operational plans – both National Programs and Provinces. Therefore, this overall strategic plan will be "married" to some two dozen or more Program, Province, and MHMS divisional or unit plans. The one strategic plan and the other 2 dozen plans will continually interact – monthly, yearly, and over the life of this 5-year plan period.

Using the NHSP and these strategic options as a guiding framework, the TWG HSS for the HSFP application has sought further guidance on the following key programme plans, i.e. the Solomon Islands National Plan for Immunization 2011-2015 (2010) (Ref 38), the Solomon Island's Expended Programme on Immunization (EPI) policy 2008 (Ref 44), the Solomon Islands Child Health Strategy 2011-2015 (2011) (Ref 34); and the National Reproductive Health Policy and Strategy 2011-2013 (2010) (Ref 46). All of these policies and strategies were informed by the NHSP and provide further guidance on the health systems strengthening efforts in realizing the immunization outcomes and the MDGs 4 and 5. Details of these policies and strategies will be discussed in the following section 2.1 c).

2.1 c) Health Systems Strengthening Policies and Strategies

This proposal for the GAVI funding from the Health System Funding Platform contains planning elements (goals, objectives, service delivery areas and activities) which would support four of the Substantive policies (namely Nos. 1,2,6,7) and three of the Organizational policies (Nos. 1,4 and 10) of the **National Health Strategic Plan (NHSP) 2011-2015** (Ref 35), as per the list below:

Relevant Substantive Policies under the NHSP

1. The health sector and some health-related sectors, especially education, will reduce the most important individual and family behaviour-related risk factors through health promotion and some prevention services;
2. The health sector and health-related sectors will reduce the most important causes of the disease burden which are feasible to reduce with cost-effective interventions and services;
6. The health sector will gradually move toward the "packaging" of health services with "levels of care" as the dominant approach;
7. The health sector and health-related sectors will improve the health status of the age and gender population groups especially women and children considered to be the highest priorities;

Relevant Organisational Policies under the NHSP

1. MoHMS; MoPS; and MoFT will focus efforts to better and more completely integrate human resource (HR) planning, production and development; HR Management;
4. Decentralise decision making to Provinces & cooperate with Provincial Governments;
10. Collaborate with Central agencies; other Ministries;; NGO, FBO's, Communities & community-based organisations (CBO's) and traditional healers;

Using these substantive and organizational policies under the NHSP as an overarching guiding framework, the TWG have sought further technical guidance on the following key programme plans, i.e. the Solomon Islands National Plan for Immunization 2011-2015 (2010) and the Solomon Island's Expended Programme on Immunization (EPI) policy (2008), the Solomon Islands Child Health Strategy 2011-2015 (2011); and the National Reproductive Health Policy and Strategy 2011-2013 (2010), as indicated in the previous section. The broad goals and the strategic objectives under each policy or plan are identifies as below:

Solomon Island's Expended Programme on Immunization (EPI) policy (2008) & Solomon Islands National Plan for Immunization 2011-2015 (2010) (Ref 44,38)

The National Plan for Immunization is a comprehensive Multi-Year Plan for Immunization of the country following the seven objectives as set out in the EPI Policy. The HSFP proposal to GAVI has been informed by these national plans, and the proposed HSS activities will contribute to the achievement of the goal and all the objectives as laid out in the EPI Policy and the cMYP.

Goal:
The aim of the EPI in the Solomon Islands to improve infant, child and maternal survival and health by controlling or eliminating targeted vaccine preventable diseases

Objectives:

1. To protect every newborn, child, pregnant woman from vaccine preventable diseases with the use of safe, appropriate and potent vaccines.
2. To have over 90% of children fully immunized by 15 months with one dose of Hepatitis B birth dose, BCG and Measles vaccine, and three doses of Pentavalent Vaccine (DPT-Hepatitis B-Hib, PENTA) and Polio vaccine by the year 2010.

3. To have over 95% of children receiving 2 doses of measles containing vaccine by the time of school entry.
4. To have over 90% of infants receive their first dose of Hepatitis B vaccine within 24 hours of birth.
5. To promote better access and utilization to immunization services by the population and ensure that there are adequate supplies of safe and potent vaccines, Auto-Disable syringes and safety boxes, and other cold chain materials at the point of immunization service delivery.
6. To provide safe immunization using vaccines that have been stored and transported at the recommended temperature and are correctly prepared and administered.
7. To monitor and evaluate immunization program performance annually.

Solomon Islands Child Health Strategy 2011-2015 (2011) (Ref 34)

The HSFP proposal to GAVI has been also informed the newly developed Child Health Strategy, and the proposed HSS activities will contribute to the achievement of both the goal and the two objectives as laid out in the Strategy.

Goal:

1. Under five mortality reduced to 29 per 1000 live births by 2015
2. Neonatal mortality reduced to 11 by 2015
3. Prevalence of underweight among children under five reduced to 5% by 2015
4. Prevalence of stunting among children under five reduced to 10% by 2015

Objectives:

1. To improve overall reproductive, maternal, newborn and child health status and key indicators by 2015
2. To strengthen health worker competency to provide good quality reproductive, maternal, newborn and child health services.

National Reproductive Health Policy and Strategy 2011-2013 (2010) (Ref 46)

The HSFP proposal to GAVI has been also informed by the National Reproductive Health (RH) Policy and Strategy, and the proposed HSS activities will contribute to the achievement of the goal and the objectives of the RH Policy, particularly the objectives 2 and 4 as below.

Goal:
The goal of the national reproductive health strategy is 'Reproductive health and rights for all Solomon Islands women, men and young persons'.

Objectives:

2. All infants and children have access to both curative and preventive paediatric services to protect and safeguard their health, with particular reference to the most common causes of infant and childhood morbidity and mortality, including respiratory illness, diarrhoeal diseases and malnutrition.

4. Improved pregnancy and neonatal outcomes by making quality maternal and newborn services more available and accessible.

2.2 Key Health Systems Constraints

→ Please describe key health systems constraints at national, sub-national and community levels preventing your country from reaching the three health MDGs (4, 5 and 6) and from improving immunisation, and from improving outcomes in reducing the burden of (two or more of) HIV/AIDS, tuberculosis and malaria. Include constraints particular to key populations and other unreached, marginalised, or otherwise disadvantaged populations (including gender related barriers).

Overall, the picture across the health sector is one of slow progress in building capacity of the core systems needed to support service delivery. Health services are used by the population to various degrees. The ambitious Health Plan promises greater attention to primary level over hospital services, prevention and promotion over curative care, and a shift of resources and authority from the centre to the provinces.

As stated in the NHSP, health staff at primary level facilities defined the following issues with their work and working environment: most staff have no job descriptions; health facilities without water or toilets; there is little implementation of infection control procedures; most facilities have no incinerator; there is a significant number of facilities without sterilisers; few facilities are using stock cards for control of medicines and supplies; there is a range of fees charged for patient services with no standardization even within the same province and with a lack of

transparency in management of fees collected; there is a wide variation of diagnostic and standard treatment manuals available; the majority favoured public health programs/health promotion staff being moved to Area Health Centre level (Ref 35).

There have been substantial efforts to strengthen critical elements of the health system, notably planning and budgeting; financial management and accountability; procurement and management of essential medicines, human resource planning and management and health information systems. These have had varying effects in building capacity and in improving business processes with most progress in planning, finance and least in health information systems (Ref 49).

During the phase of a concept note development and a subsequent gap analysis through a participatory approach involving all partners and civil societies, the four priority areas of cross-cutting HSS approaches were identified focusing on the primary health care level where the CcHSS funding would be most cost effective, namely:

1. Service Delivery.
2. Human Resources,
3. Medical Products, Vaccines, and Technology
4. Health Information,

The goals, objectives and Service Delivery Areas were formulated in the original GAVI/GF proposal for these four key areas. As noted in section C1.2 the original joint proposal had to be modified and split into the two parts; i.e. a funding request to GAVI through the HSFP application and the original GF part of the proposal to be used to inform a future cross-cutting HSS planning and resource mobilization for the Ministry of Health and Medical Services (MHMS).

Service Delivery

The Ministry of Health and Medical Services (MHMS) continues working on the Government policy of decentralization for planning in selected priority Provinces to strengthen health systems at the primary level. The role delineation and the standard packages of services in the primary, secondary and tertiary level have not been finalized yet along with the decentralizing planning process to the Primary level. However, the work is in progress (a national workshop took place in 14 – 16 Nov 2011) and the role delineation is expected to be formulated soon, with subsequent incremental implementation.

Currently no reliable data is available on access and utilization of services at the primary care level. Information on the people's preference in service delivery is now known either. National estimates show that the service utilization of outpatient visits is 1.9 per capita (2010) but the benchmark is yet to be established (NSHP). Health seeking behavior in the Solomon Islands in general is rather passive as the visits to the health centers often require prolonged and costly travel for people due to the geographical reasons. In addition, outreach services for those that are hard to reach are not sufficient, and only about 5% of the total population is served by the outreach services (Ref 5). This is a major cause of the lower health service delivery coverage in hard to reach areas.

The data from Solomon Islands Reproductive Health Surveillance System suggests that in 2004, 70% of pregnant women had four or more antenatal visits during their pregnancy, with only 12.7% of women reporting no antenatal care. Almost 85% of the delivery took place in health facilities and 55% of women received a postnatal visit within 1 week of delivery. Although the overall services utilization for MNCH services seems good, the disaggregated analysis of the deliveries with skilled birth attendants suggests that women's access to health and family planning services is particularly poor in rural areas and among certain vulnerable groups. There are clear differences by wealth quintile, mother's education, rural or urban areas and by provinces. Guadalcanal has a relatively low rate (69%) followed by Malaita (81.5%), and could benefit from province specific targeting (Ref 45). Within the provinces, the targeting on the poorest and the least educated mothers will help in improving the rate of skilled birth attended deliveries.

The national data shows that there is also an association between the child survival in the Solomon Islands with a mother's educational level and the income level of the households, as shown in the wealth quintile (Ref 45). According to the national estimates, the leading direct causes of early childhood death in the Solomon Islands are neonatal conditions followed by pneumonia, other infections, malaria, other infectious and non-communicable diseases. As for young children, an acute respiratory infection (ARI) is the most common reason for seeking health care. It implied that a proper case management of neonatal conditions, ARI and treatment of pneumonia as a part of the IMCH package at the primary care level is essential factor to reduce child mortality.

The package of services in the Area Health Centres however has not been identified along with the decentralising planning process to the primary level. Some programmes such as MNCH have developed initiatives for integrated planning to take place by including all services related to their programme. It was found that these services at primary level do not have processes to coordinate or collaborate. Therefore integration of these services at primary level will show substantial savings (e.g. removal of duplication of administrative services) which can be used for technical aspects of the programmes. There would also be enhanced delivery of services by the

registered nurses at the primary level through rationalisation of nursing services.

Infection control is generally poor, with most health facilities lacking waste disposal means. A review of cold chain, waste management, water and sanitation and facility lighting is needed and planned under this proposal. The preliminary assessments suggest that there is a strong need to strengthen all the aspects of the infection prevention and control in most facilities.

Human Resources

The need for integrated human resource (HR) Management, i.e. HR planning; production and development is the highest priority among the organizational policies in the NHSP. The legal situation for all levels of health workers to deliver vaccines, rapid testing, counselling and any new requirements in their practice needs to be reviewed for their protection and delivery of safe services. It is concerned that there is no scope of practice for the health workers for delivering the package of integrated Sexual/Reproductive health, HTM and MNCH services under the current regulations.

The HR workplan (Ref 52) identified certain constraints on implementation of the plan in the following areas: 1) over-production of health workforce beyond the absorptive capacity of the health sector; 2) lack of supply in certain professional and technical groups such as pharmacists; 3) lack of in-country educational institutions' for basic qualifications; 4) insufficient investment in radiology, pathology and partially nursing; 5) loss of medical staff from the public sector due to the ethnic tension in 2004 – 2007 and the development of a private hospital; 6) difficulty balance in devolving resources to the Provinces and meeting the immediate urban needs in Honiara; 7) lack of unified schemes of services which lead to unequal pay and conditions among health workforce, depending on the status of the posts; 8) unstable status of medical staff who are directly paid by the provinces (direct wage employees: DWE); 9) fragmentation of HR structures due to the posts at the Ministry which have been funded by donor funds on fixed term contracts with the Ministry, mostly through the Global Fund, the Secretariat of the Pacific Community (SPC) and the Health Sector Strengthening Project (HSSP); 10) MHMS poor performance in recruitment of staff; 11) absence of staff accommodation in most communities; and 12) ability or lack of addressing poor performance of staff in the workplace by the MHMS.

Medical products, vaccines and technologies

The cold chain is difficult to maintain and repair due to lack of resources (power/gas) and training of staff. UNICEF and JICA are providing support for solar cold chain which is yet to be fully implemented. It is expected that there will be more need for maintenance and repair training for the appropriate staff in during the next four years.

UNICEF has also provided technical assistance to MHMS for many aspects of cold chain and management of vaccines. However the training on vaccines management does not extend to the primary level of service. According to the latest situation analysis, 35 % fridges are not functioning. This figure improved over the last year thanks to the support for maintenance by UNICEF and JICA.

The current policy, procedures and guidelines for waste management and measurement of vaccine quality has not been fully implemented due to lack of support for the implementation phase.

Health information

Health information system in the Solomon Islands is an almost entirely paper-based reporting system. In the last two years the Ministry's health information system (HIS) has not produced aggregate numbers or any analysis as a result of the past database being re-programmed. This created an excuse for no routine health information outputs in summary form to be produced either for provinces, programs, or the Ministry as a whole. Nevertheless health information in the provinces and at NRH was collected manually through the Monthly Return Form (Ref 50).

This form represents the HIS backbone, submitted by all 328 health facilities in the 5-layered public health services delivery system (hospitals down to aid posts). The overall monthly return rate is encouragingly high, close to 90%. The hard copies (triplicates) move from the reporting health facility to the provincial health department and on to central MOH. The reports from the facilities disaggregate age and sex. The information is entered into spreadsheets at provincial level, but the electronic file is not exported to national level. Instead, the third copy is entered into spreadsheets at central level resulting in double entry. No report was produced for 2009 and an abbreviated report was produced for 2010. The reports are not published online and access is therefore limited for disease-specific programs, NGOs and international development partners (Ref 22, 48).

It is therefore difficult to measure progress towards health related MDGs 4, 5 and 6 targets in the absence of reliable data. The absence of a shared set of common indicators to track sector performance and the failure to produce reliable national health data over the past two years means that neither MHMS nor its development partners are to track the status and progress effectively.

Other example of the problem in HIS is about the coverage estimates. The current coverage of measles vaccinations are around 67% but this is from data that is not reliable due to problems with the forms for the data, collection and entry of data, haphazard analysis and incomplete data from all sources. This may mean that the coverage may be higher or lower than this data (See Section 2.1.a) and other data on general population is

lacking in efficacy.
There is also a problem to have an accurate birth cohort estimate. The HIS captures birth notification from the facility deliveries, assisted home deliveries and non-assisted home deliveries reported to the health center. It is estimated that the HIS is capturing about 87% of actual births. As the registration of births and deaths (vital statistics) is done outside of the HIS and not formally linked to the HIS birth notification, neither systems is complete enough to produce a reliable birth cohort denominator for health statistics. The inaccurate population denominators poses a challenge for EPI and other child-targeted interventions to assess its coverage and for the entire health sector to monitor its performance.

Population-based causes of death are not available and the HIS of the Ministry of Health and Medical Services (MHMS) only has data for primary health care and this data is incomplete. There is no data for hospital admissions/discharges except that stored in Medical Records in hard copies and not analysed. There is very limited data on vaccine causes of admissions or deaths. There needs to be more comprehensive coordination and strengthening the data collection systems in the MHMS clinics and those supported by churches or NGO and the private sector. Graphs and other basic analysis of the data received are done in basic fashion on a yearly basis and are rarely used as a basis for planning and surveillance data is very limited.

2.3 Current HSS Efforts

→ Please describe current HSS efforts in the country, supported by local and/or external resources, aimed at addressing the key health systems constraints.

Despite the long distances between the countries many islands, the poor and limited road network and the scattered low-density population, primary health facilities are remarkably accessible and used by most people. Within the overall budget envelope for health, malaria, TB, water and sanitation programs, and the National Referral Hospital are considered to be relatively over-financed while provincial health budgets are considered underfinanced. The Medium Term Expenditure Framework (MTEF, Ref 42) projections assume that real but not per capita allocations will be maintained from now to 2015 and that development partners will provide and increasing proportion of support as health sector budget support.

Partners supporting HSS

The MHMS is working in close collaboration with many other Partners in Health and stakeholders, be it Development Partners, Global initiatives including the Global Fund and GAVI, NGOs, CBOs, FBOs and private sector.

The table below is not exhaustive but a list of all the stakeholders in Solomon Islands but it shows key partners involved in the areas of health system development, service delivery and community services:

Agencies	Areas of support
AusAID	As the largest development partner of MHMS, involved in the Health Sector Strengthening Project (HSSP), providing support for HSS as well as for vertical programmes (HIV, MCH, Malaria, Water and sanitation)
JICA	Supporting HR, cold chain, training on maintenance and repair, community-based health promotion, waste management (excluding hazardous waste)
EC	MDG Intervention funding (not yet approved)
UNICEF	Supporting EPI (cold chain, vaccines, training) and PMTCT, VCCT, WATSAN, social welfare, support to MDGs 4, 5, 6 and 7
UNFPA	Safe motherhood & adolescent health, gender based violence
WHO	Support for SWAp, HSS, and all health related MDGs
SPC	HSS and HIV/AIDS, TB, Malaria (Global Fund)
Global Fund	Round 8 Cross-cutting HSS support (laboratories and human resources)
GAVI Alliance	Support to pentavalent vaccine 2008-2015
NGOs and FBOs under the service agreements between MHMS	
ADRA	CSS (Community systems strengthening)
Save the Children	HIV/AIDS
World Vision	WATSAN (Water and sanitation)
Other FBOs, NGOs, CBOs	
Anglican Women's group (St Isabel province)	Malaria – advocacy on mosquito nets distribution
Christian Care Center, Family Support Centre, Voice Blong Mere (VBMSI), SI Christian Association Federation of Women	Gender based Violence (GBV)
Solomon Islands Parenthood Planning Association (SIPPA)	Family planning

Health Sector Support through the Sector-wide Approach (SWAp)

The Solomon Islands' Sector Wide Approach (SWAp) was launched in 2008 and is at an early stage of implementation. A mid-term review conducted in 2011 concluded that the basic mechanisms for sector planning have been put in place and that the Ministry of Health has strong ownership over the Health Strategic Plan and has taken a lead in policy development and implementation. Joint coordination and review mechanisms between MHMS and development partners have been developed in the form of annual National Health Conferences and Joint Performance Reviews. The health budget has increased substantially since 2007 and the 2011 per capita health budget is SBD 949 (about US$120). The SWAp mid-term review identified the absence of a shared set of indicators to track sector performance and the failure to produce national health data for 2009 and 2010 as critical obstacles for monitoring results in the health sector. An abridged version of the Annual Report for 2010 has since been produced.

Service delivery

There are 328 health facilities in the health system including the National Reference Hospital (NRH) and nine provincial hospitals which provide secondary level care. Efforts are currently on-going to define the packages of service to be provided at the respective health facility levels (service delineation), and reflect the changes in integrated supervision, reporting and supply chains across disease specific programs. The Role Delineation Guidelines will describe the packages.

The basic principal of investment in children's health, nutrition and education is determined as the foundation for national development in the Solomon Islands by the National Advisory Committee on Children (NACC). NACC is a statutory body founded in 1992 to further the Convention on the Rights of the Child which directly reports directly to the Cabinet (Ref 38, 64). Please see its TORs as the Attachment No. 13.

It is described in the Solomon Islands Child Health Strategy (Ref 34) that a balanced and integrated program that incorporates almost all of the 23 essential interventions are proven to reduce child mortality. Such strategies of EPI include:

- Cold chain upgrade: change to solar panels
- Establishment of new vaccine distribution centres and upgrading of established centres
- Vaccine quality control
- Delivery at immunization clinics
- Catch-up campaign annually
- Measles SIA campaign (3rd yearly)
- Introduction of Hib vaccine (done in 2008)

Immunization of infants and pregnant mothers is carried out by nurses and midwives at the hospitals, Area Health Centers and Nurse Aid Posts during weekly child welfare clinics and outreach tours. Midwives are responsible for the Hepatitis B birth dose and BCG vaccination at birth. In addition, Vitamin A and Albendazole have been distributed along with vaccines during clinics, outreach tours and campaigns. This packaging of interventions needs to be strengthened.

The introduction of Haemophilus influenza (Hib) type B vaccine in 2008 occurred successfully and the country now delivers the pentavalent vaccine as part of its routine vaccine programme. Meningitis and pneumonia are common causes of infant mortality in Solomon Islands and it is estimated that this initiative had the potential to prevent 104-312 annual cases of Hib meningitis. Nationally, 2010 coverage of the pentavalent vaccine (DPT-HepB-Hib3) (78%) and OPV3 (78%) and BCG (84%) are generally high, but TT2 (60%), measles (67%) and HepB birth dose within 24 hours (62%) have lower coverage.

There are also ongoing activities to tackle the issue of gender based violence (GBV) under the Gender Health and Development programme by providing the gender analysis training for staff of the Ministry or Health and Medical Services and the gender based violence training for health professionals (Ref 9, 27).

Human Resources

To meet the needs of the Strategic Plan 2011 – 2015 a Human Resource and Workforce Plan (Ref 52) has been created which concentrates mainly on a Provincial Staffing Model linked to role delineation of facilities in the Provinces. Implementation of the Role Delineation Guidelines will include determining the skills, training and number of staff required at each facility, in-service training and equipping and upgrading facilities according to the needs.

In order to be able to measure the impact of the model a thorough review of the existing staff was undertaken. The exercise revealed that there were 2,734 staff engaged in health at all levels. The proposed Provincial Staffing Model envisages 46 separate staff roles spread over Hospitals, Area Health Centres, Rural Health Clinics and Nurse Aide Posts. There are 328 facilities in the Provinces of which 31 NAP's are closed (Ref 39).

Medical products, vaccines and technologies

In 2009, UNICEF has supported the Government of Solomon Islands in assessing the cold chain system and conducting the Effective Vaccine Store Management (EVSM) as well as Vaccine Management Assessment using the VMAT. The updates of the cold chain system based on the aforementioned assessment are shown in the table in the section 3.2.c.

One of the main recommendations from EVSM and Vaccine Management conducted in 2009 was to replace all kerosene/gas based equipment with solar equipment in the following 5 years (2011 to 2015). This will address the logistic issues of supply of gas which is expensive in terms of running and transport costs. The currently operating equipment may be left at the clinics with a reserve cylinder of gas as a back up during the rainy days when the solar system may not operate effectively. This will reduce the gas requirements at these facilities to less than 1 recharge per year in comparison to 4 at present.

Key activities from the 2011-2015 National Immunization Plan are listed in the Section 3.2 and the highlighted ones addressed in the current proposal for the GAVI HSFP to show the linkages to the government's on-going activities.

Health Information

There is an on-going project called PACRICS (http://pacrics.net/index.php) supported by AusAID and managed by the Secretariat of the Pacific Community (SPC) with the goal of connecting the information network among the Pacific Island Countries. PACRICS is in the process of installing 17 satellite links in Solomon Islands, one in each of the 9 provincial capitals plus another 8 in strategic population centres. Two of the links are up and running in Malaita and Guadalcanal.

The National health information system is under review and the MHMS aims at establishment of a comprehensive HIS based on the DHIS software, rationalization of the data set to integrate vertical programs and donor partner data collection into a data warehouse. There is also a discussion with WHO for the Solomon Islands to review the existing HIS situation analysis and move forward to develop a health information policy with a costed and detailed HIS strategic plan.

3. Health Systems Strengthening Objectives

3.1 HSS objectives addressed in this proposal

→ Please describe the HSS objectives to be addressed by this proposal and explain how they relate to, and flow from, the information provided in section 2 (National Health System Context). Please demonstrate how the objectives proposed to GAVI will improve health outcomes related to immunisation, and how the objectives proposed to the Global Fund will improve health outcomes for (two or more of) HIV/AIDS, tuberculosis and malaria.

When the TWG considered the structure of planning elements for the GAVI HSFP proposal in late November 2011 after the GF board announcements, it was decided to keep the hierarchy of planning elements as simple as possible. Out of the deliberations (Ref 18, 19), one Goal with two Objectives and six Service Delivery Areas were formulated, focusing squarely on the EPI and cold chain support, with linkages to IMCI and MNCH, and against the background planning and frameworks set by the National Health Strategic Plan 2011-2015 (Ref 35), the Solomon Islands Plan for Immunization 2011-2015 (Ref 38) and the Solomon Islands Child Health Strategy 2011-2015 (Ref 34); see also Attachments 1.1, 1.4 and 1.5.

The NHSP and its realization on the ground is supposed to work through a set of operational plans – in case of CH and EPI through the two aforementioned plans, i.e. Child Health Strategy and National Immunization Plan 2011-2015 (cMYP).

The proposal’s first objective “Improved availability, access and quality of immunization services, vaccine cold chain capacity, IMCI and MNCH” contribute and support the Substantive policies Nos. 2 and 6, and the Organizational policies Nos. 1,4 and 10.

At the same time, the Objective 1 is linked to the following *Solomon Islands' Expanded Programme on Immunization (EPI) Policy* (Ref 44, Attachment 1.3) objectives:

- To protect every newborn, child, pregnant woman from vaccine preventable diseases with the use of safe, appropriate and potent vaccines;
- To have over 90% of children fully immunized by 15 months with one dose of Hepatitis B birth dose, BCG and Measles vaccine, and three doses of Pentavalent Vaccine (DPT-Hepatitis B-Hib, PENTA) and Polio vaccine;
- To have over 90% of infants receive their first dose of Hepatitis B vaccine within 24 hours of birth;
- To provide safe immunization using vaccines that have been stored and transported at the recommended temperature and are correctly prepared and administered; and

- To monitor and evaluate immunization program performance annually.

The proposal's second objective "Increased demand of immunization and MNCH services" contribute and support the Substantive policies No. 1 and the Organizational policies No. 4.

At the same time, both proposed GAVI objectives are linked to the following *Solomon Islands' Expanded Programme on Immunization (EPI) Policy* objective:

- To promote better access and utilization to immunization services by the population and ensure that there are adequate supplies of safe and potent vaccines, Auto-Disable syringes and safety boxes, and other cold chain materials at the point of immunization service delivery;

The currently submitted proposal displays both, additionality and complementarity of the current MHMS and DP's efforts. Most activities proposed are complementary to the policies in place, objectives and on-going activities (procurement of fridges, boats, OBM, IMCI training, CSS activities). Several elements are additional, in particular the additions to the NHIS development.

3.2 a) Narrative description of programmatic activities

→ Please provide a narrative description of the goals, objectives, Service Delivery Areas (SDAs) and key activities of this proposal.

3.2 b) Logframe

→ Please present a logframe for this proposal as Attachment 2.

3.2 c) Evidence base and/or lessons learned

→ Please summarise the evidence base and/or lessons learned related to the proposed activities. Please provide details of previous experience of implementing similar activities where available.

3.2 a) Narrative description of programmatic activities

The HSS goal in this proposal is supported by the two objectives; the first objective to strengthen the supply side (health systems) and the second to strengthen the demand side (community systems). The hierarchy of planning elements in the proposal submitted is as follows:

Goal: Improved availability, access, quality, and demand of immunization services, IMCI and MNCH

Objective 1: Improved availability, access and quality of immunization services, vaccine cold chain capacity, IMCI and MNCH.

SDA1: HSS: Procurement and supply chain management

SDA2: HSS: Routine data collection, analysis and use

SDA3: HSS: Service delivery

SDA4: HSS: Health workforce

SDA5 HSS: Stewardship and governance

Objective 2: Increased demand of immunization and MNCH services .

SDA6: CSS: Advocacy, communication and social mobilization

Pursuant to the Concept note prepared in October (Ref 2) for the joint GAVI/GF R11 HSFP proposal, and in accordance to the Section 2, the foci representing four out of six pillars of the HSS are addressed in the proposal (i.e. service delivery, HR, HPT, HIS and are complemented by CSS activities).

The overall goal contains four crucial attributes of health services overall, relevant to immunization as well. They are:

a) Availability
b) Access
c) Quality
d) Demand

The first objective on HSS comprises the first three attributes, the second objective is aimed at CSS and increased demand. The impact and outcome indicators are chosen from the standard list of GAVI indicators and from the National Health Strategic Plan and other documents (SI Child Health Strategy Ref 34). The proposal aims at reduction of U5MR, IMR (both NHSP indicators). The crucial outcomes will be increased Penta3 coverage

(equivalent to the DTP3 coverage), coverage for all vaccinations above 80% for low performing provinces and proportion of children immunized against HepB at birth in the three targeted provinces.

The main problem perceived is the accessibility in remote areas. While the health system as such has a high level of equity in economic terms (all five economic quintiles access and utilize health services at almost the same rate), inequity is imposed by high transport cost for those in remote areas and by shortcomings of the outreach services. Therefore, RED strategy and support to outreach services figure prominently in the proposal.

Under the first objective, the broader formulated activities are divided into five standard HSS Service Delivery Areas, namely:

1.1.1. Procurement and supply chain management
1.1.2. Routine data collection, analysis and use
1.1.3. Service delivery
1.1.4. Health workforce
1.1.5. Stewardship and governance

The second objective comprises one CSS SDA,

1.2.6. Advocacy, communication and social mobilization

Each of the broader formulated activities is split into “sub-activities” or “activity components” with costing.

Ad 1.1.1. – Procurement and supply chain management: The three main activities are provisions of ice-lined electrical fridges, solar powered EPI fridges, and solar powered examination lights, respectively, with freight, installation and training cost.

The rational for provision of the examination lights to the ten RHC in need is to support the MNCH and EmONC at the primary care level. The battery capacity is not enough to run the compressor continuously and the capacity of the solar panel is not enough to charge batteries for lights. Solar powered examination lights require separate solar panels and batteries. A set includes LED examination light, hand held lamp, solar panel and batteries.

Ad 1.1.2. – Routine data collection, analysis and use.

The M&E system on MNCH and some aspects of EPI/cold chain are lacking (Ref 22, 48, 50). For this reasons, the SDA 1.1.2 , with the activities 1.1.2.1 – 1.1.2.4 were added to the current proposal, amounting to US$ 138,740.

The current HIS system, among other weaknesses specified, doesn’t capture hospital in-patients admissions and discharges. This needs to be rectified and become part of the National HIS with annual analysis and reporting.

Child death reporting form has been developed and is available, but still needs to be incorporated as part of the national HIS, with annual analysis and reporting. Records need to be collected from all clinics and from community level.

Therefore, these activities aim at piloting the additional child health data inclusion in the newly developed NHIS. Also, a locally recruited M&E person will be attached to Reproductive, Child Health Division (RCHD) at the cost of US$ 24,000 over the next four years, to ensure the links, coordination with the NHIS, as well as all the M&E requirements of the EPI and RCHD, with the essential monitoring of the GAVI activities, SDAs, outcomes and impacts. The activities under this SDA are meant to complement and expand the EPI and CH aspect of the National HIS system.

Ad 1.1.3. – Service delivery:

Re-assessing the EPI cold chain, waste management, water and sanitation and facility lighting in collaboration with key partners including UNICEF and WHO, and update the maintenance and replacement plan. EPI cold chain has deteriorated due to inadequate maintenance and investment. The EPI program has a comprehensive plan to increase the quality and capacity of cold chain by: solar powered fridges in difficult to access health centers, gas fridges in accessible health centers, and electric fridges in health centers with reliable electricity supply. The problems with transporting gas cylinders in small boats and carrying them by hand over land has proven to be an obstacle to the cold chain. This re-assessment should be scheduled for 2015 when the upgrading of the cold chain should be completed. The assessment should cover waste management, water and sanitation and light in addition to cold chain. Adequate light is essential for delivery services, emergency services at night and other unscheduled services.

One of the already identified gaps is infection control and lack of incinerators and sterilizers in particular. The activity 1.1.3.2 aims to strengthen Infection Control in all health facilities, including procurement of incinerators, sterilizing program, waste management, and hand hygiene, to support provision of safe and quality PHC services including immunization and MNCH services. In the area of waste management, collaboration could be sought from JICA based on their previous experiences of procurement of incinerators and the on-going project on waste

management (except hazardous waste) in Gizo, Western Province.

MHMS will set up a technical working group to develop appropriate outreach services in pilot sites and develop an impact evaluation methodology to measure the success of outreach. The activity 1.1.3.3 supports strengthened planning and execution of outreach vaccination services to hard to reach populations within the Reach Every District (RED) strategy, which could also deliver a package of priority MNCH packages. This is accompanied by procurement boats and spare over board motors (OBM) for selected RHC in four provinces.

The identification of the low coverage Health Centers will be done on annual basis. Subject to this assessment, micro-planning workshops with staff at identified health centers will be conducted by provincial and zone managers together with health centre staff with the aim to increase vaccination coverage through routine vaccination services supplemented by other IMCI services. For costing purposes it is tentatively assumed that each province would cover three low coverage Health Centers per year.

Ad 1.1.4. Health Workforce – Human Resources:

Three composite activities are included under the HR SDA, viz.

Training of health centre staff in Integrated Management of Childhood illnesses (IMCI) in three provincial training centers.

WHO training course for middle level management (MLM) training adapted to fit the need for Child Health Coordinators, EPI managers and Maternal and Reproductive Health managers at provincial and zone level. The purpose of this training is to strengthen the management skills at provincial and zone level and ensure that planning, implementation and monitoring is done in an integrated model. The emphasis of the generic training package is the planning cycle, target setting and monitoring of activities. The timing of the training should allow for the participants to work on the annual provincial plans for the Provincial Grants during the training. The workshops should be hands-on and help the participants plan for actual implementation of the activities. With teams of 3-4 managers from each province and three provinces attending each training, it should be possible to provide this training to the entire country in one year. Technical assistance from WHO should be considered for this activity. MCN Unit of WPRO, particularly CHD can provide technical assistance for the conduct of training (confirmed through discussions with the CHD/WPRO unit).

Annual integrated MNCH and EPI review and planning workshops in each target province. These annual workshops will utilize the planning cycle methods and skills taught during the Program Managers trainings in the first year (activity above). The output of workshops will be annual provincial workplans and proposals for the Provincial Health Grants (under SWAp) aimed at delivering the Packages of Services at primary level. Important part would be the community service training on MNCH (using the WHO training module).

Ad 1.1.5. Stewardship and governance

Briefing for the provincial MCH programmes representatives and EPI/cold chain managers on the planned activities and M&E system – Annual workshop in the three piloted provinces with explanation of the plan details, briefing, implementation status and M&E plans will take place to ensure smooth and effective and efficient implementation in line with the principle of “Value for money”.

Ad 1.2.6. Advocacy, communication and social mobilization:

One composite activity is included broadly defined as “Community mobilization on EPI and MNCH through various means by PHS, FBO, CBO, village committees, and other stakeholders – three pilot provinces.” Activities would cover all aspects of community demands for EPI and MNCH (e.g. timely vaccination, de-worming, vit-A supplementation for children and pregnant women). The important role and significance of the FBO and CBO in Solomon Islands is fully recognized. Limited capacity on preparation and management of the proposals is also recognized and the first subactivity on “Training and Facilitation of FBOs and CBOs on preparing and managing the proposals for funding of the CSS” is therefore included, in addition to other standard activities on CSS.

The selected CBOs would be then subcontracted – it is expected that in each of the three targeted provinces three CBOs would be selected, based on the submission of a good quality proposal. The selected CBOs will conduct various social mobilization activities to increase awareness and demand for EPI and MNCH services. These activities should be also coordinated with other community based activities such as community health promotion for Malaria and "Healthy Village" initiatives by JICA (in Gizo/Western Province and Honiara) (Ref 61). Support to other social mobilization using different modes of media are included in this SDA, such as radio and TV spots, use of drummer groups in the villages, and annual conduction of the "Immunization and Child Health Week" in the three pilot provinces. There will be also an annual coordination meeting between the AHCs and the representatives of the selected FBOs/CBOs to maintain strong linkages with the health systems.

The proposed community-based activities in the GAVI submission supplement and add to the activities of the

provincial level listed below from the 2011-2015 National Immunization Plan (Ref 38):

Strengthening Routine Immunization Programme
- Strengthen the capacity of the AHC Supervisors through middle level management (MLM) training
- Micro-planning workshops for the Provincial EPI Coordinators and AHC Supervisors
- Supervisory follow-up in priority AHCs by the Provincial EPI Coordinator
- Improve the quality of EPI data management at AHC and RHC through National EPI Review and on-site supportive supervision by the Provincial EPI Coordinators and AHC Supervisors

Vaccine supply quality and logistics
- Replacement of old chain equipment >10 year old
- Replacement of gas refrigerator with solar refrigerator
- Procurement of one 21 feet fiberglass boat for 27 AHCs
- Training on vaccine and logistic management for AHC

Advocacy and communications
- Plan and implement outreach strategy

Programme management
- Review policies for outreach immunization services
- Organize regular biannual EPI review meeting with provincial staff to review EPI performance

3.2 b) Logframe

Please see the Attachment No.2.

3.2 c) Evidence base and/or lessons learned

The proposed activities are categorized in the areas of: Procurement and supply chain management; routine data collection, analysis and use; service delivery and health work force; stewardship & governance, and increase demand of immunization and MNCH services at community level. Work guided under the comprehensive multiyear plan from 2006 to 2010 in these respective areas has demonstrated that:

There is an urgent need to improve the procurement and supply chain management. Currently, there are 328 health facilities (Hospitals, Area Health Centers, (AHC), Rural Health Centers (RHC) and Nurse Aid Posts (NAP), with the following equipment (Ref 38):

Summary of cold chain equipment by province

	Gas based equipment					
Province	**RCW 50EG**	**FCW 20EG**	**RCW 42EG**	**Kerosene**	**Electric**	**Solar**
Central	12	2	5	0	6	0
Choiseul	11	2	1	7	1	4
Guadalcanal	18	3	16	1	0	0
HCC	0	0	0	0	10	0
Isabel	12	3	3	7	5	0
Makira	16	2	0	11	7	1
Malaita	37	3	8	8	11	2
Renbel	3	0	0	0	0	1
Temotu	6	0	0	2	5	1
Western	15	2	1	8	11	11
Total	**130**	**17**	**34**	**44**	**56**	**20**
Grand Total	**181**			**44**	**56**	**20**

(Source: Solomon Islands National Plan for Immunization 2011-2015, Ref. 38, Attachment 1.4)

Summary of functional fridges by province, 2011

Provinces	Total Clinics	With fridges	Function fridges	Fridges not functioning
Choiseul	24	19	14	5
WP	59	36	27	9
Malaita	80	54	39	15
Guadalcanal	35	35	18	17
Central Island	27	19	12	7
Makira	37	29	12	17
Honiara City Council	8	8	8	0
Temotu	15	10	5	5
Isabel	34	23	16	7
RenBel	3	3	2	1
TOTAL	**322**	**239(74%)**	**153 (65%)**	**83(35%)**

(Source: Presentation made at the EPI regional workshop in the WHO- WPRO by the national EPI programme manager, Mr Raymond Mauriasi)

All these equipment required routine maintenance and occasional repair. Currently there is not a single refrigeration technician in the EPI who can carry out this task. The province level pharmacist has undergone some basic training on minor trouble shooting and maintenance and the minor issues is addressed by them. In case of more serious issues, the equipment needs to be sent to the National Medical Store (NMS), where the cold chain coordinator is expected to repair it. In case of necessity the equipment has to be sent to an outsourced repair service (Eastwind Pvt. Ltd.). Most often the defective unit is replaced with a new unit and the old one is not repaired or recycled, thus wasting resources. Sending equipment to the NMS is a complicated and expensive solution and the follow ups are not adequate. To achieve and to maintain the programmatic indicator 1.1 will require improved and on-going maintenance programmes.

This situation along with recommendations from the Effective Vaccine Store Management (EVSM) and Vaccine Management assessments conducted in 2009 strongly suggest the replacement of all gas refrigerators which in the long run will help solving the logistical issues related to the cost and transport of the gas cylinders.

The plans for the replacement of the gas powered refrigerators include to leaving the currently operating equipment at the clinics with a reserve cylinder of gas as a back up during the rainy days when the solar system may not operate effectively. This will reduce the gas requirements at these facilities to less than 1 recharge per year in comparison to 4 at present.

In the area of routine data collection, analysis and use, all Area Health Centres and clinics collect coverage data monthly, data from Malaita and Guadalcanal is analyzed and interventions are focused in the low performing villages within these to provinces. However, due to human resource limitations, the analysis and interventions can not be conducted at all provinces.

With regard to service delivery, the Solomon Islands have made significant progress related to the control of vaccine preventable diseases. The country along with the rest of the countries in the region was declared polio free in the year 2000. In 2003, many provinces conducted a third round of supplemental immunization activities (SIAs). This involved delivering measles vaccine to all children and catch-up vaccination with all the other vaccines. Then follow-up measles vaccination campaign targeting all children aged 1-4 years has been carried out every three years (2006 and 2009). The next SIA is scheduled for next year contributing to the interruption of endemic measles transmission in the Pacific islands.

Haemophilus Influenza Type b (Hib) vaccine was successfully introduced as DTPHepBHib vaccine into the national

immunization programme in Solomon Islands by July 2008, which protects more children from pneumonia and bacterial meningitis cases caused by Hib.

Immunization services along with other primary health care services in Solomon Islands is delivered by a network of over 300 PHC clinics - NAP, RHC, AHC, and urban clinics (UC) and by outpatients clinics based at provincial and the national hospitals. While almost 95% of the services are provided through clinics, around 5% of all immunizations are provided through satellite clinics conducted by AHCs/RHCs. Registered nurses or nurse aids are the primary personnel delivering the immunization services.

In the area of health workforce, it is categorized in five levels, pediatricians, general medical officers, midwives, nurses and nurse aids. It is the nurses and nurse aides are responsible for providing immunization services.

Efforts have been made to increase demand of immunization and MNCH services at community level. A daily radio broadcast on health issues is transmitted for 11 minutes every morning covering an array of health related subjects including immunizations. There is a significant number of faith and community based organizations that could potentially assist on increasing the demand for immunization services, however, their expertise in this field is limited.

3.3 Main Beneficiaries

→ *Please describe how the proposed activities under each objective contribute to equity (e.g., gender, geographic, economic), reach the unreached, underserved and marginalised populations with health services, and benefit the poorest and other disadvantaged populations, including any measures to reduce stigma and discrimination that these populations may face.*

The main beneficiaries under this proposal include all children and women in the country. Funding will be used to provide: the necessary training for health care workers, the essential tools to assess immunization services and the strengthening of cold chain infrastructure for the increase of immunization coverage nation-wide. As a result, the primary health care structure as a whole will benefit since primary health care services are delivered in an integrated fashion.

Following the Reaching Every District (RED) strategy, special emphasis will be given to the three most populated provinces (Guadalcanal, Malaita and Western). These provinces not only have been identified by the analysis of the 2005/06 household income and expenditure survey (Ref 28) as the areas with higher socioeconomic disparities, but also representing a higher percentage of women and children living in the poorest households compared to other parts of the country but also coverage for the birth dose of hepatitis b and the third dose of pentavalent vaccine is disproportionate within these three provinces.

The table below presents the immunization coverage by province with an analysis on access and utilization. It substantiates the selection of the three high priority provinces by the Government with high populations..

Sub-national Coverage, 2010

Provinces	Target Population < 1yr	HepB < 24hrs of birth	Hep B birth dose Total	DPT/ Penta 3	MCV1	Penta 1 – Penta 3 Drop out rate (%)	Access/ Utlizatoin *	Priority
Choisuel	728	74	99	99	89.5	-3	G/P	10
Western	**2618**	**38**	**59**	**65.5**	**57**	**-1**	**P/P**	**2**
Isabel	631	31.8	49.5	71.6	58.6	4	P/P	3
Guadalcanal	**2704**	**79**	**100**	**93**	**78.5**	**-1**	**G/P**	**4**
Central Islands	766	100	100	86.5	69.8	1	G/P	6
Malaita	**4512**	**39.3**	**66**	**65.7**	**65.5**	**15**	**P/P**	**1**
Makira/Ulawa	1344	58.8	71.4	88.8	81.9	-3	G/G	9
Renbel	93	100	100	77	74	11	G/P	7
Temotu	631	62.4	85	73	76	6	P/G	8
Honiara City Council	3733	86.8	100	84.8	58.7	14	G/P	5

*G= Good; P = Poor

Source: MHMS, EPI Country Data Analysis 2011, (Ref 60)

Specifically, the activities related to objective 1: Improved availability, access and quality of immunization services, vaccine cold chain capacity, IMCI and MNCH will directly contribute to reaching the unreached, underserved and marginalized populations outlined above by providing the necessary number of solar powered refrigerators and examination lights in areas where no electricity is available and where it is extremely difficult to transport gas cylinders.

Data collection instruments will be developed to collect immunization information from hospital children wards admission and discharge record as well as strengthening the reporting of active surveillance in sentinel hospitals as a pilot project that eventually will be expanded to cover the whole country.

Technical assistance will be provided to improve infection control and waste management practices and promote hand washing habits.

With regard to objective 2: Increase demand for immunization and MNCH services at the community level - the trainings for faith and community based organizations which are currently assisting marginalized populations in the country, will enhance their limited capacity to conduct social mobilization activities. The availability of health services will be promoted through methods other than radio in order to reach populations that do not have access to it. The Immunization and child health week will be observed the last week of April every year with special events from the National to the village level and annual coordination meetings with the participation of faith and community based organizations, NGOs and village chiefs will be conducted yearly to assess progress and to continue identifying underserved areas.

4. Performance Monitoring and Evaluation

4.1 National Monitoring and Evaluation (M&E) Plan and Performance Framework

→ Please present your National M&E Plan as Attachment 3, and the Performance Framework for this proposal (using prescribed template) as Attachment 4.

4.2 a) M&E arrangements

→ Please describe how the Performance Framework in this proposal uses existing national indicators, data collection tools and reporting systems.

4.2 b) Strengthening M&E systems

→ Please describe the M&E systems strengthening activities to be funded through this proposal.

4.1 National Monitoring and Evaluation (M&E) Plan and Performance Framework

There is no separate National Monitoring and Evaluation Plan. The Monitoring and Evaluation plan for the NHSP constitutes one of the chapters of the NHSP itself. The NHSP is attached to the proposal as Mandatory Attachment 1.1, please refer to the Monitoring and Evaluation chapter, pages 37 - 47.

The M&E chapter of the National Health Strategic Plan has defined Monitoring and Evaluation processes and timing with a core set of indicators. There is generally one indicator for each major program area or significant disease. Some of the indicators pertaining to the child health and immunization coverage for the GAVI proposal have been adopted from the NHSP (U5MR, IMR).

Operationalization of the NHSP is realized through set of National Strategic Plans for individual programmes, individual MHMS divisions and provincial operational plans.

In addition to the M&E plan included in the NHSP, **Attachment 3** presents the M&E Framework from the Solomon Islands Child Health Strategy 2011-2015 document.

The Performance Framework is presented in the required format as **Attachment 4**.

4.2 a) M&E arrangements

The following impact indicators are taken directly from the NHSP, together with the baselines and targets

1. Under-five mortality rate (U5MR)
2. Infant Mortality Rate (IMR)

Baseline 2010: U5MR – 36/1,000, IMR – 30/1,000

Target 2015: U5MR – 29/1,000, IMR – 25/1,000

The data for annual monitoring through these indicators will be obtained through the DHIS/PACRICS system, (HIS death section), as stated in the NHSP (p.42).

Out of the three outcome indicators, namely

1. By 2015, 90% of surviving infants receiving 3 doses of Penta vaccine nationwide, baseline 78% to 90%;
2. By 2015, 90% of children are fully immunized by 15 months* with one dose of measles containing vaccine nationwide, baseline 67% to 90%;
3. By 2015, coverage for all vaccinations is above 80% for the three low performing provinces (NHSP)

* The original indicator states the target by 12 months of age. It was pointed out during the discussions of the TWG that some children are brought for the vaccination few weeks/months later. Therefore, the target age was extended to 15 months.

The first and the second indicators are taken from the Solomon Islands Child Health Strategy 2011 – 2015 (Ref 34, Attachment 1.5), the third indicator from the NHSP (p.33).

The monitoring data for outcome indicators Nos. 1 and 2 will be collected through the NHIS monthly return form (Ref 50). The data for outcome indicators No. 3 through the EPI annual reports and analyses.

There are total six output/programmatic indicators under the total of six SDAs. These indicators are output oriented and specific to the individual activities proposed under GAVI. While all of them derive and flow logically from the national strategic documents, some of them are newly formulated to measure the specific outputs achieved from the GAVI funding, feeding into the national EPI and MNCH programmes.

Objective/indicator Number	Service Delivery Area	Programmatic indicator
1.1	HSS: Procurement and Supply Chain Management	By 2015, at least 90% of functioning EPI fridges (total and by type & facility)
1.2	HSS: Data Generation, Analysis & Use	Children wards admissions and discharge recording/reporting running in three Pilot provincial hospitals from Jan 2013 on-wards (Yes/No)
1.3	Service Delivery	By Dec 2013, the methodology for impact of outreach services evaluation in place, utilized and results made available on annual basis (Yes/No)
1.4	HSS: Health Workforce	Number of annual integrated MNCH and EPI review and planning workshops (one annual workshop in each of the three target provinces).
1.5	HSS: Stewardship & Governance	Annual MNCH briefing and evaluation WS conducted at national level (Yes/No)
2.1	CSS: Advocacy, communication and social mobilization	Proportion of children immunized against HepB at birth in the three targeted provinces (data collected through the monthly returns)

4.2 b) Strengthening M&E systems

As mentioned in the Section 2, the current NHIS is based on the Monthly Return Form (Ref 50) from all rural facilities and some provincial hospitals.

This form represents the HIS backbone, submitted by most of the 328 health facilities in the 5-layered public health services delivery system (hospitals down to aid posts). The form s made up of 4 pages for reporting of aggregated numbers in sex differentiated age intervals of 0-1, 1-4, 5-14, 15-49, and $\geq$ 45 years of age. The overall monthly return rate is encouragingly high, close to 90%. However, in the last two years the Ministry's health information system (HIS) has not produced aggregate numbers or any analysis as a result of the past database being re-programmed. There are parallel vertical health information systems for several national programmes, such as, e.g. malaria, Tb and HIV. The National health information system is under review and the MHMS aims at establishment of a comprehensive HIS based on the DHIS software, rationalization of the data set to integrate vertical programs and donor partner data collection into a data warehouse.

It is expected that the introduction of the District Health Information Software (DHIS) and the satellite links with the provinces supported by the PACRICS project (http://pacrics.net/index.php) will improve the situation dramatically. PACRICS is in the process of installing 17 satellite links in Solomon Islands, one in each of the 9 provincial capitals plus another 8 in strategic population centres. Two of the links are up and running in Malaita and Guadalcanal.

However, the monthly return form still doesn't capture some data essential for the monitoring of child admissions/discharges in the provincial hospitals, child deaths at the rural level, and surveillance of the VPD and AEFI.

The M&E system on MNCH and some aspects of EPI/cold chain is also lacking. For this reasons, the SDA 1.1.2 , i.e. "Routine Data Collection, Analysis and Use" with the activities 1.1.2.1 – 1.1.2.4 were added to the current proposal, amounting to US$ 138,740. These activities aim at piloting the additional child health data inclusion in the newly developed NHIS. A locally recruited M&E person will be attached to Reproductive, Child Health Division

(RCHD) over the next four years, to ensure the links, coordination with the NHIS, as well as all the M&E requirements of the EPI and RCHD, with the essential monitoring of the GAVI activities, SDAs, outcomes and impacts.

5. Gap Analysis, Detailed Work Plan And Budget

5.1 Detailed work plan and budget

→ *Please present a detailed work plan and budget as Attachment 5.*

5.2 Financial gap analysis

→ *Please present a financial gap analysis (and counterpart financing table for Global Fund applicants).*

5.3 Supporting information to explain and justify the proposed budget

→ *Please include additional information on the following:*

- *Efforts to ensure Value For Money*
- *Major expenditure items*
- *Human Resources costs and other significant institutional costs*

5.1 Summary and Detailed work plan and budget

Please see the Attachment 5.1a for the Summary Workplan and budget and the Attachment 5.1b for the Detailed Workplan and budget.

The total budget of the GAVI HSS proposal is US$ 2,399,340 over a period of fours years, i.e. 2012 - 2015 till the end year of the current national health plan. Among the total amount requested, US$ 1,910,140 is budgeted under the Objective 1 on the health systems strengthening to work on the supply side, while US$ 489,200 is budgeted under the Objective 2 on the community systems strengthening to work the demand side of the proposal.

The breakdown by the Service Delivery Areas (SDAs) shows that in the SDA 1 (27.9%) on the procurement, the procurement of the EPI cold chain equipment is following the detailed national assessment and the procurement plan. Use of the solar-power equipments is expected to improve cost-effectiveness in the longer term. In the SDA 2 (5.78%) on the data collection and analysis, the proposed activities will be conducted as an integral part of the ongoing HIS efforts and will strengthen the national HIS rather than creating a parallel structure. The SDA 3 (34.73%) on service delivery is the biggest expenditure SDA in this proposal as it includes the key activities to improve availability, access and quality of services, such as strengthening implementation of the RED strategy. Conduct of various assessments will strengthen the future planning and improve programme performance. In the SDA 4 (11.19%) on health workforce, the value for money and sustainability of the programmes are being sought by ensuring the integrated approach for EPI, MHCH and IMCI. SDA 5 is about strengthening M & E of this GAVI HSS project. In the SDA 6 (20.39%) on social mobilization, it is intended that enhancing the community awareness and demand through the use of CBOs will improve utilization of the services thereby bringing in the synergistic effect with the HSS components of the proposal.

The breakdown by different cost categories shows that the biggest budget expenditure in this proposal is infrastructure and other equipment (37%), which can be justified as all of them aim at sustaining and strengthening PHC service delivery including EPI, MNCH and IMCI. The instalment of the examination lights and strengthening the outreach services by procurement of the boats and engines would greatly improved people's access to EPI, MNCH and EmONC care. Technical and management assistance (18%) and training (16%) also constitute the second and third largest shares in the total budget; which imply there will be a significant investment in capacity building of human resources through the GAVI HSS support.

5.2 Financial gap analysis

The areas where the financial gaps exist have been identified during the process of a concept note development (Ref 2).

According to the MTEF (2011), the required expenditures for the health sector of the Solomon Islands during the period of 2012-2015 (the period the GAVI HSS funding is being requested) will be US$ 163,284 million while the available Government funding being US$ 133,497 million, which gives the funding gap of US$ 29,786 million over the four years. (Attachment 5.2 – Note that the assumption for the significant decline in the required expenditures for 2015 is based on the assumption regarding the foreseen fluctuation in capital investment which may or may not follow the time line) This US$ 29,786 million for 2012-2015 is the funding gap which has to be supported collectively by development partners. The GAVI HSS funding will contribute to fill the gap, once approved and granted to the country.

The attachment 6.2 demonstrates the external funding by donors to HSS and other relevant health programmes for the period of 2012-2015. The support from AusAID constitutes more than 50% of the total external funding support (approx 55%) followed by SPC (17%) and EC (11%). Many development partners are supportive of the Health Sector Strengthening Project (HSSP) although the firm pledges would come only on annual basis therefore the figures in the table are only estimates at present. In the areas of EPI, cold chain management, MNCH care, waste management and community mobilization, this project will maintain a strong collaboration with WHO, UNICEF and JICA among other partners.

5.3 Supporting information to explain and justify the proposed budget

Pursuant to the main principles on “Value for money”, i.e. effectiveness, efficiency and additionality /complementarity, careful consideration have been taken during the preliminary drafting of the concept note, as well as during the subsequent work on the GAVI/GF HSFP preparation and the final GAVI submission to comply with the “Value for Money” principles requirements. By dint of multiple consultations with the partners in health and all stakeholders, the team strived for designing the best and most practical ways of doing things and pursuing the desired impacts, outcomes, outputs and sustainability in the most efficient way, avoiding duplications. All the impact and outcome indicators have been consistent with the relevant national strategic documents, adopting the approaches delineated by the SIG, Development partners and other Partners in Health.

The main beneficiaries under this proposal include all children and women in the country. Following the Reaching Every District (RED) strategy, special emphasis will be given to the three most populated provinces (Guadalcanal, Malaita and Western) which are also identified to have a high percentage of women and children living in the poorest households compared to other parts of the country. The low immunization coverage in the selected target provinces has been another principal and additional factor for selection to increase the impact of the project. The proposed HSS activities therefore aim to bring a high impact to improve health of these women and children.

In the SDA 1 on the procurement, the procurement of the EPI cold chain equipment is following the detailed national assessment and the procurement plan. Use of the solar-power equipments and examination lights will improve cost-effectiveness. In the SDA 2 on the data collection and analysis, the proposed activities will be conducted as an integral part of the ongoing HIS efforts and will strengthen the national HIS rather than creating a parallel structure. The SDA 3 on service delivery is the biggest expenditure SDA in this proposal as it includes the key activities to improve availability, access and quality of services, such as strengthening implementation of the RED strategy. Conduct of various assessments will strengthen the future planning and improve programme performance. In the SDA 4 on health workforce, the value for money and sustainability of the programmes are being sought by ensuring the integrated approach for EPI, MHCH and IMCI. In the SDA 6 on social mobilization, it is intended that enhancing the community awareness and demand through the use of CBOs will improve utilization of the services thereby bringing in the synergistic effect with the HSS components of the proposal.

6. Implementation Arrangements, Capacities, and Programme Oversight

6.1 a) Lead Implementers (LI)

-> For each LI, please list the objectives they will be for responsible to implement. Please describe what lead to their selection, including their technical, managerial and financial capacities to manage and oversee implementation of objectives, including previous experience managing Global Fund and/or GAVI grants. Describe any challenges that could affect performance (refer to any current assessments of capacity if available) as well as mitigation strategies to address this.

→ Please copy and paste the tables below if there are more than two Lead Implementers (LI). Where a LI will act for more than one objective, list all objectives.

Lead Implementer:	Ministry of Health and Medical Services (MHMS)
Objective(s):	Ministry of Health and Medical Services (MHMS) will assume a primary responsible role in the implementation and monitoring of HSS activities supported by the GAVI HSFP, in collaboration with other members of the TWG (Technical Working Group), under the guidance of the ICC (Inter-Organization Coordinating Committee) and the NACC (National Advisory Committee to Children). Specific objectives include: 1) To ensure transparency in the account and management of the GAVI HSFP grants and timely reporting to the GAVI Secretariat on the disbursements; 2) To ensure the effective implementation and monitoring of the programme performance according to the approved workplan, budget and the performance framework; 3) To coordinate with the relevant Provincial Health Departments and the relevant CBOs where the activities will be implemented and ensure that the similar implementation and oversight mechanism are in place at the provincial level; 4) To initiate any corrective actions such as reprogramming based on the results of the regular monitoring of the implementation; 5) To request annual disbursement of funds based on performance; and 6) To ensure effective coordination with the national SWAp and other key partners in the health sector (e.g. Development Partners Coordinating Group - DPCG).

→ Description of the Lead Implementer's technical, managerial and financial capabilities.

It is intended that the Technical Working Group (TWG) established for coordinating the HSFP proposal development will continue to serve as a coordinating mechanism for the implementation of the GAVI HSS programmes if the application is approved and the funds are granted to the Solomon Islands. The lead of the TWG is the Director Public Health, MHMS and the key members of the TWG shall include:

- Medical Officer, Maternal and Child Health, MHMS
- EPI Programme Coordinator, MHMS
- Director Policy and Planning, MHMS
- National Cold Chain Coordinator, MHMS
- National Medical Store Manager, MHMS
- Maternal Reproductive Health Division, MHMS
- Health Promotion Division, MHMS
- UNICEF Field Office
- WHO Country Office
- JICA Representative Office
- Representatives of other relevant FBOs, NGOs and/or CBOs

The TWG includes all the representatives of relevant programmes and technical units within the Ministry in charge of EPI, maternal and child health, reproductive health, health promotion, procurement and supply and policy and planning, together with representatives from the key multilateral partners and the civil society organizations. The administrative operation of the TWG has been assisted by WHO Country Office. When and as needed, technical assistance will be provided by WHO Regional Office in Manila and WHO South Pacific Office in Suva.

→ *Description of the Lead Implementer's technical, managerial and financial capabilities.*
The EPI Programme under the Ministry of Health and Medical Services (MHMS) has been receiving the GAVI's support for pentavalent vaccines since 2008; 706,755 US& has been disbursed as of June 2011 (Solomon Islands: Country summary, GAVI). 100,000 US$ was also granted to MHMS as a vaccine introduction grant in 2008. Another 506,500 US$ is committed by GAVI to continue support the pentavalent vaccines between 2012-2015. MHMS has been also a sub-recipient for the previous Global Fund Pacific Multi-country grants, including Round 2 grant for HIV and TB, Round 2/Round 5 consolidated grants for Malaria, Round 7 grant for HIV, Round 8 for TB and the cross-cutting HSS (on laboratory strengthening and pharmaceutical services), with the SPC being the principal recipient. MHMS is the lead agency in the Health SWAp and has a considerable managerial experience in implementing projects funded by AusAID (Health Sector Strengthening Project), the World Bank (Solomon Islands Health Sector Development Programme), among others. If granted, the HSFP grants will be managed by the MHMS as an integral part of the country's health systems strengthening activities in close collaboration with the relevant technical programmes such as EPI and MNCH. As a part of the proposed activities, an international consultant (TA) will be invited at the end of every year to strengthen the capability of the local M & E officer and ensure effective programme performance monitoring and evaluation. MHMS has a proven financial capability to implement the grants and a local account assistant who was recently hired with the support of the HSSP fund (by AusAID) will also assist management of the GAVI HSFP grants.

6.1 b) Coordination between and among implementers
→ *Please describe how coordination will be achieved (a) between multiple Lead Implementers, if there is more than one nominated for the proposal; and (b) between each nominated Lead Implementer for the proposal and its respective Sub-Implementers.*
Under the GAVI HSFP, there is only one Lead Implementer which is the Ministry of Health and Medical Services, and there are no Sub-Implementers. Under the SDA 1.2.6 activities on the Community Systems Strengthening, however, the MHMS is planning to support selected CBOs and FBOs (3 organizations each in the three target provinces of Guadalcanal, Western and Malaita). Upon the approval of this proposal, the TWG would identify the key areas of focus in the community systems strengthening activities to increase awareness and demand for EPI and MNCH services. Training on proposal development and project management will be then provided to the FBOs and CBOs. There will be a call for an expression of interest (EOI) to the trained FBOs and CBOs. After the review of the submitted proposals or EOIs, the TWG will make a decision on which organizations should be given a funding support from MHMS to carry out community mobilization activities. A contract will be signed between the MHMS and the selected FBOs/CBOs and the funds will be disbursed accordingly. Oversight and monitoring of the projects will be done by MHMS. There will be an annual coordination meeting between the AHCs and the representatives of the selectees FBOs/CBOs to maintain strong linkages with the health systems. These activities should be also coordinated with other community based activities such as "Healthy Village" initiatives by JICA (in Gizo/Western Province and Honiara).

6.1 c) Sub-Implementers ***(Not Applicable for GAVI applicants)***		
(i) Will other departments, institutions or bodies be involved in implementation as Sub-Implementers?	☒ Yes	→ *go to section 6.1 c) (iii) and 6.1 c) (iv)*
	☐ No	→ *go to section 6.1 c) (ii)*
(ii) If no, why not?		
Though there is no "sub-implementer" as such in this proposal, MHMS will keep a close coordination with all the Provincial Health Departments (PHDs) and especially those in Guadalcanal, Western and Malaita Provinces to ensure regular monitoring, supervision, coordination and provision of necessary technical assistance to the provincial levels where the activities will be implemented. In terms of contacting the directors of the PHDs, MHMS will piggyback different opportunities when the PHD directors come to Honiara to attend meetings, so that no additional travel will incur for the PHD directors only for the GAVI HSS project. For the pilot three provinces, MHMS will conduct a bi-annual supervisory visits, in addition to regular communication by telephone and emails with the child health/EPI programme managers in the PHDs.		
(iii) List the identified Sub-Implementers and, for each Sub-Implementer, describe: • The roles and responsibilities to be fulfilled; • Past implementation experience; • Geographic coverage and a summary of the technical scope; • Challenges that could affect performance and mitigation strategies to address these challenges.		
The roles and responsibilities of the supported FBOs/CBOs will be to implement the agreed community mobilization activities on EPI and MNCH such as raining awareness and demand of mothers and children for timely vaccination, vitamin A supplementation, etc., in close coordination with the village committees and the local authorities. The past implementation experiences of those FBOs/CBOs will be screened at the time of the proposal review. Under this proposal, the activities will be implemented in the three pilot provinces of Guadalcanal, Western and Malatita provinces. The weak capabilities of the FBOs/CBOs in project management could be a potential challenge. MHMS intends to mitigate such ricks through providing a preparatory training on project design and management, as well as through an annual coordination meeting with the health authorities, which are all planned and budgeted under this proposal.		
iv) If the private sector and/or civil society are not involved as Sub-Implementers or only involved in a limited way, explain why.		
N/A - 9 CBOs each year will be involved in the CSS activities under this proposal).		

6.1 d) Strengthening implementation capacity

(a) Applicants are encouraged to include a funding request for technical assistance to achieve strengthened capacity and high quality services, supported by a summary of a technical assistance (TA) plan. In the table below, please provide a summary of the TA plan.

→ *Please refer to the Strengthening Implementation Capacity information note for further background and detail.*

Management and/or technical assistance **objective**	Management and/or technical assistance **activity**	**Intended beneficiary** of management and/or technical assistance	Estimated timeline	Estimated cost → *same as proposal currency*
TA for capacity building / M&E	International consultant to provide a training	National M& E officers (both central and provincial levels)	3 weeks each mission x 4 times at the end of every year	60,000 US$
TA for EPI programme assessment including cold chain assessment	International consultant conduct an assessment	National EPI Programme, MNCH programme	1 month mission at the end of year 4	40,000 US$
TA for assessment of waste management	International consultant conduct an assessment	National EPI Programme, MNCH programme, All PHC facilities	1 month mission in year 1	30,000 US$

(b) Describe the process used to identify the assistance needs listed in the above table.

MHMS will be leading a selection of these TAs with assistance of WHO.
Identification of appropriate international consultants could be assisted by WHO, together with UNICEF (especially on EPI and cold chain assessment) and also with JICA (especially on cold chain and waste management assessment).

(c) If no request for technical assistance is included in the proposal, provide a justification below.

Request for the TA is included in this proposal.

6.2 Financial management arrangements

➔ *Please describe:*

a) *The proposed financial management mechanism for this proposal;*

b) *The proposed processes and systems for ensuring effective financial management of this proposal, including the organisation and capacity of the finance department and the proposed arrangements for planning and budgeting, treasury (fund management and disbursement), accounting and financial reporting, internal control and internal audit, procurement, asset management and external audit.*

c) *Technical Assistance (TA) proposed to strengthen the financial management capacities in order to fulfil the above functions.*

Solomon Islands has not yet conducted the GAVI Financial Management Assessment (FMA). Upon the approval of the GAVI HSFP application, therefore, a necessary financial management assessment needs to be conducted to be eligible to receive the funds from GAVI.
In light of the available pooled fund mechanism under the SWAp, however, it is requested that GAVI will look into the country's existing financial management mechanism and explore a potential use of the pooled fund mechanism.
An accountant assistant currently engaged through the HSSP funds (AusAID) could be in charge of managing the GAVI HSS funds.

Mechanism / procedure	Status / Description
Has a GAVI FMA been conducted: yes / no	No
When was the last FMA conducted: mm/yyyy	N/A
If yes: Has an Aide Memoire been signed: yes / no (Document Number.....)	N/A
If yes: Will the present Aide Memoire govern the financial management of the GAVI HSS funds: yes / no	N/A
If no: Reasons for not following all the agreements in the last Aide Memoire	N/A
Next FMA scheduled for: mm/yyyy	N/A
Has a joint financing mechanism been established for the health sector: yes / no	Yes (under the SWAp pooled fund)
If yes: Will this joint financing mechanism be used for managing GAVI HSS funds: yes / no (Document Number.....)	Yes
If no: Reasons for not using the joint financing mechanism	N/A
Please provide a detailed description of the financing mechanism proposed for the management of GAVI HSS funds if all the agreements in the last Aide Memoire is not followed or a FMA has yet to be conducted.	Different development partners provide earmarked budget support through the joint financing mechanism, i.e. ‘Sector-wide Approach (SWAp) account’. The access to the funds will be done through the SWAp mechanism. The GAVI HSS funds could follow the same mechanism.

Title(s) of document(s) governing the annual budgeting process for the use GAVI HSS funds (Document Number.....)	SIG Financial Instruction (Attachment 15)
Title(s) of document(s) governing the financial management (accounting, recording and reporting) of the GAVI HSS funds (Document Number.....)	MHMS Financial Operations Guide
Title(s) of document(s) governing the audit of the GAVI HSS funds (Document Number.....)	MHMS Financial Operations Guide
Frequency of internal audits planned for GAVI HSS funds?	Twice yearly (by the Auditors Generals Department)
Frequency of external audit planned for GAVI HSS funds?	Annually
Title(s) of document(s) governing procurement procedures for GAVI HSS funds (Document Number.....)	MHMS Procurement Guide

6.3 Governance and oversight arrangements

➔ *Please describe:*

a) *The committee(s) responsible for the governance of the HSS support in the country (this should include the roles of the HSCC and the CCM, including how the roles of these bodies are aligned with Global Fund or GAVI requirements);*

b) *The mechanisms for coordinating the proposed HSS support with other health system strengthening activities and programs;*

c) *Plans (where appropriate) to strengthen governance and oversight;*

d) *Technical Assistance (TA) requirements to enhance the above governance processes.*

Ministry of Health and Medical Services (MHMS) will assume a primary responsible role in the implementation and monitoring of HSS activities supported by the GAVI HSFP, in collaboration with other members of the TWG (Technical Working Group), under the guidance of the ICC (Inter-Organization Coordinating Committee) and the NACC (National Advisory Committee on Children).
Within the MHMS, the MHMS Executive Meeting which comprises of the Permanent Secretary, the Under-Secretaries and relevant Directors, will provide necessary guidance and oversight. The Executive Meeting receives annual reports from all the division heads and different committees (including ICC and NACC). The reports will be reviewed and discussed at the annual National Health Conference and the Joint Annual Review of the Health Sector with multi-sectoral ministers and development partners.

The roles and the responsibilities of the key ICC members are listed as below:

<u>Roles and responsibilities of the key ICC members</u>

Title / Post	**Organisation**	**ICC member**	**Please list the specific roles and responsibilities of this partner in the GAVI HSS application development**

		yes/no	
Director of Public Health	Ministry of Health and Medical Services	Yes	Leadership in the proposal development, project implementation and monitoring, as well as coordination with all the partners.
Director of Planning	Ministry of Health and Medical Services	Yes	Leadership in the proposal development, and project implementation and monitoring.
Director of Reproductive and Child Health Division	Ministry of Health and Medical Services	Yes	Provision of technical data, information and guidance
Coordinator of Child Health	Ministry of Health and Medical Services	Yes	Provision of technical data, information and guidance
National EPI Coordinator	Ministry of Health and Medical Services	Yes	Provision of technical data, information and guidance
National Cold Chain Managers	Ministry of Health and Medical Services	Yes	Provision of technical data, information and guidance
Health Promotion Division	Ministry of Health and Medical Services	Yes	Provision of technical data, information and guidance
Country Liaison Office/Honiara	WHO	Yes	Provision of technical and organizational support
Chief of Field Office	UNICEF	Yes	Provision of technical and organizational support
Resident Representative	JICA	Yes	Provision of technical and organizational support

7. Risks and Unintended Consequences

7.1 Major risks

➔ *Please describe any major "internal" risks (within the control of those managing the implementation of the HSS support) and "external" risks (beyond the control of those managing the implementation of the HSS support) that might negatively affect the implementation and performance of the proposed activities.*

Risks	**Mitigating strategies**
Internal: High turnover of staff and key personnel	Preparation of the integrated MHMS HR management plan
Internal: Sources of the recurrent cost for maintenance and replacement of the procured cold chain equipment	UNICEF/JICA assistance in efficient procurement and sustenance of the current equipment
Internal: Competition on the use of some supplies (boats/fuel/OBM)	Strong supervision and coordination by the TWG, EPI programme and provincial pharmaceutical stores
External: Weak capacity of the CBOs under the contracts with MHMS	Thorough preparation and training and an annual coordination meeting under the proposed activities
External: Mass recruitment of nurses to Vanuatu resulting in lack of manpower	Integrated training for nurses leading to production of multi-skilled cadres

7.2 Unintended consequences

➔ *Please describe any possible unintended consequences that might occur as a result of implementing the proposal and the strategies to mitigate these unintended consequences.*

Unexpected additional cost incurred when installing the cold chain equipment (e.g. need for circuit breakers, wiring, etc.).

Contingency and operational budget is available at the MHMS for such situation.

Mandatory Attachments → *Please tick when the attachment is included*		
No.	*Attachment*	✓
1	1.1. National Health Strategic Plan 2011 – 2105 (NHSP) 1.2 MTEF final Nov 2011 1.3. Solomon Islands EPI Policy 2008 1.4. Solomon Islands National Plan for Immunization 2011 – 2015 1.5. Solomon Islands Child Health Strategy 2011 – 2015 1.6. Solomon Islands MHMS 2010 Annual Report 1.7. Solomon Islands Child Health Situational Analysis, May 2011 1.8 Solomon Islands National RH Policy and Strategy 1.9. Solomon Islands National Human Resource and Workforce Plan, March 2011 1.10. HSS Concept Note, October 2011 1.11. National Children's Policy with National Plan of Action, April 2010	✓
2	Logframe	✓
3	National M&E Plan	✓
4	Performance Framework	✓
5	5.1.a Summary Workplan with budget 5.1.b Detailed Workplan with detailed budget 5.2 Financial gap analysis,	✓
6	6.1 GAVI Application Supplement Part A – Government Endorsement 6.2 GAVI Application Supplement Part B – HSS External Funding	✓

Optional Attachments → *Please tick when the attachment is included*		
No.	*Attachment*	✓
7	List of Acronyms	✓
8	List of References	✓
9	Minutes - CCM meeting 27 Oct (Concept Note on HSFP approved)	✓
10a	Minutes – ICC meeting	✓
10b	ICC endorsement sheet	✓
11	Minutes – All TWG meetings	✓
12	Immunization Coverage - JRFSOL	✓
13	TOR of the National Advisory Committee to Children (NACC)	✓
14	Minutes, National Advisory Committee to Children (NACC), Special Meeting, 20 Dec 2011, Endorsement of the GAVI submission	✓
15	SIG Financial Instructions	✓