Annual Progress Report 2007

Submitted by

The Government of

Cambodia

Date of submission _____

Deadline for submission 15 May 2008

(to be accompanied with Excel sheet as prescribed)

Please return a signed copy of the document to:
GAVI Alliance Secretariat; c/o UNICEF, Palais des Nations, 1211 Geneva 10, Switzerland.

Enquiries to: Dr Raj Kumar, rajkumar@gavialliance.org or representatives of a GAVI partner agency. All documents and attachments must be in English or French, preferably in electronic form. These can be shared with GAVI partners, collaborators and general public.

This report reports on activities in 2007 and specifies requests for January – December 2009

Signatures Page for HSS

For the Royal Government of Cambodia

Ministry of Health:

Title: H.E Nuth Sokhom
Minister of Health

Signature: .....

Date: 16/05/08

Ministry of Finance:

Title: H. E Keat Chhon
Minister of Economy and Finance

Signature: .....

Date: 22 May 2008

We, the undersigned members of the National Health Sector Coordinating Committee, (Technical Working Group for Health) endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Financial accountability forms an integral part of GAVI Alliance monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form.

The TWGH Members confirm that the funds received from the GAVI Funding Entity have been audited and accounted for according to standard government or partner requirements.

Name/Title	Agency/Organisation	Signature	Date
MICHAEL O'LEARY / REPRESENTATIVE	WHO		12.05.08
Suomi Sakai / Representative	UNICEF		13.05.08
Sin Somuny / EX-Director	MEDICAM		13-05-08
SHOKO SATO / Advisor	JICA		14.05.08
KCRAWFORD / DIR OFFICE P.H.	USAID		14.05.08

Signatures Page for ISS, INS and NVS

For the Royal Government of Cambodia

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Title: H.E Nuth Sokhom
Minister of Health

Signature: .....

Date: 16/05/08

Ministry of Finance:

Title: H. E Keat Chhon
Minister of Economy and Finance

Signature: .....

Date: 22 May 2008

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MICHAEL O'LEARY / REPRESENTATIVE	WHO.		12.05.05
Sumi Sakai / Representative	UNICEF		13.05.08
SHIOKO SATO / Advisor	JICA		14.05.08
KATHERINE CRAWFORD OPH/DIRECTOR	USAID		14.05.08
HARA MIHALEA	PATH.		15-05-08

Progress Report Form: Table of Contents

Text boxes supplied in this report are meant only to be used as guides. Please feel free to add text beyond the space provided.

1. Report on progress made during 2007

1.1 *Immunization Services Support (ISS)*

Are the funds received for ISS on-budget (reflected in Ministry of Health and Ministry of Finance budget): Yes/**No**
If yes, please explain in detail how it is reflected as MoH budget in the box below.
If not, explain why not and whether there is an intention to get them on-budget in the near future?

N/A

1.1.1 Management of ISS Funds

Please describe the mechanism for management of ISS funds, including the role of the Inter-Agency Co-ordinating Committee (ICC).
Please report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

N/A

1.1.2 Use of Immunization Services Support

In 2007, the following major areas of activities have been funded with the GAVI Alliance ***Immunization Services Support*** *contribution.*

Funds received during 2007 _____
Remaining funds (carry over) from 2006 _____
Balance to be carried over to 2008 _____

Table 1: Use of funds during 2007*

Area of Immunization Services Support	Total amount in US $	AMOUNT OF FUNDS			
		PUBLIC SECTOR			PRIVATE SECTOR & Other
		Central	Region/State/Province	District	
Vaccines					
Injection supplies					
Personnel					
Transportation					
Maintenance and overheads					
Training					
IEC / social mobilization					
Outreach					
Supervision					
Monitoring and evaluation					
Epidemiological surveillance					
Vehicles					
Cold chain equipment					
Other ..... *(specify)*					
Total:					
Remaining funds for next year:					

If no information is available because of block grants, please indicate under 'other'.

Please attach the minutes of the ICC meeting(s) when the allocation and utilization of funds were discussed.

Please report on major activities conducted to strengthen immunization, as well as problems encountered in relation to implementing your multi-year plan.

Immunization coverage improved in 2007. (BCG increase from 87% to 90%, DPT-Hep B 3 increase from 80% to 82%, Hep. B birth dose increase from 44% to 53%, and measles coverage from 78% to 79%). Reports of disease outbreak of communicable disease (including measles) are continuing to decline in Cambodia. Wastage rates for all vaccines have been reduced in 2007. The drop out rate for BCG – Measles has increased in 2007 to 12% (from 10% in 2006). Suspected measles cases have increased from 508 to 1287 in 2007, and neonatal tetanus cases have declined from 69 to 50.

Coverage improvement planning (RED Strategy) was conducted in 20 operational districts (through GAVI HSS) in order to raise immunization coverage. This strategy is targeted at the hardest to reach districts with the largest numbers of un-immunized children. The funding for this activity is complemented by the government investment in outreach funding.

As Cambodia is very dependent on health outreach services to reach objectives, a "Fixed Site Strategy" to improve immunization services at health centres has been implemented in 100 health centres (Total number of health centres in Cambodia is over 960).GAVI HSS supports this initiative in 23 selected ODs. This strategy will require ongoing improvements of health promotion and communication activities in the field. This will need strengthened collaboration with the National Centre for Health promotion and health promotion programs at provincial level and below.

A multi year plan for immunization was updated in 2008 in order to align with the new health sector strategy plan and vision. Both of these documents are annexed to this report.

1.1.3 Immunization Data Quality Audit (DQA)

Next* DQA scheduled for 2009

**If no DQA has been passed, when will the DQA be conducted?*
**If the DQA has been passed, the next DQA will be in the 5th year after the passed DQA*
**If no DQA has been conducted, when will the first DQA be conducted?*

What were the major recommendations of the DQA?

N/A

Has a plan of action to improve the reporting system based on the recommendations from the DQA been prepared?

YES ☐ *NO* ☑

If yes, please report on the degree of its implementation and attach the plan.

The last DQA was conducted in 2004. According to GAVI requirements, the next GAVI scheduled external DQA is in 2009.

The MOH would like to request external assistance from GAVI to support external DQA in the third or 4th quarter of 2008.

In Cambodia, immunization data quality is normally very high. In the 2002 Data Quality Audit, there was 98% verification of reports between health centres and national level in 3 districts. There was also a very close match between DHS survey 2005 and routine health Information data on immunization coverage.

Internal data quality auditing is proposed through the GAVI HSS 2 program if this proposal is endorsed.). " In relation to health information, a system of data quality auditing to verify contractual outcomes will be introduced in Cambodia, once again building on lessons learned from HSS 1 and various pilots of Data Quality Audit (DQA) systems in immunization and at provincial level (see section 4). Secondly, through the technical support of UNFPA, a system of maternal death audits will be introduced in OD HSS Districts. Finally at Central and Provincial Levels, multi departmental monitoring teams (reinforced by comprehensive management agreements) will be strengthened to provide oversight to the internal contracting system, and report to the HSS management team on a quarterly basis the outputs of the HSS program and the performance of OD contractors (link to Objective 3)." Page 8 GAVI HSS Application. Also DQA is a strategy outlined in the Health Sector Strategic Plan (see page 47) and the upcoming MOH/World Bank/Bilateral Donor Health Sector Support Program.

Please highlight in which ICC meeting the plan of action for the DQA was discussed and endorsed by the ICC.

Please report on studies conducted regarding EPI issues during 2007 (for example, coverage surveys).

No studies were conducted in 2007.

An EPI review was last conducted in 2006.
DHS coverage surveys were last conducted in 2005.
DQA was last conducted in 2004.

1.1.4. ICC meetings

How many times did the ICC meet in 2007? ***Please attach all minutes.***
Are any Civil Society Organizations members of the ICC and if yes, which ones?

There were two ICC meeting conducted in 2007 (May and October) to review the HSS proposal and to consider immunization specific issues. Minutes are attached.

NGOs are represented at the ICC by MEDICAM. MEDICAM is the umbrella organization of civil society NGOs in Cambodia (there are over 100 active in the health sector). PATH, RACHA and RACH (local NGOs) and MEDICAM (NGO umbrella organization) are also a regular attendees at ICC meetings.

1.2. GAVI Alliance New & Under-used Vaccines Support (NVS)

1.2.1. Receipt of new and under-used vaccines during 2007

When was the new and under-used vaccine introduced? Please include change in doses per vial and change in presentation, (e.g. DTP + HepB mono to DTP-HepB) and dates shipment were received in 2006.

Vaccine	Vials size	Doses	Date of Introduction	Date shipment received (2007)
DPT-HepB	10 doses	372,000	2001	May-2007
		364,000		Oct-2007
		378,500		Dec-2007
Total		1,114,500		

Please report on any problems encountered.

None

1.2.2. Major activities

Please outline major activities that have been or will be undertaken, in relation to, introduction, phasing-in, service strengthening, etc. and report on problems encountered.

Combined DPT-HepB vaccine has covered 100% of all districts by end 2005. The combined DPT-Hep B was delivered as a schedule to Central Medical Store with the Vaccine Arrival Report sent to UNICEF.

Local distribution of DPT-HepB and other vaccines has been integrated with the essential drug distribution system of Ministry of Health.

The Multi-dose Vial Policy has been strengthened through out the country. However, it is still difficult to fully implement this policy in a few very remote areas. The wastage rate of combined vaccine in 2007 was 26%. The target in 2008 is to maintain or further reduce.

Currently, Coverage of Hepatitis B birth dose within 24 hours is 25% and coverage within 7 days the coverage is 53%. Facility base is the main strategy for delivering Hep B birth dose.

1.2.3. Use of GAVI funding entity support for the introduction of the new vaccine

These funds were received on: _____

Please report on the proportion of introduction grant used, activities undertaken, and problems encountered such as delay in availability of funds for programme use.

N/A

1.2.4. Effective Vaccine Store Management/Vaccine Management Assessment

The last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) was conducted in Nov 2003

Please summarize the major recommendations from the EVSM/VMA

1) Follow-up on missing documentation from vaccines shipments and request missing lot release certificates for all batches of vaccines.
2) Adjust or replace the thermostatic control system of the freezer room to ensure vaccine storage at –20 °C (midway in the range of –15 °C to –25 °C, as recommended by WHO). Calibrate dial thermometers and re-calibrate them annually as necessary.
3) Write and distribute a contingency plan so that personnel associated with vaccine storage are trained in emergency procedures.
4) Calculate vaccine volume estimates for all vaccines at year end when planning for the following year to assess whether peak stock volumes can be accommodated. Adjust the supply cycle of arrivals or issues accordingly.
5) Replace all four existing refrigeration units in the central store cold room and freezer room with CFC free chillers at the earliest opportunity. Future cold chain equipment should be CFC free.
6) Develop a preventive maintenance plan for all equipment and establish its routine application.
7) Improve stock card format to additionally include calculations in doses, identify manufacturer, and note VVM status upon arrival/issue. Record stock of diluents. Continue ongoing efforts to upgrade performance of computer stock recording system.
8) Conduct physical recounts of vaccines and diluents on a quarterly basis. Record and reconcile discrepancies in stock cards and in computer records.
9) Include temperature indicators in all deliveries, including freeze indicators for freeze sensitive vaccines, and modify delivery/arrival forms to note status.
10) In preparation for the shift to the new cold room facility, write and distribute standard operating procedures, starting with activities identified as highest priority.

Was an action plan prepared following the EVSM/VMA: **Yes**

If so, please summarize main activities under the EVSM plan and the activities to address the recommendations.

- Two sets of new central vaccine cold stores were installed (-25°C to -15°C and +2°C to +8°C)
- Revised stock card to include vaccine in dose were used at all levels (including manufacturer and VVM status).
- High turn over of cold store managers is a cause of difficulty for following up the EVSM recommendations.

The next EVSM/VMA* will be conducted at a date not yet specified. More discussions will be undertaken with UNICEF and the NIP to set a date and process for the next EVSM.

**All countries will need to conduct an EVSM/VMA in the second year of new vaccine support approved under GAVI Phase 2.*

1.3 Injection Safety

1.3.1 Receipt of injection safety support

Received in cash/kind

Please report on receipt of injection safety support provided by the GAVI Alliance during 2007 (add rows as applicable).

Injection Safety Material	Quantity	Date received
AD 0.5 ml	579,600	Mar 2007
Safety box 5 Ltr	6,425	Apr 2006
Note: The injection devices from GAVI were bundled with combined DPT-HepB		

Please report on any problems encountered.

No problems have been encountered.

1.3.2. Progress of transition plan for safe injections and management of sharps waste.

If support has ended, please report how injection safety supplies are funded.

The Government of Cambodia procured dilution syringes and safety boxes for BCG and Measles

Please report how sharps waste is being disposed of.

51 high temperature incinerators were installed (At least one incinerator in one province). Used safety boxes were collected from the health facilities on a regular basis and were taken to the incinerator sites. A new model of high temperature incinerator is being tested.

Please report problems encountered during the implementation of the transitional plan for safe injection and sharps waste.

There was no rupture of stock of DPT-HepB in 2007. There was 1 month rupture of stock of Measles vaccine in late 2007 at Central level. However, at the peripheral level the immunization services still continued until the next shipment.

1.3.3. Statement on use of GAVI Alliance injection safety support in 2007 (if received in the form of a cash contribution)

The following major areas of activities have been funded (specify the amount) with the GAVI Alliance injection safety support in the past year:

N/A

2. Vaccine Co-financing, Immunization Financing and Financial Sustainability

Table 2.1: Overall Expenditures and Financing for Immunization
The purpose of Table 2.1 is to help GAVI understand broad trends in immunization programme expenditures and financing flows. In place of Table 2.1 an updated cMYP, updated for the reporting year would be sufficient.

	2007	2007	2008	2009
	Actual	Planned	Planned	Planned
Expenditures by Category				
Vaccines		3,546,174	2,634,019	2,041,502
Injection supplies		435,417	398747	411115
Cold Chain equipment		221,899	792084	250000
Operational costs		2,390,467	1916373	2046954
Other (Communication and IEC)		17,319	82050	82050
Financing by Source				
Government (incl. WB loans)				
GAVI Fund				
UNICEF				
WHO				
Other (please specify)				
Total Expenditure				
Total Financing				
Total Funding Gaps				

Please describe trends in immunization expenditures and financing for the reporting year, such as differences between planned versus actual expenditures, financing and gaps. Give details on the reasons for the reported trends and describe the financial sustainability prospects for the immunization program over the coming three years; whether the funding gaps are manageable, a challenge, or alarming. If either of the latter two, explain what strategies are being pursued to address the gaps and what are the sources of the gaps —growing expenditures in certain budget lines, loss of sources of funding, a combination.....

1. Government expenditure on vaccines in 2006 was US$ 85,816 to reimburse the cost of vaccines procured in the previous year. In 2007, Government expenditure on vaccines was US$255,054. In early 2008 US$196,385 were paid for vaccine delivered late 2007.
2. In 2007, the Ministry of Economy and Finance, following advice from the NIP and GAVI partners, reinstated health outreach financing to the value of $ 1 million per year (up to 80% of children are vaccinated during outreach).
3. The prospects of sustaining the current NIP program area good, as there has been evidence of increasing government commitment to the immunization program in recent years. The government now completely funds the traditional vaccine program of the NIP.
4. The challenge in the next 3 years will be to identify sustainable finance for new vaccine introduction. Although GAVI financing will support Hib vaccine introduction 2010 – 2015 (pentavalent vaccine). As yet, no donor has been identified for the proposed JE vaccine introduction in 2009. This matter is currently being pursued through discussion with bilateral channels and the Ministry of Economy and Finance.

Table 2.2: Country Co-Financing (in US$)

Table 2.2 is designed to help understand country level co-financing of GAVI awarded vaccines. If your country has been awarded more than one new vaccine please complete a separate table for each new vaccine being co-financed.

For 1st GAVI awarded vaccine. Please specify which vaccine (ex: DTP-HepB)	**2007**	**2007**	**2008**	**2009**
DTP-HEP B	Actual	Planned	Planned	Planned
Co-financing amount (in US$ per dose)				
Government				
Other sources (please specify)	100%	100%	100%	100%
Total Co-Financing (US$ per dose)				

Please describe and explain the past and future trends in co-financing levels for the 1st GAVI awarded vaccine.

The current plan is for 100% financing of combined vaccine up to 2010The Cambodia co-financing for DPT-HepB with GAVI will start in 2010. Please refer to the Co-finance Commitment sent by Minister of Health on Apr 12, 2007 (Refer to Annex).

For 2nd GAVI awarded vaccine. Please specify which vaccine (ex: DTP-HepB)	**2007**	**2007**	**2008**	**2009**
N/A	Actual	Planned	Planned	Planned
Co-financing amount (in US$ per dose)				
Government				
Other sources (please specify)				
Total Co-Financing (US$ per dose)				

Please describe and explain the past and future trends in co-financing levels for the 2nd GAVI awarded vaccine.

It is now proposed by the MOH to submit an application for introduction of DPT-HepB-Hib Pentavalent Vaccine in late 2008 or in 2009, with the introduction of the new vaccine proposed for 2010. Government will then co-finance the GAVI New Vaccine introduction up to 2015 according to the GAVI requirement for co financing.

Table 2.3: Country Co-Financing (in US$)

The purpose of Table 2.3 is to understand the country-level processes related to integration of co-financing requirements into national planning and budgeting.

Q. 1: What mechanisms are currently used by the Ministry of Health in your country for procuring EPI vaccines?			
	Tick for Yes	List Relevant Vaccines	Sources of Funds
Government Procurement- International Competitive Bidding			
Government Procurement- Other			
UNICEF	X	The complete immunization schedule is procured through UNICEF procurement mechanisms.	Government GAVI JICA UNICEF
PAHO Revolving Fund			
Donations			
Other (specify)			

Q. 2: How have the proposed payment schedules and actual schedules differed in the reporting year?		
Schedule of Co-Financing Payments	Proposed Payment Schedule	Date of Actual Payments Made in 2007
	(month/year)	(day/month)
1st Awarded Vaccine (specify)		
2nd Awarded Vaccine (specify)	N/A	
3rd Awarded Vaccine (specify)		

Q. 3: Have the co-financing requirements been incorporated into the following national planning and budgeting systems?	
	Enter Yes or N/A if not applicable
Budget line item for vaccine purchasing	Yes
National health sector plan	Yes
National health budget	Yes
Medium-term expenditure framework	N/A
SWAp	N/A
cMYP Cost & Financing Analysis	Yes
Annual immunization plan	N/A
Other	WHO UNICEF Joint Report Form

Q. 4: What factors have slowed and/or hindered mobilization of resources for vaccine co-financing?
1. Co-financing will only start from 2010 onward.
2.
3.
4.
5.

3. Request for new and under-used vaccines for year 2009

*Section 3 is related to the request for new and under-used vaccines and injection safety for **2009**.*

3.1. Up-dated immunization targets

Confirm/update basic data approved with country application: figures are expected to be consistent with those reported in the WHO/UNICEF Joint Reporting Forms. Any changes and/or discrepancies **MUST** be justified in the space provided. Targets for future years **MUST** be provided.

Please provide justification on changes to baseline, targets, wastage rate, vaccine presentation, etc. from the previously approved plan, and on reported figures which differ from those reported in the WHO/UNICEF Joint Reporting Form in the space provided below.

There are no changes to baseline, targets, wastage rates and vaccine presentation from the previous Joint Report Form.

Table 5: Update of immunization achievements and annual targets. Provide figures as reported in the JRF in 2007 and projections from 2008 onwards.

Number of	Achievements and targets									
	2006	2007	2008	2009	2010	2011	2012	2013	2014	201
DENOMINATORS										
Births	401580	409934	419453	427492	436223	443006	450068	455423		
Infants' deaths	25,113	24,514	24,636	23,465	23,320	21,860	21,452	20005		
Surviving infants	376467	385437	394817	404028	412904	421146	428616	435418	441,682	447,5
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with **1st dose** of DTP (DTP1)*	318,903									
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with **3rd dose** of DTP (DTP3)*	301,965									
NEW VACCINES **										
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with **1st dose** of DTP (DTP1)* ..... *(new vaccine)*	357,644	334,439	375,076	383,827	392,259	400,089	415,757	422,355		
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with **3rd dose** of DPT-Hep B	335,056	314,658	359,283	371,706	384,000	395,877	407,185	413,647		
Wastage rate till 2007 and plan for 2008 beyond*** ..... *(new vaccine)*	40%	26%	30%	25%	25%	25%	25%	25%		
INJECTION SAFETY****										
Pregnant women vaccinated / to be vaccinated with TT 2+	199,536	206,307	327,173	341,994	348,978	354,405	360,054	365,751		
Infants vaccinated / to be vaccinated with BCG	326,639	346,171	375,076	383,827	392,259	400,089	415,757	422,355		
Infants vaccinated / to be vaccinated with Measles (1st dose)	294,453	305,563	347,439	363,625	379,872	395,877	407,185	413,647		

* Indicate actual number of children vaccinated in past years and updated targets (with either DTP alone or combined)
** Use 3 rows (as indicated under the heading **NEW VACCINES**) for every new vaccine introduced
*** Indicate actual wastage rate obtained in past years
**** Insert any row as necessary

3.2 Confirmed/Revised request for new vaccine *(to be shared with UNICEF Supply Division)* For 2009

In case you are changing the presentation of the vaccine, or increasing your request; please indicate below if UNICEF Supply Division has assured the availability of the new quantity/presentation of supply.

No Change

Please provide the Excel sheet for calculating vaccine request duly completed (see Annex).

Remarks
▪ **Phasing:** Please adjust estimates of target number of children to receive new vaccines, if a phased introduction is intended. If targets for hep B3 and Hib 3 differ from DTP3, explanation of the difference should be provided ▪ **Wastage of vaccines:** Countries are expected to plan for a maximum of 50% wastage rate for a lyophilized vaccine in 10 or 20-dose vial; 25% for a liquid vaccine in a10 or 20-dose vial; 10% for any vaccine (either liquid or lyophilized) in a 2-dose vial, 5% for any vaccine in 1 dose vial liquid. ▪ **Buffer stock:** The buffer stock is recalculated every year as 25% the current vaccine requirement ▪ **Anticipated vaccines in stock at start of year 2009:** It is calculated by counting the current balance of vaccines in stock, including the balance of buffer stock. Write zero if all vaccines supplied for the current year (including the buffer stock) are expected to be consumed before the start of next year. Countries with very low or no vaccines in stock must provide an explanation of the use of the vaccines. ▪ **AD syringes:** A wastage factor of 1.11 is applied to the total number of vaccine doses requested from the Fund, excluding the wastage of vaccines. ▪ **Reconstitution syringes:** it applies only for lyophilized vaccines. Write zero for other vaccines. ▪ **Safety boxes:** A multiplying factor of 1.11 is applied to safety boxes to cater for areas where one box will be used for less than 100 syringes

Table 7: Wastage rates and factors

Vaccine wastage rate	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%
Equivalent wastage factor	1.05	1.11	1.18	1.25	1.33	1.43	1.54	1.67	1.82	2.00	2.22	2.50

3.3 Confirmed/revised request for injection safety support for the year 2009

Table 8: Estimated supplies for safety of vaccination for the next two years with ..... *(Use one table for each vaccine BCG, DTP, measles and TT, and number them from 8a, 8b, 8c, etc. Please use same targets as in Table 5)*

		Formula	2009	2010
A	Target if children for DPT-Hep 1 Vaccination (for TT: target of pregnant women) *(1)*	#	383,827	392,259
B	Number of doses per child (for TT: target of pregnant women)	#	3	3
C	Number of DPT-HepB doses	A x B	1,151,481	1,176,777
D	AD syringes (+10% wastage)	C x 1.11	1,278,144	1,306,222
E	AD syringes buffer stock *(2)*	D x 0.25	319,536	326,556
F	Total AD syringes	D + E	1,597,680	1,632,778
G	Number of doses per vial	#	10	10
H	Vaccine wastage factor *(3)*	Either 2 or 1.6	1.43	1.33
I	Number of reconstitution syringes (+10% wastage) (4)	C x H X 1.11/G	182,775	173,728
J	Number of safety boxes (+10% of extra need)	(F + I) x 1.11/100	19,763	20,052

1 Contribute to a maximum of 2 doses for Pregnant Women (estimated as total births)

2 The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area.

3 Standard wastage factor will be used for calculation of reconstitution syringes. It will be 2 for BCG, 1.6 for measles and YF

4 Only for lyophilized vaccines. Write zero for other vaccines.

If quantity of current request differs from the GAVI letter of approval, please present the justification for that difference.

For 2009, GAVI approved (GAVI/07/191) date 24 August 2007
- DPT-HepB vaccine: 1,531,500 doses
- AD syringes: 1,278,200 pcs
- Safety boxes: 14,200 pcs

4. Health Systems Strengthening (HSS)

This section only needs to be completed by those countries that have received approval for their HSS proposal. This will serve as an inception report in order to enable release of funds for 2009. Countries are therefore asked to report on activities in 2007.

Health Systems Support started in: October 01, 2007

Current Health Systems Support will end in: September 30, 2008

Funds received in 2007:	Yes	
	If yes, date received:	April 11, 2007
	If Yes, total amount:	US$ 1,850,000.00
Funds disbursed to date:		US$ 1,850,000.00
Balance of installment left:		US$ Nil

Requested amount to be disbursed for Qtr.4, 2008 : US$ 331,741

and 2009 : US$1,505,849

Are funds on-budget (reflected in the Ministry of Health and Ministry of Finance budget): Yes
If not, why not? How will it be ensured that funds will be on-budget? Please provide details.

N/A

Please provide a brief narrative on the HSS program that covers the main activities performed, whether funds were disbursed according to the implementation plan, major accomplishments (especially impacts on health service programs, notably the immunization program), problems encountered and solutions found or proposed, and any other salient information that the country would like GAVI to know about. More detailed information on activities such as whether activities were implemented according to the implementation plan can be provided in Table 10.

This report is in three sections. The first section is a rapid health system strengthening assessment. The details of the assessment are annexed to this annual report. This details the progress to date of the HSS program in the field. The second section is the Provincial Activity report which provides more detail on field implementation and results. The third section is the departmental activity report which details the activities of each central department in leading implementation of the program.

A second HSS proposal was developed and submitted to GAVI in March 2008. As yet, the outcome of this funding proposal is not known.

SECTION 1- SUMMARY OF HSS FIELD ASSESSMENT OF IMPLEMENTATION

Background In October 2007, the MOH commenced internal contracting with 10 Operational Districts (ODs) with funding support from GAVI HSS and the MOH. The aim of the program is to improve immunization and MCH services in a sustainable manner through health system strengthening. For the purposes of monitoring performance of the program and providing inputs to the design of HSS 2, a rapid assessment was conducted of the HSS program in the 10 ODs.

Methods Information was sourced from three sources. (1) Three interdepartmental field teams, with the use of a question guideline, visited all 10 ODs and identified strengths, weaknesses and recommendations for improvement to the HSS program. Findings were presented at a National Workshop. (2) Stakeholder interviews were conducted with international and national partners on the strategic directions of HSS, and mechanisms for alignment and harmonization and civil society coordination. (3) Financial and HIS data was collected in order to provide insights on program and financial performance.

Main Findings: Overall, the HSS contract system has identified four important developments in health system strengthening. (1) It has been demonstrated that it is feasible through a decentralized financial management model based on internal contracting to mobilize operational funds for the delivery level on a timely basis.(2) Health worker and manager motivation can be increased through internal contracting related to timely release of health finance for operations. (3) There is general national and international stakeholder interest (if not consensus) in moving step by step towards an internal contracting model for the delivery of a comprehensive range of service at primary and secondary level of care. (4) System innovations introduced are supportive of Health Sector Plan 2 and Health Sector Support program directions regarding governance strategy and internal contracting. Therefore, GAVI HSS does not support "parallel" project systems but is integrated within the overall operating systems of the MOH (AOP, M & E, HIS). However, at this stage, it is too early to conclude if these achievements have impacted on accessibility of populations to health services. Implementation challenges identified include,(1) lack of capacity for planning and financial management at the decentralized level, (2) management fragmentation along program or project lines, (3) lack of equity in the contracting model for remote areas and (4) absence of comprehensive systems for verification of data quality (5) lack of clarity on systems and barriers of financing for community participation (6) contracting systems are not yet sufficiently comprehensive to cover the whole of OD health system (including health centre delivery and hospital care).

Conclusions: Important system innovations have been introduced at the commencement phase of HSS 1 – these include a decentralized financial management model, internal contracting mechanisms and the strengthening of inter departmental monitoring activities. At this early stage of implementation it is too early to conclude if the system innovations outlined above have impacted on accessibility of populations to health services. There are many early challenges and opportunities associated with early implementation of HSS. This highlights the need for focused attention on interdepartmental management strengthening and HSS monitoring and evaluation, as well as well aligned approaches of national and international partners to ensure these challenges can be effectively met in the coming years.

Prepared by: HSS Program Monitoring Team

SECTION 2 PROVINCIAL ACTIVITY REPORT

Implementation commenced in the first quarter of 2007, with funds reaching the facility level mid quarter 2007. As part of the interdepartmental monitoring, supervisors compared Qtr 2006 and Qtr 2007 data and this was presented at the national consultative workshop on HSS on February 5 by the OD managers.

What the data demonstrates is that across the board there have been moderate rises in immunization coverage and ante natal care, but falls in overall consultations. This data should be interpreted with caution, as the implementation timeframe is too short to make any accurate assessment of impact of internal contracting on health system performance.

Indicator	Result Qtr 4 2006	Result Qtr 4 2007	Comment
Consultation (All ages)	247,165	231,560	
Consultations (Children < 5 years)	28,117	25,586	05 ODs: MK Borey, Battambang, Angkor Chum, Kratie, Kg. Tralach
ANC (Total)	27,916	33,619	
Hep B Birth Dose (<24H)	3,989	7,099	
Measles Coverage	11,109	12,102	
DPT Hep B 3	11,035	11,399	

GAVI HSS ACTIVITY

- Internal contracting implemented in 10 ODs for a package of health services (mostly focused on EPI but including ANC and consultations)
- Development of financial guidelines for HSS (with training for PHD level)
- Implementing of IMCI (5 ODs) and child survival scorecard monitoring
- Development of a central HSS program monitoring team in order to monitor contract performance

STRENGTH

- The internal contracting System is strengthening management at the health centre
- The contract system is strengthening team work and improving communication with clients
- Budget is being received on time, so that MPA activity is increased
- Increases in EPI and ANC contacts in most districts

WEAKNESS

- ODs and health centers have limited capacity for planning and financial management (lack of clarity and financial guidelines and package of budget)
- There is lack of clarity on the quality of data and insufficient financing of coordinated monitoring and DQA at PHD and OD level
- There are inadequate incentives for remote areas in the current contract system
- At central and provincial level, there are problems because contracts are with small groups for single projects, rather than having one management performance contract for the whole team

- Although contracts include consultations and ANC, the contracts still focus mostly on immunization
- Community participation is not strong in some locations (VHSG and HCMC)
- Need comprehensive CPA/MPA package for internal contracting system
- In remote health centres in some locations, still no building and MPA essential kits / drugs

RECOMMENDATIONS

- Broaden contractual indicators to include MCH (post natal care, delivery, referrals, birth spacing) through co financing with Government and AusAID – UNFPA
- Conduct in depth evaluation of contracting system in mid year, in order to ensure (a) MCH continuum of care and (b) adequate incentive for remote health staff. Options for contracting changes include minimum and maximum payment per month with remote area service fee adjustments
- Introduce data quality audit system in order verify contract outcomes
- Strengthen more coordinated team management at central and provincial level

SECTION 3 - DEPARTMENT ACTIVITY REPORT

NATIONAL IMMUNIZATION PROGRAM- NIP

I. Describe the main activities

1. **Coverage improvement plan (CIP) on immunization**
   Coverage improvement plan (CIP) on immunization activity and monitoring in 4th Quarter 2007 for outreach immunization service delivery in unsupported districts and districts with have high numbers of un-immunized children and conducted the monitoring of outcome. The CIP strategy was introduced in Cambodia following a Reaching Every District (RED) Strategy initiated by NIP, WHO and UNICEF in early 2003. The CIP strategy implemented in 3 steps include Micro-planning in consideration on micro-planning to reaching every un-immunization children, implementation according to the micro-planning developed and strengthened supervision/monitoring. In 4th quarter 2007, CIP have been implemented by using GAVI HSS budget in 20 selected ODs.

2. **Fixed site Immunization**
   Fixed site Immunization strategy included immunization service delivery at health services delivery and monitoring on fixed site immunization activity. A fixed facility immunization strategy has been implemented by the NIP in collaboration with WHO since 2004 and in 2005, the fixed site strategy was expanded to 100 facilities. In 4th quarter 2007, by using GAVI HSS budget, the fixed site immunization strategy has also been implemented in 23 selected ODs.

3. **Review training materials and tools**
   Review training materials and tools on immunization in practice in Dec 2007 in MCHC.

II. Achievement:

1. **Immunization coverage for children under 1 year old in 2007 inceased:**

	2006	2007
- BCG:	87%	90%
- Hepatitis B birth dose	44%	53%
- OPV 3	80%	82%
- DPT-HepB 3	80%	82%
- Measles	78%	79%
- TT 2 (Pregnant women)	50%	50%

2. **Drop out rate in 2007:**

	2006	2007
- BCG-Measles	10.34%	12.22%
- DPT-Hep B 1-3	4.68%	5.50%

3. **Vaccine wastage rate reduced:**

	2006	2007
- BCG:	86%	85%
- Hepatitis B birth dose	37%	17%
- OPV	40%	36%
- DPT-HepB	27%	26%
- Measles	75%	73%
- TT	47%	47%

III. Strength

Strengths of CIP: The CIP strategy in 20 selected ODs have contributed to increasing coverage of the country at the end of year 2007. The advantages of the CIP strategy permit the development of micro-planning capacities of health centers and ensure the quality of health center immunization services delivery in their catchments area.

IV. Weakness

1. Weaknesses/Constraints of CIP:
   - Some ODs have undertaken CIP but the coverage was not improved because of population migration, denominator issue and geographical problem.
   - Additionally, there is remains the problem of sustainability financing and incentives for health workers to reach the most difficult to access areas.
2. Weaknesses and constraints of Fixed site immunization:
   - The strategy is not suitable for expansion to remote areas or areas with complicated village geography.
   - A major constraint is sustaining social mobilization finance support for fixed site.
   - Currently, there is no government budget source to finance village based social mobilization of health education.

V. Problem solving and Recommendation

1. Coverage Improvement Plan (CIP):
   - In order to increasing the immunization coverage in some ODs according to population migration and geographical issue, the micro-planning need to be strengthened and included into annual operational plan (AOP).
   - The financial sustainability and incentives for health workers to reach the most difficult to access areas should be part of AOP.
2. Fixed site immunization:
   - The remote areas or areas with complicated village geography could not be conducted fixed site immunization, it should be conducted the outreach immunization activity or CIP.
   - The social mobilization and communication activities for supporting fixed site activities have to be included into AOP.

DEPARTMENT OF PLANNING AND HEALTH INFORMATION- DPHI

Activity: MPA Planning, Supervision and Financial Management System Development

1.1. Revise and simplify OD and HC Planning Manual reference to program based budgeting

There are 3 activities was planned to do in Q4 2007 in this project sub component 1, but only one activity is implemented .The revision of MOH planning manual is based on Health Sector Strategic Plan 2008-2015 (HSP2),but in Q4 2007 HSP2 dissemination is not done yet so the other 2 activities: I.1.2.Development of Revised Manuals based on HC & OD assessment and I.1.3 Consultative workshops (2 times) in this sub component will be delayed and moved to

other quarter after commencement of Health Sector Plan 2 (see Annex)

1.1.1 Conduct HC & OD assessment on revised planning manual

Actual Result

Assessment of Planning manual: Implementation was conducted in 9 provincial Health Departments (PHDs), 16 operational districts (ODs), 15 referral hospitals (RH) and 30 health centres (HC) by using questionnaires. The questionnaires were grouped into 4 main parts addressing Planning process, Annual Operational Plan (AOP) development and AOP Implementation time frame, AOP development and AOP Implementation formats, and AOP implementation. As a result, the team found that PHDs followed all steps of planning cycle of the MoH planning manual. However, RHs and HCs did not complete all steps of the cycle. They completed the main steps with ODs and some steps are jointly done in one time. The main reason for this problem is the limited capacity of the planning team at HC and RH So far the training to these levels is limited especially on program based budgeting due to financial constraint. To improve the capacity of planning staff at HC ,the training to all contract HCs in10 ODs will be done in quarter 2/2008 after the dissemination of the planning guidelines.

Strength:
Assessment of Planning manual Implementation conducted to all selected PHDs, ODs, RHs, and RHs. The assessment team could meet and interviewed with planning team members at all level. All the questions were answered by PHDs and ODs with very clear and real practical information and useful for planning manual revision.

Weakness:

In some PHDs during the interview the team could not meet with PHDs staff from the other units. Most of RH and HC staff could not answer and understand the assessment question properly this indicated that they are not familiar with planning manual yet. There were also some limitations of the transportation during the assessment to the HCs that are far from the main road.

Problem solving and Recommendation:

To fill the gap of practical information on manual implementation at HC and RH level, involvement of more HC and RH staff from difference provinces is needed in next consultative workshop to collect more useful information for manual revision.

Planning manual is main tool to support all health institution to develop and implement AOP properly, so to strengthen the implementation of the planning manual at RHs and HCs ,only the training of manual from central team, technical support and supervision on the manual implementation from ODs and PHDs to HC and OD is the first action that we should consider.

2. Technical Support and Monitoring the implementation of financial management tool and revised planning manual of OD and HC and planning implementation

Result: Technical Support and Monitoring the implementation of revised planning manual of OD and HC and planning implementation have to do after the training of the revised manual and the training of planning guideline to HC staff. So, these activities will be done in next quarter after these trainings.

Activity: Project Management

1. Introduction of HSS project

Result

HSS project management and contract documents have been introduced to contract ODs by the central team. The planning process development has been guided by central planning team. As a result, central units supported by HSS/GAVI and 10 PHDs and ODs team now know how to prepare their plan and set targets based on indicators. Operational budgets have also been allocated to PHDs and ODs (agreed in HSS contract).

Strength:

All central units and PHDs and ODs supported by HSS/GAVI have been participated in project introduction workshop and agreed on contract. Contracted ODs prepared and provided draft work plan to the project management administration.

Weakness:

The submissions of final plan from contracted ODs were late. Target and baseline setting in some ODs were not appropriate.

Problem solving and Recommendation:

To improve the project performance, target in some ODs should be revised.
Capacity building on planning to ODs also has to strengthen through refresher training.

COMMUNICABLE DISEASE CONTROL- CDC

1. **Achievement**

a- Have organized IMCI Planning Workshop for Sihanuk Ville and Kroach Chhmar OD to introduce IMCI related activities to health officials and to incorporate them into AOP of both ODs.

b- Have conducted 3 IMCI Clinical Training Courses in which 78 health staff from Koh Thom, Chhouk, Kroach Chhmar ODs had been trained on how to manage sick children under 5 years old. The objective of the training course is to improve the skill of health center staff in case management of sick children under five years old. They are expected to contribute to reduce the child morbidity and mortality in their coverage areas and as a result, the utilization of the health services increased and child health development.

c- Have conducted ToT Course of IMCI for 11 potential trainers/ supervisors from Kroach Chhmar and Sihanuk Ville ODs.

2. **Weakness**

- Central Level: Lack of human resources and transportation means.
- OD Level: Lack of manpower for conducting routine supervision of IMCI.

3. **Problems and solving**

a- IMCI Trained health center staff in charge of MCH or EPI did not have enough time to apply IMCI because they spend most of the time with maternal& antenatal care or do EPI outreach. As a result, those health center staff would have forgotten or would not be familiar with IMCI Case Management Process. In this case, during supervision, we meet all health center staff to discuss and solve problem and let's health center chief re-assign task so that every IMCI trained staff have opportunity to apply IMCI.

b- IMCI Trained Health Center Staff denied applying IMCI: First we encourage them to apply IMCI. If there is still no success, we report to OD director to take appropriate administrative measure.

4. **Recommendation**

a- IMCI Trained Health Center Staff need to be reinforced their case management skill to ensure proper case management through routine supervision.
b- Local supervisors skills need to be strengthened further. Strengthen the facilitating supervision of OD level. Train and disseminate computer-base supervision tools.

PREVENTIVE MEDICINE DEPARTMENT- PMD

Activity : Outreach Guideline review

Achievement:

Sessions of consultative WS were organized in Kg Chhnang province to discuss the key components of outreach guideline reviewed in 2004 and lesson learned with national programs, key implementers and supporters. As a result, a draft has been developed that is more simple and feasible for the HC staff to implement.

(session 1 held in January 15-18 2008 and session2 from 22-25 January 2008)

Strength:

All participants were involved actively in the discussion with national programs and recommended many changes. Support during the session was provided by the Village Health Support Group.

Weakness

Some provinces have shortage of funding support as they only use the national budget.
There are shortages of drug.
Difficulty to meet with villagers in some places.

The draft of the revised outline still cannot be finalized and are waiting for new protocols of Malaria treatment and Nutrition programs to make the guideline in implementing nutrition promotion at outreach activities. In relation to TB, more support for training is required so that TB activities can be integrated with other activities in outreach

Staff still considers that outreach services are only for immunization and health education.

Problem and solving

Reduce outreach sessions through increasing the utilization of fixed facility.
Finalize the draft at the end of May 2008

Recommendation
Integrate monitoring the implementation of outreach guideline in monitoring of GAVI project.

Encourage staff to include more activities in outreach session rather than provide only immunization alone.

DEPARTMENT OF BUDGET AND FINANCE- DBF

Quarterly Financial Report: Period from 11 July 2007 to 31 December 2007.

On April 11 2007, the amount of US$ 1,850,000.00 has been transferred by donor (GAVI alliance) to account number 0102-35.1212-A070 under the name of "Ministry of Health (Global Alliance for vaccine & Immunization)" at National Bank of Cambodia.

At that time the HSS-GAVI project was not ready to implement its activities. It was in the stage of

under preparation project documents and necessary arrangements.

On July 11 2007, the received amount of US$ 1,850,000.00 has been transferred from Account No. 0102-35.1212-A070 to new Account No. 0102-35,1212-A347 with changes of account name "Health System Strengthening Project" at the National Bank of Cambodia in accordance with the agreement from donor (GAVI alliance). The first payment has been disbursed on 22 August 2007 for introduction workshop of HSS-GAVI project. Consequently processed for recruitment of National Program Officer, request permission to Ministry of Economy and Finance (MEF) to open Bank account at provincial level. On 3rd October 2007, MEF has approved to open bank accounts at Provincial level.

The actual project activities have been started from 1st October 2007. The implementation period of the HSS-GAVI project is 1st October 2007 to 30th September 2008 divided by four quarter.

The first year (2007-2008) of HSS-GAVI project includes the following Provinces and Operating Districts.

	Province	Operating District	Nos. of HC
1	Kratie	OD Kratie	14
2	Kampong Chnnang	OD Kampong Tralach	11
3	Battambang	OD Battambang	22
4	Kampong Cham	OD Kroch Chmar	10
5	Bantheay Meanchy	OD Monkul Borey	20
6	Siem Reap	OD Ankor Chum	9
7	Takeo	OD Prey Kabas	14
8	Kandal	OD Koh Thom	12
9	Shanouk Ville	OD Mittapheap	10
10	Kampot	OD Chhouk	15
Total	10 Provinces	10 Ods	137

2nd Generation Imprest Account at Provincial Level.
On 5th November 2007, the Department of Budget & Finance transferred the project funds to each Provincial Health Department (PHD) bank accounts as follow.

Date	Voucher No.	Description	Account Name	Amount (US$)
5.11.2007	MTO/07 - 001	Transfer money to Battambang PHD Bank Account: 0300-10-311875-1-5 (ACLEDA Bank)	2nd Generation Imprest A/C	121,861.90
5.11.2007	MTO/07 - 002	Transfer money to Bantey Mean Chey PHD Bank Account: 0200-10-312950-1-6(ACLEDA Bank)	2nd Generation Imprest A/C	92,813.60
5.11.2007	MTO/07 - 003	Transfer money to Kratie PHD Bank Account: 1600-10-314255-1-7 (ACLEDA Bank)	2nd Generation Imprest A/C	70,396.88
5.11.2007	MTO/07 - 004	Transfer money to Kg Chhnang PHD Bank Account: 1200-10-312805-1-1 (ACLEDA Bank)	2nd Generation Imprest A/C	75,865.38
5.11.2007	MTO/07 - 005	Transfer money to Siemreap PHD Bank Account: 0100-10-311735-1-5 (ACLEDA Bank)	2nd Generation Imprest A/C	88,619.30
5.11.2007	MTO/07 - 006	Transfer money to Sihanouk Ville PHD Bank Account: 0600-10-313569-1-8 (ACLEDA Bank)	2nd Generation Imprest A/C	50,166.83
5.11.2007	MTO/07 - 007	Transfer money to Kampong Cham PHD Bank Account: 1000-10-312925-1-1 (ACLEDA Bank)	2nd Generation Imprest A/C	40,032.50

5.11.2007	MTO/07 - 008	Transfer money to Kandal PHD Bank Account: 2400-10-312197-1-4 (ACLEDA Bank)	2nd Generation Imprest A/C	57,345.60
5.11.2007	MTO/07 - 009	Transfer money to Kampot PHD Bank Account: 0700-10-312930-1-9 (ACLEDA Bank)	2nd Generation Imprest A/C	92,732.00
5.11.2007	MTO/07 - 010	Transfer money to Taleo PHD Bank Account: 0800-10-313189-1-3 (ACLEDA Bank)	2nd Generation Imprest A/C	95,937.35

The requirements of each province (Including all expenditure of PHD, OD and Health Centers) are estimated by concerned National Programs and Departments. Although it is mentioned in GAVI HSS Financial Management Manual to transfer the requirement of each province by quarterly, the full budgeted amounts for one year have been transferred to PHDs' 2nd generation imprest bank accounts against with "Performance Based Management Agreement (PBMA)" signed by MOH, PHD and OD.

Quarterly Liquidation of 2nd Generation Imprest Account

1st quarter Second Generation Imprest Account liquidation statements have been received from all of the 10 PHDs. Please see details in attachment (6).

Project Expenditures and Financial Accounts

Up to end of this reporting period, the amount of US$ 146,986.82 has been spent out of US$ 1,850,000.00. (7.94 % of total budget funds). The 2nd generation bank accounts were actually opened in November 2007 at provincial level and only two months time for implementation of project in first quarter. It is anticipated to see more project expenditures in remaining quarters and utilize full amount of planed budget in end of the project.
All necessary financial statements are showing in the following attachments;

Attachment (1)	Trial Balance
Attachment (2)	Balance Sheet
Attachment (3)	Budget allocation and expenditures status
Attachment (4)	Outstanding Advance Statement
Attachment (5)	Bank Reconciliation Statement
Attachment (6)	Quarterly Liquidation Statement of 2nd Generation Imprest Account

Achievement (During Quarter 4-2007)

Development of "Financial Management Manual for PHD, OD and HC" has been finished in October 2007.
Adequate introduction training on new Financial Management Manual to respective PHD and OD's accounting staffs has been conducted during November 2007.
According to the planned budget allocation, all necessary project funds have been transferred to all PHD bank accounts in November 2007.
The functional funds disbursement channel has been set up.

Strength:

The financial management guidelines developed by the Dept. of Budget and Finance through GAVI HSS are providing a model for strengthening of decentralized financial management. During the development of GAVI HSS proposal 2, implementers and GAVI partners (including the World Bank) reported favourably on the development of these guidelines.

Training programs have already been developed to support the implementation of the financial management guidelines. The Dept. of Budget and Finance has identified clear weaknesses in decentralized financial management, and has responded by developing a training strategy through HSS to build capacity at the lower levels (using the guidelines as a standard).

Weakness

According to the primary Financial Management arrangement, the project fund could not be placed in OD level budget management center due to the weakness of financial management capacity and insufficient accounting facilities in the OD level.
Some of the provincial level financial staff have not yet understood the new Financial Management Manual.

Problem solving and Recommendations

Naturally the above mentioned weaknesses have been happening in early stage of every projects. It is necessary to conduct more follow up training to PHD and OD level. The central level finance staffs need to monitor and reconcile the provincial level project accounts in regular basis. As and when required the central level financial staffs need to go to provinces for financial training, reconciliation, updated the financial records and monitoring on project expenditures.

Are any Civil Society Organizations involved in the implementation of the HSS proposal ? If so, describe their participation?

Civil Society Organizations (CSOs) involved in the implementation of the HSS proposal:

In terms of implementation, since 2002, the National Immunization Program, through the technical facilitation of UNICEF, has developed an effective Government civil society partnership to improve immunization coverage in Cambodia. Lessons learned from this experience are being applied for HSS. Chief amongst these lessons is the need for careful district mapping of NGO activity, co planning of delivery and a systematic approach to consultation and information.

NGOs funded through USAID in particular but also other agencies provide management support at the peripheral level in Cambodia in areas such as planning, budgeting, development of community based insurance schemes, quality improvement and community outreach.

Specific groups involved in HSS support include WHO, UNICEF,(JICA, USAID, RHAC, RACHA, MEDICAM,), University of Melbourne, Provincial Health Departments (which implement GAVI HSS) and Central Department of MOH such as NIP, MCH,DPHI, DBF, CDC, and the Health Sector Support Project (World Bank) are involved in GAVI HSS Proposal Preparation. CSOs are not directly funded by GAVI HSS 1 Budget.

WHO, UNICEF, Provincial Health Departments (which implement GAVI HSS) and Central Department of MOH such as NIP, MCH,DPHI, DBF, CDC, PMD, HSSP are involved in GAVI HSS Implementation. Detailed CSO involvement in each HSS district is in the table that follows:

Table NGO Support in GAVI HSS Districts

District	NGO /IO Name	Project or Program
1. Prey Kabas	RHAC	Community DOTS, Birth Spacing, Fixed Site
	World Vision	PMTCT/VCCT HIV Aids Home Based Care
	Partners for Compassion	HIV Aids Home Based Care
2. Kg Tralach	World Vision	EPI Cold Chain and VHV and TBA meetings support
	LWS	HIV Home based care & counsel health centre. VHV meetings support
	CHEC	HIV Home based care & counseling
3. Battambang	World Vision	HIV Home based care & counseling
4. Mongkul Borey	RACHA	Safe Motherhood, Child Health, RH, HIV AIDS
	UNFPA	RMCNH
	URC	Quality Improvement
5. Angkor Chum	RACHA	Safe Motherhood, Child Health, RH, LSS Life saving skill
	BTC	Basic Health care Strengthening
6. Kroch Chmar	JICA	MCH Training Health Research
	BTC	Provincial Health Management
7. Kraties	AFH	Equity Fund
	PFHAD	Community DOTS
	OXFAM	Community DOTS
8. Sihanoukvhille	RHAC	EPI, RH, VCCT, HIV AIDS, Equity Fund
	KWCD	HIV Home based care
	French Red Cross	Centre of Hope for PLHA
	FRD and CRC	HIV Home based care
9. Koh Thom	SKY	Health Insurance
10. Chhouk	CHC DPA	DOTS community PHC and HIV

In case any change in the implementation plan and disbursement schedule as per the proposal is requested, please explain in the section below and justify the change in disbursement request. More detailed breakdown of expenditure can be provided in Table 9.

So far, there are no reported changes in the implementation plan. The MOH has received the full amount of GAVI HSS budget for one year, according to the proposal request. No more installments of fund are required from GAVI for HSS 1. A proposal for HSS 2 has been submitted for consideration by the Independent Review Panel for funding from September 2008 – 2015.

Please attach minutes of the Health Sector Coordinating Committee meeting(s) in which fund disbursement and request for next tranche were discussed. Kindly attach the latest Health Sector Review Report and audit report of the account HSS funds are being transferred to. This is a requirement for release of funds for 2009.

The MOH has received the full amount of GAVI HSS budget for one year, according to proposal request. No more installment fund required from GAVI for HSS 1. The Auditing process will be conducted by External Auditor at the end of project (30 Sept.2008). In March 2008, we have submitted to GAVI (Geneva), the proposal document for GAVI HSS 2 (2008-2015). In which the required fund amount of US$331,741.00 for Qtr.4,2008, and US$1,505,849.00 for 2009 are included.

Please find annexed:

1. Health Sector Review 2006
2. Health Sector Plan 2008 – 2015
3. Multi Year Plan for Immunization
4. Health System Rapid Assessment 2008 (including financial report HSS 1).
5. Technical Working Group for Health Minutes (1)
6. ICC minutes (3)
7. Excel Vaccine Request Spreadsheet

Table 9. HSS Expenditure in 2007 in expenditure on HSS activities and request for 2009 (*In case there is a change in the 2009 request, please justify in the narrative above)*			
Area for support	**2007 (Expenditure)**	**2007 (Balance)**	**2009 (Request) Including Qtr.4, 2008**
Activity costs			
GOAL *The goal of the HSS program* is to improve immunization coverage and child survival through district health system strengthening, by increased health centre utilization, by improving the quality and coverage of service, and by increasing demand for health services from mothers and communities			
Activity 1.1: Strengthening MPA Planning, Supervision and Financial Management System Development	US$ 9,424.54	US$ 195,429.46	US$ 231,871.00
Activity 1.2 MPA Capacity Building	US$946.20	US$195,429.46	US$201,500.00
Activity 1.3 Implementation of health service delivery strategy based on priorities identified in local area health centre plan	US$116,152.71	US$787,633.29	US$1,302,365.00
Activity 1.4 Strengthening Transport and Logistics	US$00.00	US$93,400.00	Nil
Support costs			
Management costs	US$15,352.94	US$129,770.06	US$101,854.00
M&E support costs	US$ 5,110.43	US$177,139.57	
TOTAL COSTS	**US$ 146,986.82**	**US$1,703,013.18**	**US$1,837,590.00**

Table 10. HSS Activities in 2007

Please refer to Annex 6 HSS Rapid Assessment, which gives an updated and detailed assessment of implementation of HSS 1. Listed below are the main goals and activities of the program (HSS 1 applications did not have the same structure of objectives and activities as proposed in Table 10 of the Annual progress Report).

	2007
GAOL:	The goal of the HSS program is to improve immunization coverage and child survival through district health system strengthening, by increased health centre utilization, by improving the quality and coverage of service, and by increasing demand for health services from mothers and communities.
Main Activity 1:	**Strengthening MPA Planning, Supervision and Financial Management System Development, including:**
Activity a:	Health centre and operational district planning, supervision and financial management. The annual operational plan of the health centre will include all HSS inputs (2 – 6) *(theme 1)* *137 health centres in 10 districts are now implementing annual operational plans through the contracting system commenced through GAVI.* *All central units and PHDs and ODs supported by HSS/GAVI have been participated in project introduction workshop and agreed on contract.* *Contracted ODs prepared and provided draft work plan to the project management administration.* *A draft of revised outreach guidelines has now been developed following a consultative workshop.* *Development of "Financial Management Manual for PHD, OD and HC" has been completed in October 2007.* *Adequate introduction training on new Financial Management Manual has been provided to respective PHD and OD's accounting staff in November 2007.*
Main Activity 2:	**MPA Capacity Building, including:**
Activity a:	Training for health center and operational district management (planning, health information stems and financial management); *Assessment of Planning manual: Implementation was conducted in 9 provincial Health Departments (PHDs), 16 operational districts.* *Adequate introduction training on new Financial Management Manual has been provided to respective PHD and OD's accounting staff in November 2007.*
Activity b:	Training for Child survival scorecard monitoring and expansion of IMCI Implementation to improve the quality of services at the HC, with a focus on the promotion of the well child check (preventive services including immunization) *(theme 2)* *IMCI Planning Workshop for Sihanuk Ville and Kroach Chhmar OD to introduce IMCI related activities* *3 IMCI Clinical Training Courses in which 78 health staff from Koh Thom, Chhouk, Kroach Chhmar ODs had been trained on how to manage*

	sick children under 5 years old.
Activity c:	Training for improved immunization activities at HC level, particularly in relation to linking with health system strengthening activities *Not yet commenced.*
Main Activity 3:	**Implementation of health service delivery strategy based on priorities identified in local area health centre plan, including:**
Activity a:	Performance base management system for health centre staff and managers (including PBMA) *(theme 2)* *10 operational districts have signed and commenced implementation of Performance Based Management Agreements for delivery of selected MCH services. This includes management agreements with Provinces and Districts.30 other ODs have signed performance agreements for improved immunization (coverage Improvement Planning and Fixed Site Strategy).*
Activity b:	Implementation of local area communication strategy based on local area needs and community participation (including local authority), for increased use of health facility and/or efficient outreach activity, promotion of MCH continuum of care and effective referral systems *(theme 1)* *This activity is integrated within activity 1 (a)*
Activity c:	Linking of immunization and health systems strengthening (theme 1) *150 health centres implement a fixed site utilization strategy. There has been no increase in the number from the baseline. (16 % of total). 257 health centres implement coverage improvement planning in Q 4 2007 and Q 1 2008.(27% of total)*
Main Activity 4:	**Strengthening Transport and Logistics systems; including:**
Activity a:	Transport system development for health centre outreach and referral system *(th.3)* *No activity under this heading has been undertaken in the first 6 months.*
Activity b:	Maintenance system for cold chain and other equipments *(theme 3)* *No activity has yet been undertaken in the first 6 months*

Table 11. Baseline indicators *(Add other indicators according to the HSS proposal)*

Only 1 quarter of HSS activity has been implemented. These national indicators will be reported on in the 2008 APR.

Indicator	Data Source	Baseline Value[1]	Source[2]	Date of Baseline	Target	Date for Target
1. National DTP3 coverage (%)	CDHS, 2005 (Cambodia Demographic Health Survey)	78.3%	NIP Annual Report, 2007	2005	90%	2010
2. Measles Coverage	CDHS, 2005	76.9%	NIP Annual Report, 2007	2005	90%	2010
3. Number / % of districts achieving ≥80% DTP3 coverage	NIP	25 (32%)	NIP Annual Report, 2007	2007	77 (100%)	2010
4. Under five mortality rate (per 1000)	CDHS, 2005	83	Ministry of Health & Ministry of Planning	2005	75	2010
5. % pregnant women with 2 or more ANC consultation from skilled health personnel	NSRH 2005	60%	NMCH	2005	80%	2010
6. Proportion of birth attended by skilled health personnel	CDHS, 2005	44%	NMCH	2005	70%	2010

[1] If baseline data is not available indicate whether baseline data collection is planned and when
[2] Important for easy accessing and cross referencing

Please describe whether targets have been met, what kind of problems has occurred in measuring the indicators, how the monitoring process has been strengthened and whether any changes are proposed.

At this early stage of implementation it is too early to conclude if the system innovations outlined above have impacted on accessibility of populations to health services (see data earlier). Implementation commenced in the first quarter of 2007, with funds reaching the facility level mid quarter 2007. As part of the interdepartmental monitoring, supervisors compared Qtr 2006 and Qtr 2007 data and this was presented at the national consultative workshop on HSS on February 5 by the OD managers.

What the data demonstrates is that across the board there have been moderate rises in immunization coverage and ante natal care, but falls in overall consultations. This data should be interpreted with caution, as the implementation timeframe is too short to make any accurate assessment of impact of internal contracting on health system performance (see table above).

Current contracts are targeting a 17.5 % increase overall for all consultations, ANC and immunization contacts. In quarter of 2007, there has been a increase in immunization contacts and ANC Contacts, but a decline overall in general consultations.

Overall, the HSS contract system has identified four important developments in health system strengthening. (1) It has been demonstrated that it is feasible through a decentralized financial management model based on internal contracting to mobilize operational funds for the delivery level on a timely basis.(2) Health worker and manager motivation can be increased through internal contracting related to timely release of health finance for operations. (3) There is general national and international stakeholder interest (if not consensus) in moving step by step towards an internal contracting model for the delivery of a comprehensive range of service at primary and secondary level of care. (4) System innovations introduced are supportive of Health Sector Plan 2 and Health Sector Support program directions (World Bank, DFID, AusAID, AFD) regarding governance strategy and internal contracting.

A Health Sector Strategic Plan has just been completed in 2008 (for period 2008 – 2015). The strategic plan supports many of the directions that were initiated through GAVI HSS 1 (particularly internal contracting model). The strategic plan also includes a national M & E framework which GAVI HSS program will align with. The GAVI HSS program will also use multi departmental monitoring as a strategy to develop a more integrated health systems approach to strengthening decentralized health system management and delivery.

5. Checklist

Checklist of completed form:

Form Requirement:	Completed	Comments
Date of submission	15 May 2008	
Reporting Period (consistent with previous calendar year)	Yes	
Government signatures	Yes	
ICC endorsed	Yes	
ISS reported on	N/A	
DQA reported on	Yes	
Reported on use of Vaccine introduction grant	N/A	
Injection Safety Reported on	No	
Immunisation Financing & Sustainability Reported on (progress against country IF&S? indicators)	Yes	
New Vaccine Request including co-financing completed and Excel sheet attached	Yes	
Revised request for injection safety completed (where applicable)	No	
HSS reported on	Yes	
ICC minutes attached to the report	Yes	
HSCC minutes, audit report of account for HSS funds and annual health sector evaluation report attached to report	Yes	

6. Comments

ICC/HSCC comments:

Please refer to ICC and TWGH minutes for details (in Annexes)

~ End ~