

**Application Form for Country Proposals**

**Providing Support for IPV Introduction**

**Submitted by**

**The Government of Solomon Islands**

**Date of submission: 12 September 2014**

**This form is applicable to applications submitted in 2014**

**Document date: February 2014**

**This document replaces all previous versions and incorporates revisions to the cover page only.**

**The completed application documents must be submitted electronically to the GAVI Secretariat at** [**proposals@GAVIalliance.org**](mailto:proposals@gavialliance.org) **by the application deadline.**

Enquiries to: [proposals@GAVIalliance.org](mailto:proposals@gavialliance.org?subject=Applications%20for%20New%20Vaccines%20Support) or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and general public. The application and attachments must be submitted in English, French, Spanish, or Russian.

Note: Please ensure that the application has been received by the GAVI Secretariat on or before the day of the deadline.

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

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**Acronyms**

AD Auto-disable

AEFI Adverse events following immunization

DRCHD Director of Reproductive and Child Health Division

EPI Expanded Programme on Immunization

EVM Effective vaccine management

GAVI Global Alliance for Vaccines and Immunizations

FMA Financial management assessment

Hib Haemophilus Influenzae type b

ICC Inter-Agency Coordinating Committee

IPV Inactivated polio vaccine

MDGs Millennium Development Goals

MHMS Ministry of Health and Medical Services

MOF Ministry of Finance

mOPV2 Monovalent oral polio vaccine 2

NITAG National Immunization Technical Advisory Group

NRA National Regulatory Authority

OPV Oral polio vaccine

OPV2 Oral polio vaccine 2

PCV Pneumococcal vaccine

RCHT Reproductive and Child Health Team

SAGE Strategic Advisory Group of Experts

UNICEF United Nations Children’s Fund

VIG Vaccine Introduction Grant

WHO World Health Organization

#### Table 1. Summary

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| The Government of: Solomon Islands | | | | Date of Submission: 12 September 2014 | |
| IPV introduction date: 1st September 2015 | | | | Current Pentavalent schedule:  6weeks, 10 weeks, 14 weeks after birth | |
| Co-financing : No | | | | If co-financing, please specify amount ($) per dose: | |
| Procurement mean (UNICEF SD, PAHO, self-procurement): UNICEF SD | | | | | |
| Vaccine preference  (in order of first to third) | | | Reason for choice of presentation | | Expected wastage rate\* |
| 1. 10-dose vial | | | 1. Saves storage space, technically  feasible | | 1. 50% |
| 2. 5-dose vial | | | 2. Saves storage space, technically  feasible | | 2. 30% |
| 3. 2-dose vial | | | 3. Saves storage space, technically  feasible | | 3. 10% |
|  | | |  | | *\* Cannot exceed 50% for 10-dose vials, 30% for 5-dose vials, 10% for 2-dose vials, or 5% for 1-dose vials* |
|  | |  | |  |  |
| Year | Number in target population for IPV | | | Number in birth cohort | Number of surviving infants |
| 2014 | 17,490 | | | 18,031 | 17,490 |
| 2015 | 17,896 | | | 18,450 | 17,896 |
| 2016 | 18,314 | | | 18,880 | 18,314 |
| 2017 | 18,739 | | | 19,319 | 18,739 |
| 2018 | 19,175 | | | 19,768 | 19,175 |
|  |  | | |  |  |

**Fiduciary management arrangement data**

The one-time vaccine introduction grant for IPV will be transferred to the Government of Solomon Islands. The country has completed a financial management assessment (FMA) and the financial management modalities – including bank details – agreed with GAVI are still applicable. The country has signed Aide Memoire derived from the FMA and it hereby confirms that there is no modification relating to the existing financial management arrangements.

**Signatures**

#### Government

The Government of Solomon Islands acknowledges that this new vaccine introduction is intended to contribute to the eradication of polio as reflected in the Global Polio Eradication Initiative’s Polio Eradication and Endgame Strategic Plan. (<http://www.polioeradication.org/resourcelibrary/strategyandwork.aspx#strategyandwork.aspx?s=2&_suid=1382372983385049930892531473775>).

The Government of Solomon Islands requests support from GAVI for the use of inactivated polio vaccine.

The Government of Solomon Islands commits itself to improving immunization services on a sustainable basis. The Government requests that the GAVI Alliance and its partners contribute financial and technical assistance to support immunization of the targeted population with one dose of IPV as outlined in this application.

Annex 2 attached shows the amount of support requested from the GAVI Alliance for the introduction of IPV.

Table 2. Ministers

|  |  |
| --- | --- |
| **Minister of Health**  **(or delegated authority)** | |
| **Name** | Hon Charles SIGOTO |
| **Date** |  |
| **Signature** |  |
| **Minister of Finance**  **(or delegated authority)** | |
| **Name** | Hon Rick HOUENIPWELA |
| **Date** |  |
| **Signature** |  |

Table 3. List of individuals who compiled this application

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** | **Position** | **Telephone** | **Email** |
| Dr Divinal OGAOGA | Director Reproductive and Child health Division | 6777513627 | dogaoga@moh.gov.sb |
| Dr Damene YASSIN | WHO Consultant | 6777895264 | damenea@yahoo.com. |
| Dr Ibrahim DADARI | UNICEF EPI Consultant | 6777834623 | idadari@unicef.org |
| Mr Raymond MAURIASI | National EPI Coordinator | 6777500832 | rmauriasi@moh.gov.sb |

#### National Coordinating Body – Inter- Agency Coordinating Committee (ICC) for Immunization or equivalent

We the members of the ICC confirm that a quorum of the committee met on 11 September 2014 to review this proposal. By the terms of reference for our committee, we endorsed this proposal at that meeting, based on the supporting documentation attached.

The endorsed minutes of this meeting are attached as Annex 3.

Table 4. List of ICC members

|  |  |  |
| --- | --- | --- |
| **Name/Title** | **Agency/Organisation** | **Signature** |
| Dr Tenneth DALIPANDA- Under Secretary Health Improvement | Ministry of Health and Medical Services |  |
| Dr Audrey AUMUAA - WHO Country Representative (AG) | World Health Organization Solomon Islands |  |
| Mr Kang YUN JONG- UNICEF Chief of Field Office | United Nations Children’s Fund Solomon Islands |  |
| Dr Divinal OGAOGA- Director Reproductive and Child Health Division | Ministry of Health and Medical Services |  |
| Dr Titus NASI- Head of Paediatric Department | National Referral Hospital |  |
| Dr Leeanne PANISI – Head of Obstetrics and Gynaecology | National Referral Hospital |  |
| Mr Timmy MONEA – Director of Pharmacy Services | National Medical Store |  |
| Erin ALEESON – Second Secretary, Health | Department of Foreign Affairs and Trade - Australian Aid Program |  |
| Hemah AQUILLA –Hygiene Promotion Officer | World Vision Solomon Islands |  |
| Mr Benedict ESIBAEA – Director Primary Education | Ministry of Education Human Resource Development |  |

Table 5. Contact person in case the GAVI Secretariat has queries on this submission

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Dr Divinal OGAOGA | **Title** | Director Reproductive and Child Health Division |
| **Tel no** | 6777513627 |
| **Fax no** | 67720085 | **Address** | Ministry of Health and Medical Services  Honiara, Solomon Islands |
| **Email** | dogaoga@moh.gov.sb |

**GAVI ALLIANCE**

**GRANT TERMS AND CONDITIONS**

Countries will be expected to sign and agree to the following GAVI Alliance terms and conditions in the application forms, which may also be included in a grant agreement to be agreed upon between GAVI and the country:

***FUNDING USED SOLELY FOR APPROVED PROGRAMMEMES***

The applicant country (“Country”) confirms that all funding provided by the GAVI Alliance for this application will be used and applied for the sole purpose of fulfilling the programme(s) described in this application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for this application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.

***AMENDMENT TO THIS PROPOSAL***

The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in this application. The GAVI Alliance will document any change approved by the GAVI Alliance, and this application will be amended.

***RETURN OF FUNDS***

The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the programme(s) described in this application. The country’s reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance’s request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

***SUSPENSION/ TERMINATION***

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in this application, or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in this application if a misuse of GAVI Alliance funds is confirmed.

***ANTICORRUPTION***

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with this application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

***AUDITS AND RECORDS***

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

***CONFIRMATION OF LEGAL VALIDITY***

The Country and the signatories for the government confirm that this application is accurate and correct and forms a legally binding obligation on the Country, under the Country’s law, to perform the programmes described in this application.

***CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARENCY AND ACCOUNTABILITY POLICY***

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements.

***ARBITRATION***

Any dispute between the Country and the GAVI Alliance arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in this application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in this application.

***Use of commercial bank accounts***

The eligible country government is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support, including HSS, ISS, CSO and vaccine introduction grants.  The undersigned representative of the government confirms that the government will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

Injectable Polio Vaccine (IPV) introduction plan

**Executive summary**

The Solomon Islands was declared polio free, in conjunction with other countries in the Western Pacific Region in 2000. Incidence of polio and maternal neonatal tetanus (MNT) has been sustained at zero level. Solomon Islands adopted the global strategy for polio eradication and has been implementing the strategies since then. Maintaining polio free status till achievement of global polio eradication is one of the strategies of the multi-year immunization plan of the country. AFP surveillance system is in place with sentinel sites, and refresher trainings were conducted in July and August 2014. The routine immunization services will be improved on a sustainable basis.

The introduction of IPV is a key element of the Polio Eradication and Endgame Strategic Plan 2013-2018 which was drawn up in response to the May 2012 World Health Assembly declaring the completion of poliovirus eradication to be a programmatic emergency for global public health. As the world is closer to polio eradication more cases of paralysis due to vaccine derived polio virus have been reported. Although WPV2 was last reported in 1999, VDPV2 has continued to paralyse children. Therefore introduction of IPV will help to reduce risks from OPV2, to interrupt transmission in the case of outbreaks, and also to hasten eradication by boosting immunity against poliovirus types 1 and 3 in children who have previously received OPV.

IPV will be introduced nationally and the introduction date will be the 1st September 2015. After completion of the implementation plan, information, education and communication (IEC) materials will be developed with partners including communication plan for educating communities. Training plans for introducing IPV will be developed simultaneously. Adverse Events Following Immunization (AEFI) guidelines have been prepared and will be adapted for monitoring AEFI after the introduction of IPV. Basic training on vaccine safety was conducted in all the provinces in 2012 and 2013. In 2016 there will be synchronized global switch from tOPV to bOPV.

Immunization in Solomon Islands is progressing, and IPV is planned to be given together with Penta3 and OPV3 as recommended by SAGE at 14 weeks after birth. The country prefers the 10-dose liquid presentation vaccine since it is logistically and technically feasible. The cold chain capacity required for the IPV introduction is accommodative and the other operational aspects of the vaccine delivery are manageable at all levels given the country’s experience of new vaccine introductions in the recent past years including integration of multiple injections into the national routine child vaccination programme. An Inter-agency Coordinating Committee (ICC) is in place in country and the committee supervises the programme. The Expanded Programme on Immunization (EPI) is managed by nurses in health facilities with the guidance of the National EPI Coordinator and Director of Reproductive and Child Health Division. The National Comprehensive Multi-Year Plan 2011-2015 for EPI in Solomon Islands was issued in 2010 and it addresses the sustainability of vaccines.

The national IPV introduction work plan has been completed. Policy/documents (immunization handbook, policy, reporting forms and immunization register) revision has been initiated and the documents will be printed and distributed at national and sub-national levels. Effective vaccine management (EVM) assessment was conducted in August 2012 and cold chain capacity has improved significantly to accommodate new vaccines. Plans are put in place to replace cold chain equipment and to order and distribute vaccine. Procurement of vaccine will be done through United Nations Children’s Fund (UNICEF) Supply Division.

Community awareness will be carried out through radio, personal communication, television, puppet shows, cartoons (for children), newspapers, dramas, churches, wall painting, posters and banners. Support from UNICEF and WHO is requested for this activity. Training of trainers (TOT) will be done in Honiara and will be facilitated by WHO.

The total amount of vaccine introduction grant requested from GAVI is US$ 98,754.17 with 123,718 doses of IPV, and associated supplies of 136,092 AD syringes and 1,363 safety boxes calculated on the basis of the target population from 2015 to 2018. The main challenge in Solomon Islands is that the islands are scattered, making accessing the remote islands costly. In this regard, activities such as training will be conducted along with other planned activities to share costs. Vaccine distribution will be done along with other drugs to the extent possible to reduce freight costs.

1. **Justification for introduction of IPV and national decision-making process**

The introduction of IPV is a key element of the endgame plan and global readiness to manage risks associated with OPV2 cessation. The primary role of IPV will be to maintain immunity against type 2 polio virus while removing OPV2 globally. More specifically, IPV is planned to be introduced for the following reasons:

i) To reduce risks: Once OPV2 is withdrawn globally, IPV will help fill the immunity gap by priming population against type 2 polio virus should it be reintroduced. A region immunized with IPV would have a lower risk of re-emergence or reintroduction of wild or vaccine-derived type 2 polio virus.

ii) To interrupt transmission in the case of outbreak: Should be needed to control an outbreak, the immunity levels needed to stop transmission will be easier to reach with mOPV2 compared to use of mOPV2 in a completely unvaccinated population. Thus introducing IPV now could facilitate future outbreak control.

iii) To hasten eradication: IPV will boost immunity against poliovirus types 1 and 3 in children who have previously received OPV, which could further hasten the eradication of these two wild viruses.

The introduction of IPV will also increase the use of new vaccines and it will also contribute to the achievement of MDGs.

The country has an existing well-functioning ICC and during the most recent ICC meeting the IPV introduction plan was discussed and endorsed. The ICC meeting to finalize the plan and endorsement was convened on 11 September 2014 and the minutes of the meeting are attached in Annex 3. The ICC consists of members from Ministry of Health and Medical Services (MHMS), Ministry of Education Human Resource Development, WHO, UNICEF, World Vision, Department of Foreign Affairs and Trade – Australian Aid Program and Women Group. The country does not have a functioning National Regulatory Authority (NRA), National Immunization Technical Advisory Group (NITAG) or academic and training institutions whose nominees could be involved in the decision making process. The ICC is the responsible body for the introduction of all new vaccines.

IPV introduction will be on the same lines as was adapted during the introduction of other new vaccines in the country (Haemophilus Influenzae type b/Hib and Pentavalent) taking into considerations the lessons learned from these introductions such as single dose Penta with five antigens which decreases the burden on the health system and increases acceptance by health workers and community, working together with GAVI and other partners, transition challenges with new vaccine introduction particularly service delivery strategies for phasing in the new vaccine and logistic issues.

Planning, implementing and evaluating are key parts of this introduction. Technical assistance from WHO and UNICEF has been requested and the timeline of activities has been developed and shared with technical partners for assistance. The cold chain system was assessed, gaps were identified, and the improvement plan is being implemented.

**2. Overview of IPV**

**2.1 Vaccine preference**

Solomon Islands is planning to introduce IPV on the 1st September 2015.The vaccine preference would be 10-dose vials to minimize storage space and the multi-dose vials are

technically feasible based on the current WHO guidelines.

Table 6. IPV vaccine preferences and estimated date of introduction

|  |  |  |  |
| --- | --- | --- | --- |
| **Preferred IPV vaccine** | **Month and year of first vaccination** | **Preferred second presentation** | **Preferred third presentation** |
| 10- dose vials | 1st September 2015 at 14 weeks after birth | 5- dose vials | 2-dose vials |

**2.2 Country licensure status**

Solomon Islands does not have a functioning NRA. The country has Drug Therapeutic Committee that regulates the importation of new drugs and chemicals. Solomon Islands also has a National Policy on Dangerous Drugs. For vaccines the country uses only WHO pre-qualified vaccines. National vaccine licensure will not be needed for IPV. As long as vaccines are WHO pre-qualified there are no other needs and the country accepts the Expedited Procedure for national registration of WHO-prequalified vaccines. The preferred presentations have been discussed in the ICC and plans endorsed.

The Solomon Islands customs regulations and requirements for pre-delivery inspection include bill of lading which is taken by pharmacy authorities for clearance by customs. In case of delays UNICEF will inform the pharmacy and others concerned and plans for receipt and clearance are done for timely clearance.

**2.3 Target population and vaccine supply**

Solomon Islands will introduce IPV on the 1st of September 2015. The estimated target population for 2015 is 17,896 and projections up to 2018 are given below.

Table 7. Estimated target population, vaccine and supplies requirements from 2015 –

2018

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Target children** | **Estimated coverage** | **Number doses/ person** | **Estimated wastage** | **Total doses** | **Buffer** | **Total doses requirement** | **AD syringes** | **Safety boxes** |
| 2015 | 17,896 | 80% | One dose | 50% (10-dose vial) | 21,476 | 7,159 (4months) | 28,635 | 31494 | 315 |
| 2016 | 18,314 | 100% | One dose | 50% (10-dose vial) | 27,471 | 5,370 (3 months) | 32,841 | 36126 | 362 |
| 2017 | 18,739 | 100% | One dose | 50% (10-dose vial) | 28,109 | 3,580 (2months) | 31,689 | 34856 | 349 |
| 2018 | 19,175 | 100% | One dose | 50% (10-dose vial) | 28,763 | 1,790 (I month) | 30,553 | 33609 | 337 |
| **Total** |  | | | | **105,810** | **17,899** | **123,718** | **136,092** | **1,363** |

All vaccines and other supplies like AD syringes, needles and safety boxes are procured through UNICEF Supply Division. However the country gets its pentavalent vaccines through GAVI co-financing mechanism. Vaccines are kept under appropriate cold chain temperature and monitoring of vaccine temperature is done twice daily and it is plotted in charts.

**3. Introduction and implementation considerations**

**3.1 Policy development**

The National Immunization Policy and the Comprehensive Multi-Year Plan will be revised in December 2014 to include IPV in the national immunization schedule. The policy will recommend introducing one dose of IPV while continuing to provide OPV doses as done in the past. Maintaining high OPV coverage, strengthening of AFP surveillance, and other existing polio eradication efforts remain to be critical components of the polio eradication strategies. The immunization schedule for other vaccines will remain the same while IPV will be given at 14 weeks of age during the same visit as the third dose of OPV.

After receiving the vaccine, child has to wait for at least 20 minutes to observe for reactions. Penta is administered on the left outer thigh. PCV (which will be introduced in January 2015) and IPV injections are given on the right outer thigh. Penta is administered alone on the left thigh because local reaction to Penta (redness and swelling) is generally stronger than for IPV and PCV. The dose of IPV is 0.5ml administered Intramuscular (IM). There should be a minimum of 2.5 cm gap between the PCV and IPV injections given on the right thigh. Other routine vaccines that are due to be given at the same time can also be co-administered as per the recommendations.

Injection safety practices are in place and are followed by nurses. Nurses are aware of AEFI and the reporting system is in place. Training on WHO safety basic course was conducted in all provinces. The immunization staff take AEFI kit with them for every session.

Table 8: Routine Immunization schedule of Solomon Islands with IPV vaccine

introduced

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Vaccine** | **Age** | | | | | |
| **Birth** | **6 weeks** | **10 weeks** | **14 weeks** | **1 year** | **School entry (6 years)** |
| BCG | **X** |  |  |  |  |  |
| HepB within 24 hours | **X** |  |  |  |  |  |
| Oral polio Vaccine (OPV) |  | **X** | **X** | **X** |  | **X** |
| PCV |  | **X** | **X** | **X** |  |  |
| IPV |  |  |  | **X** |  |  |
| DPT-HepB-Hib (Pentavalent) |  | **X** | **X** | **X** |  |  |
| Measles |  |  |  |  | **X** |  |
| Tetanus |  |  |  |  |  | **X** |

**3.2 National coordination mechanism to ensure the successful introduction**

There is buy in from all relevant key stakeholders in the immunization space in the Solomon Islands. Already key stakeholders including government and partners alike have been involved in the preparatory activities for the development of an IPV introduction and proposal plan. The plan is to have IPV administered with Penta 3 at 14 weeks of life. Decisions on and implementation of the IPV introduction plan will be done collaboratively with more meetings of the technical working group to be held.

The Inter-agency Coordinating Committee on Immunization (ICC) consists of Government and partners plays a role to make key decisions on immunization matters. The technical working group which consists of experts on immunization from both government and partners provides the technical guidance and recommendations to the ICC. Based on experiences from previous introductions, there is task sharing among all stakeholders to ensure the success of the new vaccines introduction with partners taking lead roles in technical support in their respective areas of key competencies.

Upon submitting this IPV proposal request the MHMS will proceed with sensitizing key stakeholders and establish IPV introduction framework. MHMS will also start working on a social mobilization plan which may include a knowledge, attitude, practice and perception (KAPP) study. In April and May 2014, a training plan will be developed. It will include all components relevant to the introduction of the vaccines including AEFI. In the meantime MHMS will continue expanding the cold chain capacity with installation of procured equipment and repairs. The MHMS will communicate with UNICEF to start the process of vaccine procurement upon receipt of GAVI’s approval and will ensure vaccine distribution at least one month before introduction. The proposed date of IPV introduction is the 1st of September 2015 which will be flagged off by a national launch.

The detailed timeline of activities is provided in Annex 1.

**3.3 Affordability and financial sustainability**

The required costing is illustrated in Annex 2. Funding is being requested to GAVI, WHO and UNICEF. A total of US$ 155,254.17 is needed for introduction and of this US$98,754.17 is requested from GAVI, US$30,000 from WHO and US$16,500 from UNICEF. The estimate of the costs is made based on activities planned and other financial needs as detailed in Annex 2A. The non-vaccine operational costs have been identified for introduction and summarized in Annex 2B. However, funds are not fully secured. Currently the Solomon Islands Government pays 100% of the cost for all vaccines except Pentavalent which is co-financed with GAVI, and the proposals of PCV introduction and HPV demonstration have been approved. The MHMS pays annually according to invoice received from GAVI through UNICEF SD. It is the responsibility of MHMS Account Section to make the payment. In this regard follow-up is usually done by the Programme Coordinator. Payments may be late due to other problems (e.g. lost/misplaced purchase voucher) but are not due to lack of funds. The one-time vaccine introduction grant for IPV will be transferred to the Government of Solomon Islands. The country has a Comprehensive Multi-Year Plan which addresses the sustainability of vaccines and the revised version will include IPV to be sustained by payment from the Government like the other vaccines. The cMYP will be revised in December 2014 to include IPV.

**3.4 Overview of cold chain capacity at zone, provincial and central levels**

The National medical store has sufficient cold chain storage capacity with a 40m3 WICR and some back up ice-lined refrigerators for storage. Centrally there are ice pack freezers and cold boxes for distribution and use during outreach to remote islands. Overall, 16 % of the health facilities will require some new cold chain equipment in the form of solar refrigerators and cold boxes. Nationally, 76% of the cold chain equipment is functional in all provinces. The biggest cold chain equipment gaps are in Temotu, Malaita, Central and Isabel provinces which have functionality of less than 60%. Already some cold chain equipment has been procured using GAVI HSS funds and UNICEF funding which will be installed in identified areas of need by the end of 2014. With this, all vaccines can be accommodated with adequate preventive maintenance and monitoring.

Solomon Islands conducted its last EVM assessment in 2012 and is planning to conduct one next year 2015. The MHMS with the support of partners has been implementing the last EVM recommendations with procurements and installation of cold chain equipment. The MHMS is also currently developing a cold chain equipment maintenance guideline with partner support.

**3.5 Waste management and injection safety**

Solomon Islands has adopted the WHO and UNICEF joint policy on safety of injections that recommend the use of only AD syringes and safety boxes together with quality vaccines for all types of immunization activities including routine and supplemental immunization activities. Therefore only AD syringes will be used to administer IPV and other vaccines integrated in the immunization programme. Adequate amount of injection supplies and safety boxes will be procured and distributed to all vaccination sites.

Injectable vaccines are provided by only skilled nurses and nurses are trained and practice safe use of AD syringes. The practices of using AD syringes include removal of the syringe and needle from plastic wrapping (peel open the syringe plunger end of the package) or detach the plastic caps, fixing the needle to the syringe if it is not already in place, taking off the needle cap without touching the needle, inserting the needle in the vaccine vial and bring the tip of the needle to the lowest part of the bottom of the vial, keeping the needle tip in the fluid at all times, making sure to empty the full contents of the vial, to remove the needle from the vial, to remove air bubbles, holding the syringe upright and tap the barrel and then carefully push to the close mark, locate the injection site, and pushing the plunger forward and injecting the vaccine are practiced by nurses at all levels. After injection, the plunger will automatically lock and this will ensure that the syringe cannot be reused. After use, needles are not re-capped and the needle and syringe are disposed in a safety box.

In hospitals incinerators are used for disposal of injection waste and the clinics practise closed pit burning and burying. (Burning < 400oC including pit burning, brick oven burners, drum burners; Incineration > 800oC). The country uses WHO pre-qualified vaccines which are procured through UNICEF SD and it does not procure vaccines directly.

There will be extensive supportive supervision to monitor the appropriate practice of safe injections including discarding the partially preserved multi- dose open IPV vial after six hours or at the end of the session according to the current WHO Guidelines.

**3.6 Health worker training and supervision**

The trainings for IPV introduction will be a two-tier training first being for the TOTs (supervisors) in Honiara and then the trainings will be rolled out to provinces. There will be no extra human resources who will be needed for the training. When other new vaccines were introduced a similar procedure was followed and difficulties were not encountered. Technical support for this would be requested from WHO and UNICEF as and when needed.

Training materials and information gathered from WHO position paper and documents are reviewed and checked. Training activity will be starting in June to July 2015 as supervisors will have time to visit their areas. Handbooks, posters will be revised by working committee with the aid of Health Promotion Unit and other requirements will be assisted by Reproductive and Child Health Team (RCHT).

The training will be done as a whole training package with group trainings where all topics relevant to introduction will be addressed. Pre-introduction supervision is needed and supervisors will check all clinics and ensure all materials needed for introduction are available on ground e.g., forms, registers, guideline procedures, field work handbook etc. Supportive supervisions will be carried out using a checklist.

**3.7 Risks and challenges**

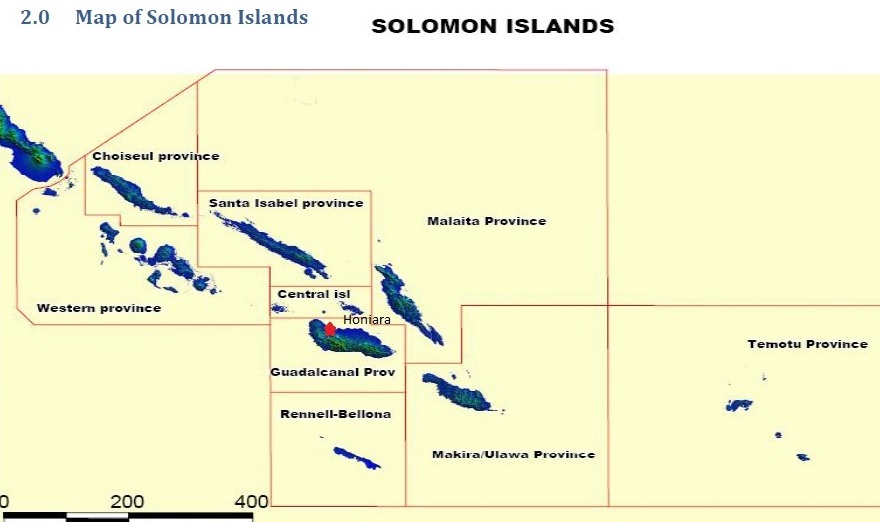
The major challenge anticipated is introducing Pneumococcal Vaccine (PCV), IPV and Human Papillomavirus Vaccine (HPV) in the same year and its burden on the health system with parental fear of multiple injections during the same visit. This will be addressed during training and supportive supervision as well as by raising community awareness using different strategies. The other challenges include ensuring safe injection by adhering to multi-dose vial policy, provision of multiple injections using a sterile method, missing of community awareness programmes transmitted through mass media, fear of increased AEFI and transportation cost due to scattered and remote islands

To address these challenges and risks training of health workers with practical demonstration, reminders and fact sheets will be conducted. Strong and continuing awareness is needed through mass media and personal communication including house-to-house for those with no access to radios or public awareness system. Although no serious adverse reactions are reported for IPV, immunization providers will carry emergency kits to vaccination sites.

**4. Situational analysis of the immunization programme**

**4.1 General context of the country**

The Solomon Islands is a double-chain archipelago of more than 900 islands in the south-west Pacific, east of Papua New Guinea and north of Vanuatu. It covers a land mass of 28,400 sq. km (11, 000 sq. mi) widely scattered over 1.3 million sq. km across the Pacific Ocean, with most of its smaller islands uninhabited. The capital city, Honiara, is located on the island of Guadalcanal. The ethnic groups consist of Melanesians (94.5%), Polynesians (3%), Micronesians (1.2%) and others (1.3%). The country is divided into nine provinces and Honiara City Council. The estimated total population is 578,741 with 85,823 children under the age of five, 18, 0311 under one year and 17, 4901 surviving infants. The country is highly dependent on subsistence farming and fishing, and 84% of the population lives in rural areas. The 2014 World Bank update reported Solomon Islands’ GNI per capita to be at US$ 1,610 for 2013. Life expectancy at birth for male and female is 64.9 and 66.7, respectively. Under 5 mortality rate is 37 per 1000 live births with IMR of 26 per 1000 live births2. Measles (MCV 1) immunization coverage among one-year-old is 76% with Pentavalent-3 (DPT-HepB-Hib) at 84% (2013)3.



A key objective in the Ministry of Health’s National Health Strategic Plan 2012-2015 is to improve child survival. The implementation of the strategic plan, through a strengthened primary health care service, is one of the priority actions under the child survival objective.

The multiyear immunization plan focuses on nine strategies:

1) Increase routine immunization coverage by 90% by 2012,

2) Re-establish and maintain well-functioning cold chain system and delivery of safe

and secure immunization services,

3) Strengthen surveillance on EPI target diseases,

4) Maintain polio-free status till achievement of global polio eradication,

5) Achieve measles elimination by 2012,

6) Reduce chronic carrier rates of hepatitis B to < 2% measured among children less

than 5 years by 2012 and accelerate hepatitis B control in general population,

7) Decrease disease burden of invasive Hib disease through effective introduction of

Hib vaccine,

8) Improve management capacity on EPI and further strengthen health system.

Targets have been set to enable monitoring of the plan.

9) Explore potential introduction of other new vaccines such as pneumococcal,

Rotavirus and HPV vaccines.

**4.2 Geographical, economic, policy, cultural, gender and social barriers to**

**immunization**

The Solomon Islands immunization programme targets all eligible children and women of child bearing age for TT vaccination. The policy recommends giving vaccine for all eligible individuals regardless of sex, race, religion or disability status. There are no cultural practices in the country that hinder access to utilization of immunization services. The programme has shown significant progress in coverage over the last decade and there is no significant difference in the immunization coverage between male and female sex or among the different ethnic groups. The country is highly dependent on subsistence farming and fishing, and 84% of the population lives in rural areas. In Solomon Islands the cost of living is quite high but the GDP is low. The gross domestic product (GDP) in 2009 was US$ 1,256 per capita. The 2014 World Bank update reported Solomon Islands’ GNI per capita to be at US$ 1,610 for 2013. The Government has made vaccination services to be free of charge to all eligible population.

The key barriers to immunization programme are:

1. Shortcomings in service delivery strategies and human resource capacity
2. Threats to immunization supply chain management and logistics such as maintenance and repair issues and accessibility of gas for refrigerators to outer islands
3. Constraints in data quality management, archiving and analysis
4. Gaps in monitoring and supportive supervision

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Projected population of 2014 from National Census, Solomon Islands, November 2009

2 National Reproductive Health Policy and Strategy, Solomon

Islands, 2011-2013

3EPI administrative coverage, MOH, Solomon Islands, 2013

Solomon Islands is scattered and thinly populated making the travel costs very high. Immunization coverage in the country has been improving over the years and the Penta 3 coverage for 2013 was 84%.

The table below summarises the antigen wise vaccine coverage trends for 2012 and 2013.

Table 9. Trends in national vaccine coverage

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Trends of national vaccine coverage** | | | | |
| **Vaccine** | **Vaccine Used** | **Target population** | **Coverage reported (JRF)** | |
| **Most recent year 2013** | **Previous year 2012** |
| BCG | 20-dose vial | 17,621 | 82 % | 82 % |
| OPV 3 | 10-dose vial | 17,621 | 86 % | 85.7 % |
| DTP 1 / Penta 1 | Single dose vial | 17,621 | 88 % | 94 % |
| DTP 3 / Penta 3 | Single dose vial | 17,621 | 84 % | 89 % |
| HPV 1 | NA | NA | NA | NA |
| HPV 3 | NA | NA | NA | NA |
| Measles 1 | 10-dose vial | 17,621 | 76 % | 84 % |
| Measles 2 | 10-dose vial | 17,621 | NA | 100 % |
| PCV 1 | NA | NA | NA | NA |
| PCV 3 | NA | NA | NA | NA |
| Rota 1 | NA | NA | NA | NA |
| Rota 2 or 3 | NA | NA | NA | NA |

**4.3 Findings from recent programme reviews**

In November 2012, representatives from the World Health Organization (WHO), United Nations Children’s Fund (UNICEF), Global Alliance for Vaccines and Immunizations (GAVI), Japan International Cooperation Agency (JICA), and Ministry of Health Mongolia conducted a review of the Solomon Island’s Expanded Programme on Immunization which marked the first programme review in the country. The agencies confirmed the high level of international commitment and support for the programme, and identified a number of achievements, issues and recommendations.

The following achievements were made in the past ten years:

* The Solomon Islands was declared polio free, in conjunction with other countries in the Western Pacific Region in 2000.
* Incidence of polio and MNT has been sustained at zero level.
* 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 other vaccines. Then follow-up measles vaccination campaign targeting all children aged 1 – 4 years has been carried out every three years (2006, 2009 and 2012). The rapid coverage assessment of the June 2012 National measles and rubella campaign was 95%.
* Haemophilus Influenzae type b (Hib) vaccine was successfully introduced as DPT-HepB-Hib vaccine into the national programme in July 2008. The addition of Pentavalent has increased demand and coverage because of single injection for five antigens, reduction of vaccine wastage and injection waste. . The cold chain programme has shifted its fridges from kerosene to gas and solar power, which are easier to maintain and will be cost effective in the medium and long term.
* Training was given for all provincial cold chain managers for cold chain maintenance and repair by external consultant (total 15 participants). Refresher training on cold chain was done in Honiara City Council (HCC), Guadalcanal and Western provinces (total of 56 participants).
* Provincial EPI review with basic EPI and cold chain training was conducted in 5 out of the 10 provinces in 2012.
* EPI and MCH programme has been well integrated at all levels. It has been easier for caretakers to receive more services in a single visit.
* Effective Vaccine Management (EVM) assessment was conducted in 2009, second in August 2012 and the next is planned for 2015.
* Community awareness on and demand for immunization has increased.

The key findings of the review that should be addressed included: different estimates for the number of target children, inadequate cold chain, weak vaccine management, inadequate earmarked funds for outreach, supervision and transportation at health facility level, delayed arrival of funds and lack of knowledge about EPI funds, weak data management, lack of guidelines on adverse events following immunization , lack of appropriate equipment for disposal of immunization waste, lack of EPI micro planning and insufficient regular supportive supervision. The review team identified several priority areas for consideration by the government to expand the scope and increase the impact of Expanded Programme on Immunization (EPI) in Solomon Islands. The MHMS has been working to address the recommendations of the International Review Team. Accordingly guidelines for AEFI have been developed. Strengthening of cold chain, vaccine management, transportation, data management and provision of fund and equipment for waste disposal have been progressively improving.

Internal programme review which was conducted in 2012 has identified some of the strengths of the immunization programme for introduction of new vaccines including:

* Strong political commitment
* Dedicated staff
* Community participation
* Involvement of Health Promotion Unit and
* Previous experience of successful introduction of new vaccines
  1. **Stock management**

Routine vaccines and supplies are forecasted on an annual basis. Vaccines are procured through the UNICEF pooled procurement mechanism (Vaccines Independence Initiative) except pentavalent vaccine which is financed through GAVI co-funding. Forecast is based on an annual target population inclusive of a four month buffer and estimated wastage rate. Stock management at the central level is done currently using mSupply systems. Once vaccines are received it is recorded into the online real-time stock management system. Batch cards are also used to delineate different vaccines batches.

Two months’ worth of stock is distributed to the provincial level. At the provincial and health facility levels, stock management is done manually using stock records book where receipts and dispatches to lower facilities are entered. Before sending vaccines to the provincial levels, their requirements for two months are estimated in the vaccine order calculation forms using their current available stock to ensure minimum and maximum stock levels are maintained. Stock record keeping is not likely to be impacted majorly by IPV introduction but stock forms will be revised to incorporate IPV.

Solomon Islands consists of a number of small islands which are accessible by air and boats travel. Distribution inland is mainly by cars and the Government has some boats for distributing to the islands. IPV introduction will not affect the frequency of vaccine distribution to the lower levels. However, there will be need for more supportive supervision to ensure vaccine handling guidelines are adhered to including IPV.

**5. Monitoring and evaluation**

**5.1 Updating of monitoring tools**

To accommodate the addition of IPV, The MHMS will update immunization forms, vaccination cards, or electronic databases used for recording and reporting vaccine administration, forms for ordering vaccines, and vaccine stock ledgers, and any other forms that list the national immunization programme vaccines. These include:

* Immunization registers
* Baby books
* Tally sheets
* Summary sheets
* Stock ledgers
* Vaccine Management Tools
* Electronic databases (DHIS and mSupply system)

In addition to the forms, the various information systems that use these data will also be updated to reflect the addition of IPV. This includes systems that aggregate immunization coverage data from provincial level upwards, including reporting at the national level to UNICEF/WHO. Early communication with the national health information system is needed to ensure adequate lead-time to change the system.

The introduction of IPV in Solomon Islands will create an avenue to review how information is gathered and used for the immunization programme and to improve the quality of routinely reported data as well as using the data to improve programme performance at all levels. Evaluation of IPV introduction will be based on monitoring routine vaccine coverage data and other indicators signalling a successful introduction.

Baby books: The IPV dose should be recorded on the child’s baby book, which is kept with the child to report vaccination status, and other information such as growth monitoring. The updated baby book will clearly indicate the clinic where the IPV dose was received and date of administration should be entered. If a child already has an older card without space for recording IPV administration, the information should be transferred to a new updated card.

Tally sheet: Tally sheets are important for monitoring vaccine demand by supervisors. This will be revised to capture IPV, alongside all other vaccines.

Immunization Register: New books with a column for IPV will be provided for recording the date when IPV is administered, alongside all other vaccines at the same contact.

Stock record: Accurate vaccine forecasting and ordering depends on knowing the quantity of vaccines in stock at all times. Also record the number of open vials and unopened vials with reason (VVM change, expiry, freezing, breakage, other). The mSupply database will be reviewed to include IPV as well.

Integrated monthly report: Stock record forms will vary for the health facility versus the zone and provincial levels.

Synergies in application with other vaccines introduction have been taken into considerations. As the country is planning to introduce PCV in January 2015 and HPV demonstration in March 2015, monitoring and evaluation tools will be revised together to accommodate the introduction of IPV as well as PCV and HPV.

**5.2 Adverse Events Following Immunization (AEFI) monitoring and reporting**

AEFI guidelines have been developed based on the WHO guidelines and adapted to Solomon Islands context. The guidelines include a protocol on how to report, investigate and manage any AEFI causality. AEFI monitoring is integrated in all EPI programme guidelines and health workers are continuously sensitized on the reportable AEFIs.

Training on AEFI monitoring is already integrated in the training plan and therefore all EPI staff will be trained on AEFI during the integrated training for IPV introduction. The potential AEFI that can occur due to programme errors will be described along with precautions to avoid the problems by strictly adhering to the safety procedures described in the national AEFI guidelines. In view of increasing public awareness and introduction of new vaccines, the EPI programme is taking measures to strengthen the AEFI surveillance system. This will be further reviewed and adopted for use. Basic training course on vaccine safety was conducted for staff in 2013.

Solomon Islands does not have AEFI Expert Review Committee but nurses do have guidelines to follow on poison drugs and to give medications during AEFI. For monitoring adverse events at all levels for IPV and strengthening AEFI monitoring for other vaccines, as step forward following the training and development of guidelines, the AEFI reporting forms and case investigation forms will be printed and made available at all levels. The monthly zero reporting will be encouraged and any reportable adverse event will be reported from provinces to the national level. A list of reportable AEFI has been included in the guidelines. Staffs need to ensure that all vaccines are checked before use and double check with the client that the child receiving the vaccine is the right child and vaccines administered at the right site, route and dose. AEFI surveillance will be further strengthened to detect, treat, and/or refer any case of severe AEFI to the nearest referral hospital.

**6. Advocacy, communication, and social mobilisation**

Adequate sensitisation of the community and its leadership including the political, religious and traditional leaders is key to the success of any new vaccine introduction such as IPV. The government of Solomon Islands is committed to the successful introduction of IPV and there is highest political commitment. Awareness on the importance and time of introduction to political leaders will be facilitated by the officials of Ministry of Health and Medical Services.

There is a health promotion team in place which anchors advocacy and social mobilization plans. This team consists of stakeholders and communication experts from government and partners alike with the government taking the lead role. A costed communication and sensitization plan will be drafted by the health promotion team which will target the most effective method of community awareness and mobilization on IPV introduction. Various channels of communication will be explored making reference to best practices and lessons learnt from previous vaccines introduction in the country. This will include but not limited to mass and focused media channels including radio, newspaper, churches, drama, pamphlets, posters, flyers, banners, etc. Based on the availability of funding, this IPV introduction might benefit from a KAPP study looking at key messaging to reach the community. IEC materials which will be developed will be field tested before introduction.

A launching ceremony aimed at creating more awareness and conveying the importance of IPV in the end game strategy for polio eradication is planned to be conducted at national level and possibly at provincial level. People will be invited to watch and listen to the key messages given by high Governmental authorities. Immunization coverage details and photos of vaccine preventable diseases will be displayed. Counters will be established and manned by heath staffs to answer questions and public will be given time to the extent possible to share experiences.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Annex 1. IPV Introduction Timeline of Activities** | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Activity** | **Year/Month of IPV Introduction Plan** | | | | | | | | | | | | | | | | | | | | | | | |
| **2014** | | | | | | | | | | | | **2015** | | | | | | | | | | | |
| **J** | **F** | **M** | **A** | **M** | **J** | **J** | **A** | **S** | **O** | **N** | **D** | **J** | **F** | **M** | **A** | **M** | **J** | **J** | **A** | **S** | **O** | **N** | **D** |
| Draft implementation plan for introducing IPV with OPV3 at Penta 3 health contact |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Brief key stakeholders |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Funding secured from GAVI and other partners |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Establish procedures for implementation |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Adapt Information, Education and Communication (IEC) materials & develop communication plan for educating communities |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Review and revise immunization forms |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Confirm space at regional and district cold stores |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Clear vaccine supply from customs |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Finalize budget |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Financial resources received at central level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Pre-arranged budget is transferred from central to region and district levels |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Develop training plan for introducing IPV with OPV3 at Penta 3 health contact |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Microplanning at district levels |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Implement training plan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Implement communication strategy |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Transport vaccine to districts |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Delivery of IPV to target population |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Training on AEFI, develop AEFI guidelines and strengthen AEFI system |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Institute monitoring of adverse events following immunization (AEFIs) for IPV and continue monitoring of AEFI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Supportive supervision visits central to district |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Supportive supervision visits district to health facility |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Monthly reporting of IPV doses delivered |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Analyze reported IPV data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Submit financial report to GAVI (6 months after delivery of IPV) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | J | F | M | A | M | J | J | A | S | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D |

Annex 2A. Budget and financing: Details of operation costs

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | |  | |  | |  | | | |  | | |  |
| **Country: Solomon Islands**  **Target population= 17,896** | | |  | | **Current exchange rate to 1 USD:** | | | | | | **7.2** | | |  |
|  | | |  | |  | | | |  | |  | | |  |
| **Cost Category** | | | **Unit Description (e.g. name of training or item)** | | **Unit price (local currency)** | | | | **Multiplier (e.g. no. of days or items)** | | **Total (local currency)** | | | **Total in US$** |
| **Program management and coordination:** | | |  | |  | | | |  | | **$1,860.00** | | | **$258.33** |
|  | | |  | |  | | | |  | |  | | |  |
| Technical working group meetings, ICC  meetings, | | | 4 Meetings | | 200 | | | | 4 | | $800.00 | | | $111.11 |
| Briefing of stakeholders | | | 1 Meeting | | 200 | | | | 1 | | $200.00 | | | $27.78 |
|  | | |  | |  | | | |  | |  | | |  |
| Develop training plan for introducing   IPV with OPV3 at Penta 3 health contact | | | 3 Stakeholder meeting to agree on training areas | | 200 | | | | 3 | | $600.00 | | | $83.33 |
|  | | | Printing of training plan (20 copies) | | 260 | | | | 1 | | $260.00 | | | $36.11 |
|  | | |  | |  | | | |  | |  | | |  |
| **Planning and preparations:** | | |  | |  | | | |  | | **$157,790.00** | | | **$21,915.28** |
| One National Microplanning training and  briefing (20 participants) for 5 days | | | Transportation | | 1552 | | | | 20 | | $31,040.00 | | | $4,311.11 |
|  | | | Accommodation (shared rooms) | | 500 | | | | 10 | | $25,000.00 | | | $3,472.22 |
|  | | | Perdiem | | 100 | | | | 20 | | $10,000.00 | | | $1,388.89 |
|  | | | Venue cost | | 3000 | | | | 3 | | $9,000.00 | | | $1,250.00 |
|  | | | Catering | | 150 | | | | 20 | | $9,000.00 | | | $1,250.00 |
|  | | | Stationaries | | 500 | | | | 1 | | $500.00 | | | $69.44 |
| Ten Provincial Microplanning and meeting (10  staff) for 3 days excluding Honiara | | | Transportation (group) | | 1500 | | | | 5 | | $7,500.00 | | | $1,041.67 |
|  | | | Accommodation (shared rooms) | | 350 | | | | 5 | | $8,750.00 | | | $1,215.28 |
|  | | | Perdiem | | 100 | | | | 10 | | $9,000.00 | | | $1,250.00 |
|  | | | Venue cost | | 500 | | | | 3 | | $15,000.00 | | | $2,083.33 |
|  | | | Catering | | 100 | | | | 10 | | $30,000.00 | | | $4,166.67 |
|  | | | Stationaries for 10 provinces | | 300 | | | | 10 | | $3,000.00 | | | $416.67 |
|  | | |  | |  | | | |  | |  | | |  |
| **Social mobilization, IEC, advocacy:** | | |  | |  | | | |  | | **$136,180.00** | | | **$18,913.89** |
|  | | |  | |  | | | |  | |  | | |  |
| Develop health communication and  information strategy 20 participants | | | Stakeholder (for refreshment) meetings | | 100 | | | | 4 | | $400.00 | | | $55.56 |
|  | | | Printing/sharing of the strategy | | 1500 | | | | 1 | | $1,500.00 | | | $208.33 |
| Development of communication and  information materials | | | Production of communication materials (newspaper, posters, pamphlets, flyers, street banners) 300 copies | | $12.00 | | | | 300 | | $36,000.00 | | | $5,000.00 |
|  | | | Radio spot | | 80 | | | | 42 | | $3,360.00 | | | $466.67 |
|  | | | News paper | | 250 | | | | 4 | | $1,000.00 | | | $138.89 |
|  | | | Church information | | 300 | | | | 10 | | $3,000.00 | | | $416.67 |
|  | | |  | |  | | | |  | |  | | |  |
| National training on social mobilization using  developed materials | | | Transportation | | 1552 | | | | 10 | | $15,520.00 | | | $2,155.56 |
|  | | | Accommodation | | 500 | | | | 5 | | $12,500.00 | | | $1,736.11 |
|  | | | Perdiem | | 100 | | | | 10 | | $5,000.00 | | | $694.44 |
|  | | | Venue cost | | 3000 | | | | 3 | | $9,000.00 | | | $1,250.00 |
|  | | | Catering | | 150 | | | | 10 | | $4,500.00 | | | $625.00 |
|  | | | Stationaries | | 500 | | | | 1 | | $500.00 | | | $69.44 |
|  | | |  | |  | | | |  | |  | | |  |
| Launch of IPV introduction | | | Radio talk back show | | 4000 | | | | 1 | | $4,000.00 | | | $555.56 |
|  | | | Venue preparation | | 900 | | | | 1 | | $900.00 | | | $125.00 |
|  | | | T-shirts and caps | | 120 | | | | 100 | | $12,000.00 | | | $1,666.67 |
|  | | | Provincial launching | | 3000 | | | | 9 | | $27,000.00 | | | $3,750.00 |
| **Other training & meetings:** | | |  | |  | | | |  | | **$65,900.00** | | | **$9,152.78** |
|  | | |  | |  | | | |  | |  | | |  |
| 10 Training of vaccinators at the provincial level  (18 staff for 3 days) | | | Transportation (shared) | | 1500 | | | | 9 | | $13,500.00 | | | $1,875.00 |
|  | | | Accommodation (shared rooms) | | 300 | | | | 9 | | $13,500.00 | | | $1,875.00 |
|  | | | Perdiem | | 100 | | | | 18 | | $18,000.00 | | | $2,500.00 |
|  | | | Venue cost | | 500 | | | | 3 | | $15,000.00 | | | $2,083.33 |
|  | | | Catering | | 100 | | | | 18 | | $5,400.00 | | | $750.00 |
|  | | | Stationaries | | 500 | | | | 1 | | $500.00 | | | $69.44 |
|  | | |  | |  | | | |  | |  | | |  |
| **Document production:** | | |  | |  | | | |  | | **$7,400.00** | | | **$1,027.78** |
| National EPI policy, cMYP and guideline review | | | Revision of registers, forms, cards, policy/cMYP and immunization hand book | | 200 | | | | 4 | | $800.00 | | | $111.11 |
|  | | | Stakeholders meeting and endorsement by ICC | | 200 | | | | 3 | | $600.00 | | | $83.33 |
|  | | | Printing and distribution | | 120 | | | | 50 | | $6,000.00 | | | $833.33 |
|  | | |  | |  | | | |  | |  | | |  |
| **Human resources and incentives:** | | |  | |  | | | |  | | **$26,000.00** | | | **$3,611.11** |
| Volunteers support | | |  | |  | | | |  | |  | | |  |
|  | | | Transportation | | $350 | | | | 20 | | $7,000.00 | | | $972.22 |
|  | | | Accommodation | | $200 | | | | 20 | | $4,000.00 | | | $555.56 |
|  | | | Perdiem | | $100 | | | | 20 | | $10,000.00 | | | $1,388.89 |
|  | | | refreshment | | $50 | | | | 20 | | $5,000.00 | | | $694.44 |
|  | | |  | |  | | | |  | |  | | |  |
| **Cold chain equipment** | | |  | |  | | | |  | | **$26,500.00** | | | **$3,680.56** |
| Purchase of new fridges | | |  | | 4000 | | | | 3 | | $12,000.00 | | | $1,666.67 |
| Delivery and installation of equipment | | | Freight | | 500 | | | | 3 | | $1,500.00 | | | $208.33 |
|  | | | Perdiem | | 100 | | | | 5 | | $1,500.00 | | | $208.33 |
|  | | | Accommodation | | 300 | | | | 3 | | $4,500.00 | | | $625.00 |
|  | | | Fuel and boat hire | | 800 | | | | 5 | | $4,000.00 | | | $555.56 |
|  | | | Fares | | 1000 | | | | 3 | | $3,000.00 | | | $416.67 |
|  | | |  | |  | | | |  | |  | | |  |
| **Transport for implementation and supervision:** | | |  | |  | | | |  | | **$16,200.00** | | | **$2,250.00** |
| Freight for vaccine distribution | | | Freight national to province | | 500 | | | | 20 | | $10,000.00 | | | $1,388.89 |
| Fuel for vaccine distribution | | | Fuel and boat hire | | 400 | | | | 5 | | $2,000.00 | | | $277.78 |
| Supervision | | | Perdiem | | 100 | | | | 3 | | $300.00 | | | $41.67 |
|  | | | Accommodation | | 300 | | | | 3 | | $900.00 | | | $125.00 |
|  | | | Fares | | 1000 | | | | 3 | | $3,000.00 | | | $416.67 |
|  | | |  | |  | | | |  | |  | | |  |
|  | | |  | |  | | | |  | |  | | |  |
| **Immunization session supplies:** | | |  | |  | | | |  | | **$2,700.00** | | | **$375.00** |
| Distribution of vaccines from provinces to  clinics | | | Freight | | 300 | | | | 9 | | $2,700.00 | | | **$375.00** |
|  | | |  | |  | | | |  | |  | | |  |
| **Waste management:** | | |  | |  | | | |  | | **$2,000.00** | | | **$277.78** |
| Safety boxes, plastic for other waste | | | Procure | | 2000 | | | | 1 | | $2,000.00 | | | $277.78 |
| **Surveillance and monitoring:** | | |  | |  | | | |  | | **$51,944.00** | | | $7,214.44 |
| Training on AEFI, develop AEFI guidelines and  strengthen AEFI system (12 participants) for 3  days | | | Transportation (from provinces) | | 1552 | | | | 12 | | $18,624.00 | | | $2,586.67 |
|  | | | Accommodation (shared) | | 450 | | | | 6 | | $13,500.00 | | | $1,875.00 |
|  | | | Perdiem | | 100 | | | | 12 | | $6,000.00 | | | $833.33 |
|  | | | Venue cost | | 3000 | | | | 3 | | $9,000.00 | | | $1,250.00 |
|  | | | Catering | | 120 | | | | 12 | | $4,320.00 | | | $600.00 |
|  | | | Stationaries | | 500 | | | | 1 | | $500.00 | | | $69.44 |
|  | | |  | |  | | | |  | |  | | |  |
| **Evaluation:** | | |  | |  | | | |  | | **$6,906.00** | | | **$959.17** |
| National Staff and Provincial Staff Supervisory  Visit 3x Officers | | | Transportation | | 1552 | | | | 3 | | $4,656.00 | | | $646.67 |
|  | | | Accommodation | | 250 | | | | 3 | | $750.00 | | | $104.17 |
|  | | | Perdiem | | 100 | | | | 3 | | $1,500.00 | | | $208.33 |
|  | | |  | |  | | | |  | |  | | |  |
| **Technical assistance:** | | |  | |  | | | |  | | **$192,500.00** | | | **$26,736.11** |
| TA to assist in the introduction | | |  | |  | | | |  | |  | | |  |
|  | | | Airfare | | $22,000 | | | | 1 | | $22,000.00 | | | $3,055.56 |
|  | | | Perdiem | | $10,000 | | | | 17 | | $170,000.00 | | | $23,611.11 |
|  | | |  | |  | | | |  | |  | | |  |
|  | | | Meeting- debriefing | | $500 | | | | 1 | | $500.00 | | | $69.44 |
| **Data management** | | |  | |  | | | |  | | **$17,150.00** | | | **$2,381.94** |
| Analyze data | | | Analyze data | | $3,150 | | | | 1 | | $3,150.00 | | | $437.50 |
| Call in/ see Low performing areas zones | | | Call in/ see Low performing zones by supervisor | | $7,000 | | | | 2 | | $14,000.00 | | | $1,944.44 |
| **Other:** | | |  | |  | | | |  | |  | | |  |
|  | | |  | |  | | | |  | |  | | |  |
| **TOTAL** | | |  | |  | | | |  | | **711,030.00** | | | **$98,754.17** |
| **Annex 2B. Budget and financing : Operational costs summary in US$** | | | | | | | | | |  | |  |
|  |  |  | |  | |  | |  | |  | |  |
|  |  |  | | **Government support** | | **Partners' support\*** | | | | **Existing GAVI HSS funding** | | **Requested GAVI VIG** |
|  | **Cost Category** | **TOTAL COST** | | **Amount** | | **Name** | | **Amount** | | **Amount** | | **Amount requested** |
| **US$** | | **US$** | | **US$** | | **US$** | | **US$** |
| **1** | **Program management and coordination** |  | | 10,000 | |  | |  | |  | | **$258.33** |
| **2** | **Planning and preparations** |  | |  | |  | |  | |  | | $21,915.28 |
| **3** | **Social mobilization, IEC and advocacy** |  | |  | |  | |  | |  | | $18,913.89 |
| **4** | **Other training and meetings** |  | |  | | WHO | | 15,000 | |  | | $9,152.78 |
| **5** | **Document production** |  | |  | |  | |  | |  | | $1,027.78 |
| **6** | **Human resources and incentives** |  | |  | |  | |  | |  | | $3,611.11 |
| **7** | **Cold chain equipment** |  | |  | | UNICEF | | 16,500 | |  | | $3,680.56 |
| **8** | **Transport for implementation and supervision** |  | |  | |  | |  | |  | | $2,250.00 |
| **9** | **Immunization session supplies** |  | |  | |  | |  | |  | | $375.00 |
| **10** | **Waste management** |  | |  | |  | |  | |  | | $277.78 |
| **11** | **Surveillance and monitoring** |  | |  | |  | |  | |  | | $7,214.44 |
| **12** | **Evaluation** |  | |  | |  | |  | |  | | $959.17 |
| **13** | **Technical assistance** |  | |  | |  | |  | |  | | $26,736.11 |
| **14** | **Data management** |  | |  | | WHO | |  | |  | | $2,381.94 |
| **15** | **Other: KAPP survey and RCA** |  | |  | | 15,000 | |  | | 0 |
|  | **Total** | **155,254.17** | | **$10,000.00** | |  | | **$46,500.00** | | **0** | | **$98,754.17** |