*GAVI Alliance*

# Annual Progress Report 2012

Submitted by

## The Government of

## *Cambodia*

Reporting on year: **2012**
Requesting for support year: **2014**
Date of submission: **5/22/2013 6:40:30 AM**

**Deadline for submission: 9/24/2013**

Please submit the APR 2012 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavialliance.org or representatives of a GAVI Alliance partner. The documents can be shared with GAVI Alliance partners, collaborators and general public. The APR and attachments must be submitted in English, French, Spanish, or Russian.

**Note**: *You are encouraged to use previous APRs and approved Proposals for GAVI support as reference documents. The electronic copy of the previous APRs and approved proposals for GAVI support are available at* http://www.gavialliance.org/country/

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.

**GAVI ALLIANCE**
**GRANT TERMS AND CONDITIONS**

**FUNDING USED SOLELY FOR APPROVED PROGRAMMES**

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

**AMENDMENT TO THE APPLICATION**

The Country will notify the GAVI Alliance in its Annual Progress Report (APR) if it wishes to propose any change to the programme(s) description in its application. The GAVI Alliance will document any change approved by the GAVI Alliance, and the Country's 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 its 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 the Country's application, or any GAVI Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in its 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 its 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 Country confirm that its application, and APR, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

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

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

**USE OF COMMERCIAL BANK ACCOUNTS**

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support. The Country confirms that it will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

**ARBITRATION**

Any dispute between the Country and the GAVI Alliance arising out of or relating to its 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 languages of the arbitration will be English or French.

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 the 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 its application.

***By filling this APR the country will inform GAVI about:***

*Accomplishments using GAVI resources in the past year*

*Important problems that were encountered and how the country has tried to overcome them*

*Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners*

*Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released*

*How GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.*

# 1. Application Specification

Reporting on year: **2012**

Requesting for support year: **2014**

## 1.1. NVS & INS support

| Type of Support | Current Vaccine | Preferred presentation | Active until |
|---|---|---|---|
| Routine New Vaccines Support | DTP-HepB-Hib, 1 dose(s) per vial, LIQUID | DTP-HepB-Hib, 1 dose(s) per vial, LIQUID | 2015 |
| Routine New Vaccines Support | Measles second dose, 10 dose(s) per vial, LYOPHILISED | Measles second dose, 10 dose(s) per vial, LYOPHILISED | 2015 |
| INS | | | |

**DTP-HepB-Hib (Pentavalent)** vaccine: Based on current country preferences the vaccine is available through UNICEF in fully liquid 1 and 10 dose vial presentations and in a 2 dose-2 vials liquid/lyophilised formulation, to be used in a three-dose schedule. Other presentations are also WHO pre-qualified, and a full list can be viewed on the WHO website, but availability would need to be confirmed specifically.

## 1.2. Programme extension

No NVS support eligible to extension this year

## 1.3. ISS, HSS, CSO support

| Type of Support | Reporting fund utilisation in 2012 | Request for Approval of | Eligible For 2012 ISS reward |
|---|---|---|---|
| VIG | Yes | N/A | N/A |
| COS | No | No | N/A |
| ISS | Yes | next tranche: N/A | Yes |
| HSS | Yes | next tranche of HSS Grant Yes | N/A |
| CSO Type A | No | Not applicable N/A | N/A |
| CSO Type B | No | CSO Type B extension per GAVI Board Decision in July 2012: N/A | N/A |
| HSFP | No | N/A | N/A |

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

## 1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2011 is available here.

# 2. Signatures

## 2.1. Government Signatures Page for all GAVI Support (ISS, INS, NVS, HSS, CSO)

By signing this page, the Government of Cambodia hereby attests the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies, and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in this Annual Progress Report (APR).

For the Government of Cambodia

Please note that this APR will not be reviewed or approved by the Independent Review Committee (IRC) without the signatures of both the Minister of Health & Minister Finance or their delegated authority.

| Minister of Health (or delegated authority) | | Minister of Finance (or delegated authority) | |
|---|---|---|---|
| **Name** | H.E.Dr. MAM BUN HENG | **Name** | H.E. KEAT CHHON |
| **Date** | | **Date** | |
| **Signature** | | **Signature** | |

*This report has been compiled by (these persons may be contacted in case the GAVI Secretatiat has queries on this document):*

| Full name | Position | Telephone | Email |
|---|---|---|---|
| Prof. Sann Chan Soeung | Adviser to Minister of Health | +855 12 933 344 | workmoh@gmail.com |

## 2.2. ICC signatures page

*If the country is reporting on Immunisation Services (ISS), Injection Safety (INS) and/or New and Under-Used Vaccines (NVS) supports*

**In some countries, HSCC and ICC committees are merged. Please fill-in each section where information is appropriate and upload in the attached documents section the signatures twice, one for HSCC signatures and one for ICC signatures**

The GAVI Alliance Transparency and Accountability Policy (TAP) is an integral part of GAVI Alliance monitoring of country performance. By signing this form the ICC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

### 2.2.1. ICC report endorsement

We, the undersigned members of the immunisation Inter-Agency Coordinating Committee (ICC), endorse this report. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

| Name/Title | Agency/Organization | Signature | Date |
|---|---|---|---|

| | | | |
|---|---|---|---|
| See full listing in Attachment # | Full list provided in Attachment # | | |

ICC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

GAVI APR EPI and HSS Sections were endorsed by the Health Partners in Cambodia at the Technical Working Group meeting on 11 April 2013. Note that the Technical Working Group for Health meeting performs the functions of the ICC and also the HSCC.

Comments from the Regional Working Group:

N/A

## 2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), TWGH , 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.

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the HSCC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management. Furthermore, the HSCC confirms that the content of this report has been based upon accurate and verifiable financial reporting.

| Name/Title | Agency/Organization | Signature | Date |
|---|---|---|---|
| N/A | N/A | | |

HSCC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

Note that HSCC functions are performed by the Technical Working Group for Health, formal communication to GAVI as to this change provided in the attachments.

Comments from the Regional Working Group:

N/A

## 2.4. Signatures Page for GAVI Alliance CSO Support (Type A & B)

Cambodia is not reporting on CSO (Type A & B) fund utilisation in 2013

## 3. Table of Contents

*This APR reports on Cambodia's activities between January – December 2012 and specifies the requests for the period of January – December 2014*

**Sections**

## 4. Baseline & annual targets

Countries are encouraged to aim for realistic and appropriate wastage rates informed by an analysis of their own wastage data. In the absence of country-specific data, countries may use indicative maximum wastage values as shown on the **Wastage Rate Table** available in the guidelines. Please note the benchmark wastage rate for 10ds pentavalent which is available.

| Number | Achievements as per JRF | | Targets (preferred presentation) | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 2012 | | 2013 | | 2014 | | 2015 | |
| | Original approved target according to Decision Letter | Reported | Original approved target according to Decision Letter | Current estimation | Previous estimates in 2012 | Current estimation | Previous estimates in 2012 | Current estimation |
| **Total births** | 388,003 | 355,268 | 397,160 | 354,407 | 406,533 | 350,142 | 416,127 | 343,968 |
| **Total infants' deaths** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total surviving infants** | 388003 | 355,268 | 397,160 | 354,407 | 406,533 | 350,142 | 416,127 | 343,968 |
| **Total pregnant women** | 388,003 | 365,703 | 397,160 | 354,407 | 406,533 | 350,142 | 416,127 | 343,968 |
| **Number of infants vaccinated (to be vaccinated) with BCG** | 388,003 | 352,564 | 397,160 | 354,407 | 406,533 | 350,142 | 416,127 | 343,968 |
| **BCG coverage** | 100 % | 99 % | 100 % | 100 % | 100 % | 100 % | 100 % | 100 % |
| **Number of infants vaccinated (to be vaccinated) with OPV3** | 368,603 | 336,860 | 377,302 | 336,496 | 386,206 | 332,634 | 395,206 | 326,769 |
| **OPV3 coverage** | 95 % | 95 % | 95 % | 95 % | 95 % | 95 % | 95 % | 95 % |
| **Number of infants vaccinated (to be vaccinated) with DTP1** | 368,603 | 342,970 | 377,302 | 340,230 | 386,206 | 336,136 | 395,321 | 330,209 |
| **Number of infants vaccinated (to be vaccinated) with DTP3** | 368,603 | 336,860 | 377,302 | 336,496 | 386,206 | 332,634 | 395,321 | 326,769 |
| **DTP3 coverage** | 95 % | 95 % | 95 % | 95 % | 95 % | 95 % | 95 % | 95 % |
| **Wastage[1] rate in base-year and planned thereafter (%) for DTP** | 0 | 2 | 5 | 5 | 5 | 5 | 5 | 5 |
| **Wastage[1] factor in base-year and planned thereafter for DTP** | 1.00 | 1.02 | 1.05 | 1.05 | 1.05 | 1.05 | 1.05 | 1.05 |
| **Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib** | 368,603 | 342,970 | 377,302 | 340,230 | 386,206 | 336,136 | 395,206 | 330,209 |
| **Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib** | 368,603 | 336,860 | 377,302 | 336,496 | 386,206 | 332,634 | 395,206 | 326,769 |
| **DTP-HepB-Hib coverage** | 95 % | 95 % | 95 % | 95 % | 95 % | 95 % | 95 % | 95 % |
| **Wastage[1] rate in base-year and planned thereafter (%)** | 0 | 2 | 0 | 5 | 5 | 5 | 5 | 5 |
| **Wastage[1] factor in base-year and planned thereafter (%)** | 1.05 | 1.02 | 1.05 | 1.05 | 1.05 | 1.05 | 1.05 | 1.05 |
| **Maximum wastage rate value for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID** | 5 % | 5 % | 5 % | 5 % | 5 % | 5 % | 5 % | 5 % |
| **Number of infants vaccinated (to be vaccinated) with 1st dose of Measles** | 368,603 | 331,757 | 377,302 | 336,496 | 386,206 | 332,634 | 395,321 | 326,769 |
| **Number of infants vaccinated (to be vaccinated) with 2nd dose of Measles** | 368,603 | 145,303 | 377,302 | 336,496 | 386,206 | 332,634 | 395,321 | 326,769 |

| Number | Achievements as per JRF | | Targets (preferred presentation) | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 2012 | | 2013 | | 2014 | | 2015 | |
| | Original approved target according to Decision Letter | Reported | Original approved target according to Decision Letter | Current estimation | Previous estimates in 2012 | Current estimation | Previous estimates in 2012 | Current estimation |
| **Measles coverage** | 95 % | 41 % | 95 % | 95 % | 95 % | 95 % | 95 % | 95 % |
| **Wastage[1] rate in base-year and planned thereafter (%) {0}** | 1 | 50 | 1 | 50 | 0 | 50 | 0 | 50 |
| **Wastage[1] factor in base-year and planned thereafter (%)** | 2 | 2 | 2 | 2 | 1 | 2 | 1 | 2 |
| **Maximum wastage rate value for Measles second dose, 10 dose(s) per vial, LYOPHILISED** | 50.00 % | 40.00 % | 50.00 % | 40.00 % | 50.00 % | 40.00 % | 50.00 % | 40.00 % |
| **Pregnant women vaccinated with TT+** | 360,054 | 259,337 | 364,395 | 318,966 | 369,073 | 315,127 | 372,853 | 309,571 |
| **TT+ coverage** | 93 % | 71 % | 92 % | 90 % | 91 % | 90 % | 90 % | 90 % |
| **Vit A supplement to mothers within 6 weeks from delivery** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Vit A supplement to infants after 6 months** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Annual DTP Drop out rate [ ( DTP1 – DTP3 ) / DTP1 ] x 100** | 0 % | 2 % | 0 % | 1 % | 0 % | 1 % | 0 % | 1 % |

** Number of infants vaccinated out of total surviving infants

*** Indicate total number of children vaccinated with either DTP alone or combined

**** Number of pregnant women vaccinated with TT+ out of total pregnant women

1 The formula to calculate a vaccine wastage rate (in percentage): [ ( A B ) / A ] x 100. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

# 5. General Programme Management Component

## 5.1. Updated baseline and annual targets

**Note:** Fill in the table in section 4 Baseline and Annual Targets before you continue

The numbers for 2012 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2012.** The numbers for 2013 - 2015 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

In fields below, please provide justification and reasons for those numbers that in this APR are different from the referenced ones:

- Justification for any changes in **births**

  Estimates for the number of births for 2013 to 2015 have been updated according to the latest census projections (Census Report Number 12 - January 2011, National Institutes of Statistics provided as an attachment, see pages 132 to 134). This reflects a reduction in birth estimates from that provided in the cMYP, and these new figures will be reflected in the next cMYP (2015 to 2020) that will be developed during 2014.

  Birth estimates for 2013 are also in line with that reported in the 2012 WHO/UNICEF Joint Reporting Form.

- Justification for any changes in **surviving infants**

  N/A

- Justification for any changes in targets by vaccine. **Please note that targets in excess of 10% of previous years' achievements will need to be justified.**

  N/A

- Justification for any changes in **wastage by vaccine**

  N/A

## 5.2. Immunisation achievements in 2012

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2012 and how these were addressed:

The DTP-HepB-Hib(Penta) coverage target of 94% in the 2011 APR was achieved with the official estimated coverage for Penta 3 reported in the 2012 JRF of 95%. Importantly, high immunization coverage rates are increasingly uniform across all districts with 36 of 79 districts reporting Penta3 coverage > 95% and 22 of 79 districts reporting Penta3 coverage >80% , Two (2) of 79 districts reported Penta3 coverage < 50%. Targets for BCG,OPV and measles vaccine were either achieved or exceed. Wastage targets for DTP-HepB-Hib were bettered (target 5% - achieved 3%).

Key immunization achievements for 2012 were:

- No lab confirmed measles cases in Cambodia since November 2011, following successful measles SIA in 2011.
- NIP supported the expansion of the timely provision Hep B birth dose in maternity and delivery wards in all provincial hospital in whole country through greater collaboration with midwifery services
- MNTE pre validation assessment driven by UNICEF identified the highest risk districts for MNTE, with full validation expected in 2014.
- Measles 2nd dose (M18) was introduced (GAVI supported) in to routine immunization activity in whole country in June 2012
- NIP applied the High Risk Strategy that was the basis of the successful measles SIA in 2011 to the routine EPI in 3 provinces that targeted the community level for immunization improvements, and will expand 3 more provinces in the 2nd quarter in 2013
- The NIP with the Cambodian University of Health Science undertook a HepB sero survey in 3 provinces (urban and two rural) with technical support from WHO and CDC USA. This clearly demonstrated the impact of the introduction of HepB vaccine in Cambodia,with the results of this work expected to be published in the medical literature soon.
- Immunization practice, disease surveillance, cold chain and vaccine management was conducted to new EPI staff in 24 provinces
- Cold Chain assessment conducted in third quarter in 2012 and cold chain inventory updated

5.2.2. If targets were not reached, please comment on reasons for not reaching the targets:

N/A

## 5.3. Monitoring the Implementation of GAVI Gender Policy

5.3.1. At any point in the past five years, were sex-disaggregated data on DTP3 coverage available in your country from administrative data sources and/or surveys? **yes, available**

If yes, please report the latest data available and the year that it is from.

| Data Source | Reference Year for Estimate | DTP3 Coverage Estimate | |
|---|---|---|---|
| | | Boys | Girls |
| DHS 2010 | 2010 | 84.6 | 85.1 |

5.3.2. How have any discrepancies in reaching boys versus girls been addressed programmatically?

DHS 2010 found no discrepancies between boys versus girls for immunization delivery in Cambodia

5.3.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **No**

5.3.4. How have any gender-related barriers to accessing and delivering immunisation services (eg, mothers not being empowered to access services, the sex of service providers, etc) been addressed programmatically ? (For more information on gender-related barriers, please see GAVI's factsheet on gender and immunisation, which can be found on http://www.gavialliance.org/about/mission/gender/)

N/A

## 5.4. Data assessments

5.4.1. Please comment on any discrepancies between immunisation coverage data from different sources (for example, if survey data indicate coverage levels that are different than those measured through the administrative data system, or if the WHO/UNICEF Estimate of National Immunisation Coverage and the official country estimate are different)

The DHS 2010 confirms the dramatic improvement in reported immunization coverage in Cambodia since 2005, and estimates that the rate of fully immunized children is 79%.

Discrepancies do occur for some antigens especially at the sub national level, and this reflect issue surrounding estimates based on 2008 population census and changes that have occurred with fertility rates and movement of people since then.

* Please note that the WHO UNICEF estimates for 2012 will only be available in July 2013 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2011 to the present? **Yes**

If Yes, please describe the assessment(s) and when they took place.

WHO undertook an assessment of health facility data quality in 2011, that included a strong focus on immunization coverage data. Summary of results

At the national level, health facility reporting produces data of good quality for most indicators of intervention coverage, but problems with the denominators which seem to be too low:

- Completeness of reporting: excellent; 99.8% of facilities submitted monthly reports for the year and there were no missing/zero values at the provincial and district level for four tracer indicators (Antenatal care second visit–ANC2–, measles immunization, institutional deliveries, and outpatient department –OPD–).
- Internal consistency of the reported data: good; extreme outlying values from provinces were very rare, consistency over time was good, consistency between antenatal care first visit (ANC1) and diphteria-tetanus-pertussis vaccine first dose (DTP1) was good, DTP1 and DTP3 (diphteria-tetanus-pertussis vaccine third dose) consistency was good; no facility data verification was conducted in 2011
- Consistency of population denominators: fair; projections are based on 2008 census with published birth and death rates; highly consistent with UN projections and high level of internal consistency; the
- survey findings however suggest that the national population denominators for diphteria-tetanus-pertussis vaccine (DTP) is too low.
- External comparison of coverage rates: poor correspondence for measles immunization but no reason to assume that antenatal care and deliveries at public health facilities based on facility reporting were poor.

For the assessment of performance in the 24 provinces the data quality assessment shows that:

- Completeness of reporting: excellent; for all provinces.
- Internal consistency of the reported data: good; extreme outlying values from provinces were very rare, consistency over time was good, consistency between ANC1 and DTP1 was good, one fourth of provinces had DTP3 higher than DTP1.
- Consistency of population denominators: not good for all provinces; the analysis using the survey findings suggest that population denominators are often too low, especially in Phnom Penh.
- External comparison of coverage rates: poor correspondence; coverage of measles immunization based on facility reporting were much higher than that from the survey data, with some provinces having greater differences.

Cambodia has a well-functioning reporting system, which has performed consistently over the past years. It can be further strengthened in two ways: (1) conduct a regular facility survey with data verification to know the accuracy of reporting for key indicators; (2) review and improve the provincial population denominators using the census and Cambodia Demographic and Health Survey (CDHS) 2010 results.

A copy of this assessment is provided in Attachment

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2010 to the present.

Results of this assessment were released in 2012 and WHO is currently further supporting the Department of Planning and Health Information to strengthen the health information system around the areas highlighted in this review.

5.4.4. Please describe any plans that are in place, or will be put into place, to make further improvements to administrative data systems.

N/A

## 5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

| **Exchange rate used** | 1 US$ = 1 | Enter the rate only; Please do not enter local currency name |
|---|---|---|

**Table 5.5a:** Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

| **Expenditure by category** | **Expenditure Year 2012** | **Source of funding** | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | **Country** | **GAVI** | **UNICEF** | **WHO** | **N/A** | **N/A** | **N/A** |
| Traditional Vaccines* | 926,431 | 926,431 | 0 | 0 | 0 | 0 | 0 | 0 |
| New and underused Vaccines** | 3,873,809 | 258,905 | 3,614,904 | 0 | 0 | 0 | 0 | 0 |
| Injection supplies (both AD syringes and syringes other than ADs) | 1,666,908 | 1,574,985 | 91,923 | 0 | 0 | 0 | 0 | 0 |
| Cold Chain equipment | 23,539 | 0 | 0 | 0 | 23,539 | 0 | 0 | 0 |
| Personnel | 41,458 | 21,058 | 20,400 | 0 | 0 | 0 | 0 | 0 |
| Other routine recurrent costs | 896,229 | 336,156 | 271,370 | 16,876 | 271,827 | 0 | 0 | 0 |
| Other Capital Costs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Campaigns costs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| N/A | | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | | |
| Total Expenditures for Immunisation | 7,428,374 | | | | | | | |
| | | | | | | | | |
| Total Government Health | | 3,117,535 | 3,998,597 | 16,876 | 295,366 | 0 | 0 | 0 |

* Traditional vaccines: BCG, DTP, OPV (or IPV), Measles 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support.

5.5.1. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2013 and 2014

N/A

## 5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **Yes, partially implemented**

**If Yes,** briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country in the table below:

| **Action plan from Aide Mémoire** | **Implemented?** |
|---|---|
| FMA conducted 2012 | Not selected |

If the above table shows the action plan from Aide Memoire has been fully or partially implemented, briefly state exactly what has been implemented

Ministry of Health is currently awaiting receipt of the FMA Aide Memoire from GAVI for review and signing by the Ministry of Health

If none has been implemented, briefly state below why those requirements and conditions were not met.

N/A

## 5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2012? **12**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2013 endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Updated baseline and annual targets to 5.5 Overall Expenditures and Financing for Immunisation

APR 2012 endorsed by Health Partners at the Technical Working Group for Health (TWGH) meeting on 11 April 2013. Please see attached minutes for comments and discussions from TWGH members.

Note that the TWGH meets monthly and addresses all health programs and issues, immunization is a regular topic of this forum and was discussed at six (6) meeting during 2012. Minutes of all of these meetings are included in the attachments.

Are any Civil Society Organisations members of the ICC? **Yes**

**If Yes,** which ones?

| List CSO member organisations: |
|---|
| List of NGO participants is included on the attached TWGH meeting minutes |

## 5.8. Priority actions in 2013 to 2014

What are the country's main objectives and priority actions for its EPI programme for 2013 to 2014

To achieve measles and MNTE elimination validation in 2014.

To undertake the successful rubella vaccine introduction and MR SIA in 2013

To expand the NIP high risk community strategy throughout Cambodia linked to measles 2nd dose

Improve HepB vaccine timely birth dose coverage at the health facility level

To update the cMYP in 2014 that includes a long term plan for new vaccine introduction (pneumococcal, HPV, rotavirus, JE)

## 5.9. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety

Please report what types of syringes are used and the funding sources of Injection Safety material in 2012

| Vaccine | Types of syringe used in 2012 routine EPI | Funding sources of 2012 |
|---|---|---|
| BCG | AD syringe | Government |
| Measles | AD syringe | Government/GAVI |
| TT | AD syringe | Government |
| DTP-containing vaccine | AD syringe | Government/GAVI |

Does the country have an injection safety policy/plan? **Yes**

**If Yes:** Have you encountered any obstacles during the implementation of this injection safety policy/plan?

**If No**: When will the country develop the injection safety policy/plan? (Please report in box below)

There have been no obstacles encountered with the implementation of the injection safety policy in Cambodia

Please explain in 2012 how sharps waste is being disposed of, problems encountered, etc.

Used AD syringes are disposed of in safety boxes at all immunization sites, and these are burnt in special high temperature incinerators that are located in all provinces.

# 6. Immunisation Services Support (ISS)

## 6.1. Report on the use of ISS funds in 2012

| | Amount US$ | Amount local currency |
|---|---|---|
| Funds received during 2012 *(A)* | 0 | 0 |
| Remaining funds (carry over) from 2011 *(B)* | 485,772 | 485,772 |
| Total funds available in 2012 *(C=A+B)* | 485,772 | 485,772 |
| Total Expenditures in 2012 *(D)* | 173,691 | 173,691 |
| Balance carried over to 2013 *(E=C-D)* | 312,081 | 312,081 |

6.1.1. Briefly describe the financial management arrangements and process used for your ISS funds. Indicate whether ISS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of ISS funds, such as delays in availability of funds for programme use.

ISS funds are managed through the Department of Budget and Finance within the MOH. All ISS funds are reflected in the annual operational planning system of the MOH. ISS funds are monitored through the Department of Budget and Finance processes. ISS funding budgets and implementation are presented to the Technical Working Group for Health for information of partners.

In APR 2011, balance carried over to 2012 reported as 410,441 USD, but this has been amended in the 2012 APR to 485,772 USD. The reason for this amendment is due to the accountancy standards used by the Department of Budget and Finance (DBF), which register an expenditure when all funds have been released, implemented and fully acquitted. The reason why the carry over funds in 2012 have been increased is that activities in the 2011 APR were reported as expenditure for GAVI purposes, but were still not considered expenditures by the DBF under their accountancy standards, reducing the total funds considered spent during 2011 accordingly. For 2012, this has been amended to bring the financial reports provided by DBF inline with the expenditure reported to GAVI in the APR. Please note that this issues was highlighted during the 2012 Financial Management Assessment by GAVI Secretariat. Further explanation provided in attachment from DBF.

6.1.2. Please include details on the type of bank account(s) used (commercial versus government accounts), how budgets are approved, how funds are channelled to the sub-national levels, financial reporting arrangements at both the sub-national and national levels, and the overall role of the ICC in this process

ISS funds are deposited in a GAVI Government Account, budgets are approved through the annual operational planning process of the MOH, budgets are plans are review through the iSCS and the TWG for Health.

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2012

1-Coverage Improvement Planning, which involves additional immunization rounds in high risk areas/communities

2-Fixed Site Immunization to support meetings between health centre staff and Village Health Support Groups, and supervision by National, Provincial immunization staff of immunization performance at the health centre level.

3-Supervision of the implementation Measles 2nd doses through on site visits by national and provincial immunization staff

6.1.4. Is GAVI's ISS support reported on the national health sector budget? **Yes**

## 6.2. Detailed expenditure of ISS funds during the 2012 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2012 calendar year (Document Number 7) (Terms of reference for this financial statement are attached in Annexe 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

6.2.2. Has an external audit been conducted? **No**

6.2.3. External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year.  If an external audit report is available for your ISS programme during your governments most recent fiscal year, this must also be attached  (Document Number 8).

## 6.3. Request for ISS reward

Calculations of ISS rewards will be carried out by the GAVI Secretariat, based on country eligibility, based on JRF data reported to WHO/UNICEF, taking into account current GAVI policy.

# 7. New and Under-used Vaccines Support (NVS)

## 7.1. Receipt of new & under-used vaccines for 2012 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2012 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

**Table 7.1**: Vaccines received for 2012 vaccinations against approvals for 2012

| | [ A ] | [ B ] | | |
|---|---|---|---|---|
| **Vaccine type** | **Total doses for 2012 in Decision Letter** | **Total doses received by 31 December 2012** | **Total doses of postponed deliveries in 2012** | **Did the country experience any stockouts at any level in 2012?** |
| DTP-HepB-Hib | 1,161,100 | 1,072,700 | 0 | Not selected |
| Measles | 921,600 | 921,600 | 0 | Not selected |

**Please also include any deliveries from the previous year received against this Decision Letter*

If values in [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilisation than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date? ...)

  Note that GAVI Decision Letter (dated 27 September 2011) advised that total doses of DTP-HepB-Hib in 2012 would be 1,072,700. The decision letter from GAVI is attached

- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

  **GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.**

  N/A

If **Yes** for any vaccine in **Table 7.1**, please describe the duration, reason and impact of stock-out, including if the stock-out was at the central, regional, district or at lower facility level.

N/A

## 7.2. Introduction of a New Vaccine in 2012

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2012, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

| DTP-HepB-Hib, 1 dose(s) per vial, LIQUID | | |
|---|---|---|
| **Phased introduction** | No | |
| **Nationwide introduction** | Yes | 01/06/2012 |
| **The time and scale of introduction was as planned in the proposal? If No, Why ?** | Yes | |

| Measles second dose, 10 dose(s) per vial, LYOPHILISED | | |
|---|---|---|
| **Phased introduction** | No | |
| **Nationwide introduction** | Yes | |
| **The time and scale of introduction was as planned in the proposal? If No, Why ?** | Yes | |

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **February 2014**

If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 9) )

PIE for Pentavalent vaccine conducted in 2011, report provide to GAVI in the 2011 APR. All recommendations have been fully implemented and are being used to guide the process for the development of a pneumoccoal vaccine application to GAVI in 2013

7.2.3. Adverse Event Following Immunization (AEFI)

Is there a national dedicated vaccine pharmacovigilance capacity? **Yes**

Is there a national AEFI expert review committee? **No**

Does the country have an institutional development plan for vaccine safety? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

Does your country have a risk communication strategy with preparedness plans to address vaccine crises? **Not selected**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **Not selected**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Not selected**

Does your country conduct special studies around:

a. rotavirus diarrhea? **Not selected**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Not selected**

If so, does the National Immunization Technical Advisory Group (NITAG) or the Inter-Agency Coordinating Committee (ICC) regularly review the sentinel surveillance and special studies data to provide recommendations on the data generated and how to further improve data quality? **Not selected**

Do you plan to use these sentinel surveillance and/or special studies data to monitor and evaluate the impact of vaccine introduction and use? **Not selected**

Please describe the results of surveillance/special studies and inputs of the NITAG/ICC:

## 7.3. New Vaccine Introduction Grant lump sums 2012

### 7.3.1. Financial Management Reporting

| | Amount US$ | Amount local currency |
|---|---|---|
| Funds received during 2012 (A) | 0 | 0 |
| Remaining funds (carry over) from 2011 (B) | 116,500 | 116,500 |
| Total funds available in 2012 (C=A+B) | 116,500 | 116,500 |
| Total Expenditures in 2012 (D) | 101,181 | 101,181 |
| Balance carried over to 2013 (E=C-D) | 15,319 | 15,319 |

Detailed expenditure of New Vaccines Introduction Grant funds during the 2012 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2012 calendar year ( Document No 10,11) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

### 7.3.2. Programmatic Reporting

Please report on major activities that have been undertaken in relation to the introduction of a new vaccine, using the GAVI New Vaccine Introduction Grant

1. Training for all health staff on the new 2nd measles dose, particularly at the provincial and district level

2. Social mobilization on the new 2nd measles dose through launch ceremony attended be Minister of Health and and radio broadcasts and TV spots (in conjunction with UNICEF) for 3 months.

3. National workshop on measles 2nd dose introduction into the immunization schedule for key immunization program staff and partners

Please describe any problem encountered and solutions in the implementation of the planned activities

N/A

Please describe the activities that will be undertaken with any remaining balance of funds for 2013 onwards

Further supervision of measles 2nd dose introduction and quality of coverage levels, with a focus on high risk areas.

## 7.4. Report on country co-financing in 2012

**Table 7.4 :** Five questions on country co-financing

| | **Q.1: What were the actual co-financed amounts and doses in 2012?** | |
|---|---|---|
| **Co-Financed Payments** | **Total Amount in US$** | **Total Amount in Doses** |
| Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID | 247,800 | 77,700 |
| Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED | 0 | 0 |
| | | |
| | **Q.2: Which were the amounts of funding for country co-financing in reporting year 2012 from the following sources?** | |
| Government | Government of Cambodia | |
| Donor | N/A | |
| Other | N/A | |

| | | |
|---|---|---|
| | **Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?** | |
| **Co-Financed Payments** | **Total Amount in US$** | **Total Amount in Doses** |
| Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID | | |
| Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED | | |
| | | |
| | **Q.4: When do you intend to transfer funds for co-financing in 2014 and what is the expected source of this funding** | |
| **Schedule of Co-Financing Payments** | Proposed Payment Date for 2014 | Source of funding |
| Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID | September | Government |
| Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED | | N/A - 2nd dose fully GAVI funded |
| | | |
| | **Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing** | |
| | | |

If the country is in default, please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Default Policy: http://www.gavialliance.org/about/governance/programme-policies/co-financing/

N/A

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **Yes**

## 7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at http://www.who.int/immunization_delivery/systems_policy/logistics/en/index6.html

*It is mandatory for the countries to conduct an EVM prior to an application for introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timelines whose progress report is reported with annual report. The EVM assessment is valid for a period of three years.*

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **March 2012**

Please attach:

(a) EVM assessment **(Document No 12)**

(b) Improvement plan after EVM **(Document No 13)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 14)**

Progress report on EVM/VMA/EVSM Improvement Plan' is a mandatory requirement

Are there any changes in the Improvement plan, with reasons? **No**

If yes, provide details

N/A

When is the next Effective Vaccine Management (EVM) assessment planned? **March 2015**

## 7.6. Monitoring GAVI Support for Preventive Campaigns in 2012

Cambodia does not report on NVS Preventive campaign

## 7.7. Change of vaccine presentation

Cambodia does not require to change any of the vaccine presentation(s) for future years.

## 7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2013

Renewal of multi-year vaccines support for Cambodia is not available in 2013

## 7.9. Request for continued support for vaccines for 2014 vaccination programme

In order to request NVS support for 2014 vaccination do the following

Confirm here below that your request for 2014 vaccines support is as per 7.11 Calculation of requirements **Yes**

If you don't confirm, please explain

N/A

## 7.11. Calculation of requirements

**Table 7.11.1:** Specifications for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID

| ID | | Source | | 2012 | 2013 | 2014 | 2015 | TOTAL |
|---|---|---|---|---|---|---|---|---|
| | **Number of surviving infants** | Table 4 | # | 355,268 | 354,407 | 350,142 | 343,968 | 1,403,785 |
| | **Number of children to be vaccinated with the first dose** | Table 4 | # | 342,970 | 340,230 | 336,136 | 330,209 | 1,349,545 |
| | **Number of children to be vaccinated with the third dose** | Table 4 | # | 336,860 | 336,496 | 332,634 | 326,769 | 1,332,759 |
| | **Immunisation coverage with the third dose** | Table 4 | % | 94.82 % | 94.95 % | 95.00 % | 95.00 % | |
| | **Number of doses per child** | Parameter | # | 3 | 3 | 3 | 3 | |
| | **Estimated vaccine wastage factor** | Table 4 | # | 1.02 | 1.05 | 1.05 | 1.05 | |
| | **Vaccine stock on 31st December 2012 * (see explanation footnote)** | | # | | | | | |
| | **Vaccine stock on 1 January 2013 ** (see explanation footnote)** | | # | 582,260 | | | | |
| | **Number of doses per vial** | Parameter | # | | 1 | 1 | 1 | |
| | **AD syringes required** | Parameter | # | | Yes | Yes | Yes | |
| | **Reconstitution syringes required** | Parameter | # | | No | No | No | |
| | **Safety boxes required** | Parameter | # | | Yes | Yes | Yes | |
| **g** | **Vaccine price per dose** | Table 7.10.1 | $ | | 2.04 | 2.04 | 1.99 | |
| **cc** | **Country co-financing per dose** | Co-financing table | $ | | 0.20 | 0.20 | 0.20 | |
| **ca** | **AD syringe price per unit** | Table 7.10.1 | $ | | 0.0465 | 0.0465 | 0.0465 | |
| **cr** | **Reconstitution syringe price per unit** | Table 7.10.1 | $ | | 0 | 0 | 0 | |
| **cs** | **Safety box price per unit** | Table 7.10.1 | $ | | 0.5800 | 0.5800 | 0.5800 | |
| **fv** | **Freight cost as % of vaccines value** | Table 7.10.2 | % | | 6.40 % | 6.40 % | 6.40 % | |
| **fd** | **Freight cost as % of devices value** | Parameter | % | | 0.00 % | 0.00 % | 0.00 % | |

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

## Co-financing tables for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID

| Co-financing group | Low |
|---|---|

| | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|
| Minimum co-financing | 0.20 | 0.20 | 0.20 | 0.20 |
| Recommended co-financing as per APR 2011 | | | 0.20 | 0.20 |
| Your co-financing | 0.20 | 0.20 | 0.20 | 0.20 |

**Table 7.11.2**: Estimated GAVI support and country co-financing (**GAVI support**)

| | | 2013 | 2014 | 2015 |
|---|---|---|---|---|
| Number of vaccine doses | # | 977,900 | 961,200 | 941,800 |
| Number of AD syringes | # | 1,139,200 | 1,119,400 | 1,099,600 |
| Number of re-constitution syringes | # | 0 | 0 | 0 |
| Number of safety boxes | # | 12,650 | 12,425 | 12,225 |
| Total value to be co-financed by GAVI | $ | 2,179,000 | 2,141,500 | 2,048,500 |

**Table 7.11.3**: Estimated GAVI support and country co-financing (**Country support**)

| | | 2013 | 2014 | 2015 |
|---|---|---|---|---|
| Number of vaccine doses | # | 99,500 | 97,800 | 98,500 |
| Number of AD syringes | # | 0 | 0 | 0 |
| Number of re-constitution syringes | # | 0 | 0 | 0 |
| Number of safety boxes | # | 0 | 0 | 0 |
| Total value to be co-financed by the Country <sup>[1] </sup> | $ | 215,500 | 212,000 | 208,500 |

**Table 7.11.4**: Calculation of requirements for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID (part 1)

| | | Formula | 2012 | 2013 | | |
|---|---|---|---|---|---|---|
| | | | Total | Total | Government | GAVI |
| A | **Country co-finance** | *V* | 0.00 % | 9.23 % | | |
| B | **Number of children to be vaccinated with the first dose** | *Table 5.2.1* | 342,970 | 340,230 | 31,412 | 308,818 |
| C | **Number of doses per child** | *Vaccine parameter (schedule)* | 3 | 3 | | |
| D | **Number of doses needed** | *B X C* | 1,028,910 | 1,020,690 | 94,234 | 926,456 |
| E | **Estimated vaccine wastage factor** | *Table 4* | 1.02 | 1.05 | | |
| F | **Number of doses needed including wastage** | *D X E* | 1,049,489 | 1,071,725 | 98,946 | 972,779 |
| G | **Vaccines buffer stock** | *(F – F of previous year) * 0.25* | | 5,559 | 514 | 5,045 |
| H | **Stock on 1 January 2013** | *Table 7.11.1* | 582,260 | | | |
| I | **Total vaccine doses needed** | *F + G – H* | | 1,077,334 | 99,463 | 977,871 |
| J | **Number of doses per vial** | *Vaccine Parameter* | | 1 | | |
| K | **Number of AD syringes (+ 10% wastage) needed** | *(D + G – H) * 1.11* | | 1,139,137 | 0 | 1,139,137 |
| L | **Reconstitution syringes (+ 10% wastage) needed** | *I / J * 1.11* | | 0 | 0 | 0 |
| M | **Total of safety boxes (+ 10% of extra need) needed** | *(K + L) /100 * 1.11* | | 12,645 | 0 | 12,645 |
| N | **Cost of vaccines needed** | *I x vaccine price per dose (g)* | | 2,193,453 | 202,507 | 1,990,946 |
| O | **Cost of AD syringes needed** | *K x AD syringe price per unit (ca)* | | 52,970 | 0 | 52,970 |
| P | **Cost of reconstitution syringes needed** | *L x reconstitution price per unit (cr)* | | 0 | 0 | 0 |
| Q | **Cost of safety boxes needed** | *M x safety box price per unit (cs)* | | 7,335 | 0 | 7,335 |
| R | **Freight cost for vaccines needed** | *N x freight cost as of % of vaccines value (fv)* | | 140,381 | 12,961 | 127,420 |
| S | **Freight cost for devices needed** | *(O+P+Q) x freight cost as % of devices value (fd)* | | 0 | 0 | 0 |
| T | **Total fund needed** | *(N+O+P+Q+R+S)* | | 2,394,139 | 215,467 | 2,178,672 |
| U | **Total country co-financing** | *I x country co-financing per dose (cc)* | | 215,467 | | |
| V | **Country co-financing % of GAVI supported proportion** | *U / (N + R)* | | 9.23 % | | |

**Table 7.11.4**: Calculation of requirements for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID (part 2)

| | | Formula | 2014 | | | 2015 | | |
|---|---|---|---|---|---|---|---|---|
| | | | Total | Government | GAVI | Total | Government | GAVI |
| A | Country co-finance | *V* | 9.23 % | | | 9.46 % | | |
| B | Number of children to be vaccinated with the first dose | *Table 5.2.1* | 336,136 | 31,034 | 305,102 | 330,209 | 31,254 | 298,955 |
| C | Number of doses per child | *Vaccine parameter (schedule)* | 3 | | | 3 | | |
| D | Number of doses needed | *B X C* | 1,008,408 | 93,100 | 915,308 | 990,627 | 93,761 | 896,866 |
| E | Estimated vaccine wastage factor | *Table 4* | 1.05 | | | 1.05 | | |
| F | Number of doses needed including wastage | *D X E* | 1,058,829 | 97,755 | 961,074 | 1,040,159 | 98,449 | 941,710 |
| G | Vaccines buffer stock | *(F – F of previous year) * 0.25* | 0 | 0 | 0 | 0 | 0 | 0 |
| H | Stock on 1 January 2013 | *Table 7.11.1* | | | | | | |
| I | Total vaccine doses needed | *F + G – H* | 1,058,879 | 97,760 | 961,119 | 1,040,209 | 98,454 | 941,755 |
| J | Number of doses per vial | *Vaccine Parameter* | 1 | | | 1 | | |
| K | Number of AD syringes (+ 10% wastage) needed | *(D + G – H) * 1.11* | 1,119,333 | 0 | 1,119,333 | 1,099,596 | 0 | 1,099,596 |
| L | Reconstitution syringes (+ 10% wastage) needed | *I / J * 1.11* | 0 | 0 | 0 | 0 | 0 | 0 |
| M | Total of safety boxes (+ 10% of extra need) needed | *(K + L) /100 * 1.11* | 12,425 | 0 | 12,425 | 12,206 | 0 | 12,206 |
| N | Cost of vaccines needed | *I x vaccine price per dose (g)* | 2,155,878 | 199,038 | 1,956,840 | 2,065,856 | 195,529 | 1,870,327 |
| O | Cost of AD syringes needed | *K x AD syringe price per unit (ca)* | 2,155,878 | 0 | 52,049 | 2,065,856 | 0 | 51,132 |
| P | Cost of reconstitution syringes needed | *L x reconstitution price per unit (cr)* | 0 | 0 | 0 | 0 | 0 | 0 |
| Q | Cost of safety boxes needed | *M x safety box price per unit (cs)* | 7,207 | 0 | 7,207 | 7,080 | 0 | 7,080 |
| R | Freight cost for vaccines needed | *N x freight cost as of % of vaccines value (fv)* | 137,977 | 12,739 | 125,238 | 132,215 | 12,514 | 119,701 |
| S | Freight cost for devices needed | *(O+P+Q) x freight cost as % of devices value (fd)* | 0 | 0 | 0 | 0 | 0 | 0 |
| T | Total fund needed | *(N+O+P+Q+R+S)* | 2,353,111 | 211,776 | 2,141,335 | 2,256,283 | 208,042 | 2,048,241 |
| U | Total country co-financing | *I x country co-financing per dose (cc)* | 211,776 | | | 208,042 | | |
| V | Country co-financing % of GAVI supported proportion | *U / (N + R)* | 9.23 % | | | 9.46 % | | |

**Table 7.11.4**: Calculation of requirements for (part 3)

| | | Formula |
|---|---|---|
| | | |
| **A** | **Country co-finance** | *V* |
| **B** | **Number of children to be vaccinated with the first dose** | *Table 5.2.1* |
| **C** | **Number of doses per child** | *Vaccine parameter (schedule)* |
| **D** | **Number of doses needed** | *B X C* |
| **E** | **Estimated vaccine wastage factor** | *Table 4* |
| **F** | **Number of doses needed including wastage** | *D X E* |
| **G** | **Vaccines buffer stock** | *(F – F of previous year) * 0.25* |
| **H** | **Stock on 1 January 2013** | *Table 7.11.1* |
| **I** | **Total vaccine doses needed** | *F + G – H* |
| **J** | **Number of doses per vial** | *Vaccine Parameter* |
| **K** | **Number of AD syringes (+ 10% wastage) needed** | *(D + G – H) * 1.11* |
| **L** | **Reconstitution syringes (+ 10% wastage) needed** | *I / J * 1.11* |
| **M** | **Total of safety boxes (+ 10% of extra need) needed** | *(K + L) /100 * 1.11* |
| **N** | **Cost of vaccines needed** | *I x vaccine price per dose (g)* |
| **O** | **Cost of AD syringes needed** | *K x AD syringe price per unit (ca)* |
| **P** | **Cost of reconstitution syringes needed** | *L x reconstitution price per unit (cr)* |
| **Q** | **Cost of safety boxes needed** | *M x safety box price per unit (cs)* |
| **R** | **Freight cost for vaccines needed** | *N x freight cost as of % of vaccines value (fv)* |
| **S** | **Freight cost for devices needed** | *(O+P+Q) x freight cost as % of devices value (fd)* |
| **T** | **Total fund needed** | *(N+O+P+Q+R+S)* |
| **U** | **Total country co-financing** | *I x country co-financing per dose (cc)* |
| **V** | **Country co-financing % of GAVI supported proportion** | *U / (N + R)* |

**Table 7.11.1:** Specifications for Measles second dose, 10 dose(s) per vial, LYOPHILISED

| ID | | Source | | 2012 | 2013 | 2014 | 2015 | TOTAL |
|---|---|---|---|---|---|---|---|---|
| | **Number of surviving infants** | Table 4 | # | 355,268 | 354,407 | 350,142 | 343,968 | 1,403,785 |
| | **Number of children to be vaccinated with the first dose** | Table 4 | # | 331,757 | 336,496 | 332,634 | 326,769 | 1,327,656 |
| | **Number of children to be vaccinated with the second dose** | Table 4 | # | 145,303 | 336,496 | 332,634 | 326,769 | 1,141,202 |
| | **Immunisation coverage with the second dose** | Table 4 | % | 40.90 % | 94.95 % | 95.00 % | 95.00 % | |
| | **Number of doses per child** | Parameter | # | 1 | 1 | 1 | 1 | |
| | **Estimated vaccine wastage factor** | Table 4 | # | 2.00 | 2.00 | 2.00 | 2.00 | |
| | **Vaccine stock on 31st December 2012 * (see explanation footnote)** | | # | | | | | |
| | **Vaccine stock on 1 January 2013 ** (see explanation footnote)** | | # | 680,000 | | | | |
| | **Number of doses per vial** | Parameter | # | | 10 | 10 | 10 | |
| | **AD syringes required** | Parameter | # | | Yes | Yes | Yes | |
| | **Reconstitution syringes required** | Parameter | # | | Yes | Yes | Yes | |
| | **Safety boxes required** | Parameter | # | | Yes | Yes | Yes | |
| **g** | **Vaccine price per dose** | Table 7.10.1 | $ | | 0.27 | 0.29 | 0.30 | |
| **cc** | **Country co-financing per dose** | Co-financing table | $ | | 0.00 | 0.00 | 0.00 | |
| **ca** | **AD syringe price per unit** | Table 7.10.1 | $ | | 0.0465 | 0.0465 | 0.0465 | |
| **cr** | **Reconstitution syringe price per unit** | Table 7.10.1 | $ | | 0 | 0 | 0 | |
| **cs** | **Safety box price per unit** | Table 7.10.1 | $ | | 0.5800 | 0.5800 | 0.5800 | |
| **fv** | **Freight cost as % of vaccines value** | Table 7.10.2 | % | | 14.00 % | 14.00 % | 14.00 % | |
| **fd** | **Freight cost as % of devices value** | Parameter | % | | 10.00 % | 10.00 % | 10.00 % | |

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

## Co-financing tables for Measles second dose, 10 dose(s) per vial, LYOPHILISED

| **Co-financing group** | Low |
|---|---|

| | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|
| **Minimum co-financing** | 0.00 | 0.00 | 0.00 | 0.00 |
| **Recommended co-financing as per APR 2011** | | | 0.00 | 0.00 |
| **Your co-financing** | 0.00 | 0.00 | 0.00 | 0.00 |

### Table 7.11.2: Estimated GAVI support and country co-financing (GAVI support)

| | | 2013 | 2014 | 2015 |
|---|---|---|---|---|
| **Number of vaccine doses** | # | 768,700 | 665,400 | 653,700 |
| **Number of AD syringes** | # | 479,700 | 369,300 | 362,800 |
| **Number of re-constitution syringes** | # | 85,400 | 73,900 | 72,600 |
| **Number of safety boxes** | # | 6,275 | 4,925 | 4,850 |
| **Total value to be co-financed by GAVI** | $ | 271,500 | 242,000 | 245,500 |

### Table 7.11.3: Estimated GAVI support and country co-financing (Country support)

| | | 2013 | 2014 | 2015 |
|---|---|---|---|---|
| **Number of vaccine doses** | # | 0 | 0 | 0 |
| **Number of AD syringes** | # | 0 | 0 | 0 |
| **Number of re-constitution syringes** | # | 0 | 0 | 0 |
| **Number of safety boxes** | # | 0 | 0 | 0 |
| **Total value to be co-financed by the Country <sup>[1] </sup>** | $ | 0 | 0 | 0 |

**Table 7.11.4**: Calculation of requirements for Measles second dose, 10 dose(s) per vial, LYOPHILISED (part 1)

| | | Formula | 2012 | 2013 | | |
|---|---|---|---|---|---|---|
| | | | Total | Total | Government | GAVI |
| **A** | **Country co-finance** | *V* | 0.00 % | 0.00 % | | |
| **B** | **Number of children to be vaccinated with the first dose** | *Table 5.2.1* | 145,303 | 336,496 | 0 | 336,496 |
| **C** | **Number of doses per child** | *Vaccine parameter (schedule)* | 1 | 1 | | |
| **D** | **Number of doses needed** | *B X C* | 145,303 | 336,496 | 0 | 336,496 |
| **E** | **Estimated vaccine wastage factor** | *Table 4* | 2.00 | 2.00 | | |
| **F** | **Number of doses needed including wastage** | *D X E* | 290,606 | 672,992 | 0 | 672,992 |
| **G** | **Vaccines buffer stock** | *(F – F of previous year) * 0.25* | | 95,597 | 0 | 95,597 |
| **H** | **Stock on 1 January 2013** | *Table 7.11.1* | 680,000 | | | |
| **I** | **Total vaccine doses needed** | *F + G – H* | | 768,689 | 0 | 768,689 |
| **J** | **Number of doses per vial** | *Vaccine Parameter* | | 10 | | |
| **K** | **Number of AD syringes (+ 10% wastage) needed** | *(D + G – H) * 1.11* | | 479,624 | 0 | 479,624 |
| **L** | **Reconstitution syringes (+ 10% wastage) needed** | *I / J * 1.11* | | 85,325 | 0 | 85,325 |
| **M** | **Total of safety boxes (+ 10% of extra need) needed** | *(K + L) /100 * 1.11* | | 6,271 | 0 | 6,271 |
| **N** | **Cost of vaccines needed** | *I x vaccine price per dose (g)* | | 209,853 | 0 | 209,853 |
| **O** | **Cost of AD syringes needed** | *K x AD syringe price per unit (ca)* | | 22,303 | 0 | 22,303 |
| **P** | **Cost of reconstitution syringes needed** | *L x reconstitution price per unit (cr)* | | 3,158 | 0 | 3,158 |
| **Q** | **Cost of safety boxes needed** | *M x safety box price per unit (cs)* | | 3,638 | 0 | 3,638 |
| **R** | **Freight cost for vaccines needed** | *N x freight cost as of % of vaccines value (fv)* | | 29,380 | 0 | 29,380 |
| **S** | **Freight cost for devices needed** | *(O+P+Q) x freight cost as % of devices value (fd)* | | 2,910 | 0 | 2,910 |
| **T** | **Total fund needed** | *(N+O+P+Q+R+S)* | | 271,242 | 0 | 271,242 |
| **U** | **Total country co-financing** | *I x country co-financing per dose (cc)* | | 0 | | |
| **V** | **Country co-financing % of GAVI supported proportion** | *U / (N + R)* | | 0.00 % | | |

**Table 7.11.4**: Calculation of requirements for Measles second dose, 10 dose(s) per vial, LYOPHILISED (part 2)

| | | Formula | 2014 | | | 2015 | | |
|---|---|---|---|---|---|---|---|---|
| | | | Total | Government | GAVI | Total | Government | GAVI |
| A | Country co-finance | *V* | 0.00 % | | | 0.00 % | | |
| B | Number of children to be vaccinated with the first dose | *Table 5.2.1* | 332,634 | 0 | 332,634 | 326,769 | 0 | 326,769 |
| C | Number of doses per child | *Vaccine parameter (schedule)* | 1 | | | 1 | | |
| D | Number of doses needed | *B X C* | 332,634 | 0 | 332,634 | 326,769 | 0 | 326,769 |
| E | Estimated vaccine wastage factor | *Table 4* | 2.00 | | | 2.00 | | |
| F | Number of doses needed including wastage | *D X E* | 665,268 | 0 | 665,268 | 653,538 | 0 | 653,538 |
| G | Vaccines buffer stock | *(F – F of previous year) * 0.25* | 0 | 0 | 0 | 0 | 0 | 0 |
| H | Stock on 1 January 2013 | *Table 7.11.1* | | | | | | |
| I | Total vaccine doses needed | *F + G – H* | 665,368 | 0 | 665,368 | 653,638 | 0 | 653,638 |
| J | Number of doses per vial | *Vaccine Parameter* | 10 | | | 10 | | |
| K | Number of AD syringes (+ 10% wastage) needed | *(D + G – H) * 1.11* | 369,224 | 0 | 369,224 | 362,714 | 0 | 362,714 |
| L | Reconstitution syringes (+ 10% wastage) needed | *I / J * 1.11* | 73,856 | 0 | 73,856 | 72,554 | 0 | 72,554 |
| M | Total of safety boxes (+ 10% of extra need) needed | *(K + L) /100 * 1.11* | 4,919 | 0 | 4,919 | 4,832 | 0 | 4,832 |
| N | Cost of vaccines needed | *I x vaccine price per dose (g)* | 190,296 | 0 | 190,296 | 193,477 | 0 | 193,477 |
| O | Cost of AD syringes needed | *K x AD syringe price per unit (ca)* | 190,296 | 0 | 17,169 | 193,477 | 0 | 16,867 |
| P | Cost of reconstitution syringes needed | *L x reconstitution price per unit (cr)* | 2,733 | 0 | 2,733 | 2,685 | 0 | 2,685 |
| Q | Cost of safety boxes needed | *M x safety box price per unit (cs)* | 2,854 | 0 | 2,854 | 2,803 | 0 | 2,803 |
| R | Freight cost for vaccines needed | *N x freight cost as of % of vaccines value (fv)* | 26,642 | 0 | 26,642 | 27,087 | 0 | 27,087 |
| S | Freight cost for devices needed | *(O+P+Q) x freight cost as % of devices value (fd)* | 2,276 | 0 | 2,276 | 2,236 | 0 | 2,236 |
| T | Total fund needed | *(N+O+P+Q+R+S)* | 241,970 | 0 | 241,970 | 245,155 | 0 | 245,155 |
| U | Total country co-financing | *I x country co-financing per dose (cc)* | 0 | | | 0 | | |
| V | Country co-financing % of GAVI supported proportion | *U / (N + R)* | 0.00 % | | | 0.00 % | | |

**Table 7.11.4**: Calculation of requirements for (part 3)

| | | Formula |
|---|---|---|
| | | |
| **A** | **Country co-finance** | *V* |
| **B** | **Number of children to be vaccinated with the first dose** | *Table 5.2.1* |
| **C** | **Number of doses per child** | *Vaccine parameter (schedule)* |
| **D** | **Number of doses needed** | *B X C* |
| **E** | **Estimated vaccine wastage factor** | *Table 4* |
| **F** | **Number of doses needed including wastage** | *D X E* |
| **G** | **Vaccines buffer stock** | *(F – F of previous year) * 0.25* |
| **H** | **Stock on 1 January 2013** | *Table 7.11.1* |
| **I** | **Total vaccine doses needed** | *F + G – H* |
| **J** | **Number of doses per vial** | *Vaccine Parameter* |
| **K** | **Number of AD syringes (+ 10% wastage) needed** | *(D + G – H) * 1.11* |
| **L** | **Reconstitution syringes (+ 10% wastage) needed** | *I / J * 1.11* |
| **M** | **Total of safety boxes (+ 10% of extra need) needed** | *(K + L) /100 * 1.11* |
| **N** | **Cost of vaccines needed** | *I x vaccine price per dose (g)* |
| **O** | **Cost of AD syringes needed** | *K x AD syringe price per unit (ca)* |
| **P** | **Cost of reconstitution syringes needed** | *L x reconstitution price per unit (cr)* |
| **Q** | **Cost of safety boxes needed** | *M x safety box price per unit (cs)* |
| **R** | **Freight cost for vaccines needed** | *N x freight cost as of % of vaccines value (fv)* |
| **S** | **Freight cost for devices needed** | *(O+P+Q) x freight cost as % of devices value (fd)* |
| **T** | **Total fund needed** | *(N+O+P+Q+R+S)* |
| **U** | **Total country co-financing** | *I x country co-financing per dose (cc)* |
| **V** | **Country co-financing % of GAVI supported proportion** | *U / (N + R)* |

## 8. Injection Safety Support (INS)

This window of support is no longer available

## 9. Health Systems Strengthening Support (HSS)

**Instructions for reporting on HSS funds received**

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2012**. All countries are expected to report on:

   a. Progress achieved in 2012

   b. HSS implementation during January – April 2013 (interim reporting)

   c. Plans for 2014

   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2012, or experienced other delays that limited implementation in 2012, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2012 fiscal year starts in January 2012 and ends in December 2012, HSS reports should be received by the GAVI Alliance before **15th May 2013**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2013, the HSS reports are expected by GAVI Alliance by September 2013.

3. Please use your approved proposal as reference to fill in this Annual Progress Report. Please fill in this reporting template thoroughly and accurately and use additional space as necessary.

4. If you are proposing changes to approved objectives, activities and budget (reprogramming) please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org.

5. If you are requesting a new tranche of funding, please make this clear in Section 9.1.2.

6. Please ensure that, **prior to its submission to the GAVI Alliance Secretariat, this report has been endorsed by the relevant country coordination mechanisms** (HSCC or equivalent) as provided for on the signature page in terms of its accuracy and validity of facts, figures and sources used.

7. Please attach all required supporting documents. These include:

   a. Minutes of all the HSCC meetings held in 2012

   b. Minutes of the HSCC meeting in 2013 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2012 calendar year

   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

9. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send the APR back to your country for clarifications (which may cause delays in the release of further HSS funds), to recommend against the release of further HSS funds or only approve part of the next tranche of HSS funds.

## 9.1. Report on the use of HSS funds in 2012 and request of a new tranche

Please provide data sources for all data used in this report.

9.1.1. Report on the use of HSS funds in **2012**

Please complete Table 9.1.3.a and 9.1.3.b (as per APR) for each year of your country's approved multi-year HSS programme and both in US$ and local currency

**Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 9.1.3.a and 9.1.3.b.**

9.1.2. Please indicate if you are requesting a new tranche of funding **Yes**

If yes, please indicate the amount of funding requested: **1314270** US$

These funds should be sufficient to carry out HSS grant implementation through December 2014.

9.1.3. Is GAVI's HSS support reported on the national health sector budget? **Not selected**

NB: Country will fill both $ and local currency tables. This enables consistency check for TAP.

Table 9.1.3a (US)$

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|
| Original annual budgets (*as per the originally approved HSS proposal*) | 1850000 | 987043 | 1010070 | 1032260 | 1052865 | 1071540 |
| Revised annual budgets (*if revised by previous Annual Progress Reviews*) | 1850000 | 337500 | 1524793 | 1532900 | 1498472 | 1452639 |
| Total funds received from GAVI during the calendar year (*A*) | 1850000 | 337500 | 1509500 | 1464000 | 1228000 | 1121000 |
| Remaining funds (carry over) from previous year (*B*) | 0 | 1703013 | 711280 | 1085434 | 1378898 | 1436496 |
| Total Funds available during the calendar year (*C=A+B*) | 1850000 | 2040513 | 2220780 | 2549434 | 2606898 | 2557496 |
| Total expenditure during the calendar year (*D*) | 146987 | 1329233 | 1136703 | 1170536 | 1170402 | 1103378 |
| Balance carried forward to next calendar year (*E=C-D*) | 1703013 | 711280 | 1084077 | 1378898 | 1436496 | 1454118 |
| **Amount of funding requested for future calendar year(s)** [please ensure you complete this row if you are requesting a new tranche] | 337500 | 1524793 | 1532900 | 1498472 | 1452639 | 1314270 |

| | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|
| Original annual budgets (*as per the originally approved HSS proposal*) | 1088545 | 1104205 | 1118980 | 0 |
| Revised annual budgets (*if revised by previous Annual Progress Reviews*) | 1314270 | 1314270 | 1404830 | 0 |
| Total funds received from GAVI during the calendar year (*A*) | | | | |
| Remaining funds (carry over) from previous year (*B*) | 1454218 | | | |
| Total Funds available during the calendar year (*C=A+B*) | | | | |
| Total expenditure during the calendar year (*D*) | | | | |
| Balance carried forward to next calendar year (*E=C-D*) | | | | |
| **Amount of funding requested for future calendar year(s)** [please ensure you complete this row if you are requesting a new tranche] | 1314270 | 1404830 | 0 | 0 |

Table 9.1.3b (Local currency)

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|
| Original annual budgets (*as per the originally approved HSS proposal*) | 1850000 | 987043 | 1010070 | 1032260 | 1052865 | 1071540 |
| Revised annual budgets (*if revised by previous Annual Progress Reviews*) | 1850000 | 337500 | 1524793 | 1532900 | 1498472 | 1452639 |
| Total funds received from GAVI during the calendar year (*A*) | 1850000 | 337500 | 1509500 | 1464000 | 1228000 | 1121000 |
| Remaining funds (carry over) from previous year (*B*) | 0 | 1703013 | 711280 | 1085434 | 1378898 | 1436496 |
| Total Funds available during the calendar year (*C=A+B*) | 1850000 | 2040513 | 2220780 | 2549434 | 2606898 | 2557496 |
| Total expenditure during the calendar year (*D*) | 146987 | 1329233 | 1136703 | 1170536 | 1170402 | 1103378 |
| Balance carried forward to next calendar year (*E=C-D*) | 1703013 | 711280 | 1084077 | 1378898 | 1436496 | 1454118 |
| **Amount of funding requested for future calendar year(s)** [please ensure you complete this row if you are requesting a new tranche] | 337500 | 1524793 | 1532900 | 1498472 | 1452639 | 1314270 |

| | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|
| Original annual budgets (*as per the originally approved HSS proposal*) | 1088545 | 1104205 | 1118980 | 0 |
| Revised annual budgets (*if revised by previous Annual Progress Reviews*) | 1314270 | 1314270 | 1404830 | 0 |
| Total funds received from GAVI during the calendar year (*A*) | | | | |
| Remaining funds (carry over) from previous year (*B*) | 1454218 | | | |
| Total Funds available during the calendar year (*C=A+B*) | | | | |
| Total expenditure during the calendar year (*D*) | | | | |
| Balance carried forward to next calendar year (*E=C-D*) | | | | |
| **Amount of funding requested for future calendar year(s)** [please ensure you complete this row if you are requesting a new tranche] | 1314270 | 1404830 | 0 | 0 |

**Report of Exchange Rate Fluctuation**

Please indicate in the table Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

| Exchange Rate | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|
| Opening on 1 January | 3992 | 4077 | 4165 | 4051 | 4039 | 4054 |
| Closing on 31 December | 4077 | 4165 | 4051 | 4039 | 3995 | 3999 |

**Detailed expenditure of HSS funds during the 2012 calendar year**

Please attach a detailed financial statement for the use of HSS funds during the 2012 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January April 2013 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

**Financial management of HSS funds**

Briefly describe the financial management arrangements and process used for your HSS funds. Notify whether HSS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of HSS funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements at both the sub-national and national levels; and the overall role of the HSCC in this process.

**BUDGET APPROVALS**

The use of GAVI HSS funds is based on approved activities under the MoH's exercise of the national Annual Operational Plan (AOP) that is led by the Department of Planning and Health Information (DPHI). GAVI HSS activities and their corresponding budgets are planned, reviewed and approved on a yearly basis through the AOP process for all levels of implementation, including central program units, provincial health departments, operational districts, and health centers.

Midterm and annual HSS workshops take place toreview past performance and proposed activities. The workshops are attended by all GAVI HSS implementing units, collaborating MoH units, as well as relevant national and international partners. During these two workshops, activities and costs are negotiated and ultimately integrated into the AOPs of the Provinces and Districts, the process of which is facilitated by DPHI. For the 10 Operational Districts (OD) considered focus for HSS GAVI funds, targets and conditions arenegotiated into contracts between OD and MoH Department of Budget and Finance (DBF). These contracts are signed by the Secretary of State for Health, Provincial Health Department Directors, Operational District Directors and Health Centre Managers, and contain the conditions and expected performance targets for release of funds.

**FINANCIAL ARRANGEMENTS**

The GAVI HSS monies are discrete funds and received and disbursed through a government USD account of the donor funding mechanism of the Ministry of Health's (MoH)Health Sector Support Program II, 2009-2013, (HSSP 2). GAVI HSS financial processes and procedures follow those described in the financial guidelines of the HSSP2. The MoH's Department of Budget and Finance (DBF) manages the disbursements to and coordinate the use of funds of all implementing levels of GAVI HSS.

Financial mechanisms are in place for the 10 Operational Districts considered high riskunder HSS GAVI. The negotiated contracts (described above) form the basis for the annual release of funds to the 9 Provinces. Funds are deposited into a provincially located commercial bank. The Provinces in turn releasethe funds to the 10 ODs on a monthly basis into safety boxes. The amount isbased on the health center performance on the Minimum Package of Activities (MCH and EPI service package) during the previous month.

Departments atnational level request for cash advance for workshops and trainings. For other activities such as supervision and monitoring visits, they staff are reimbursed with a check to the person whosigned the MoU with DBF.

Health Facility Centers report to the ODs at monthly meetings and based on their previous month's performance receive their funds following verification from technical and accountant staff. In turn OD's reportmonthly to Provinces and Provinces report quarterly to DBF at national level.

The Aide-Memoire dated May 9, 2013 has described financial arrangements for remainder of the GAVI HSS Grant cycle, for which there are some minor changes to grant agreement and processed (see attachments for signed Aide-Memoire).

**Has an external audit been conducted? Yes**

**External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 21)**

## 9.2. Progress on HSS activities in the 2012 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 9.2. It is very important to be precise about the extent of progress and use the M&E framework in your original application and approval letter.

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 9.2: HSS activities in the 2012 reporting year

| **Major Activities** (insert as many rows as necessary) | **Planned Activity for 2012** | **Percentage of Activity completed (annual)** (where applicable) | **Source of information/data** (if relevant) |
|---|---|---|---|
| **1.1 Service delivery contracts: performance based contracts with health centers** | Establish and implement annual operational plans and performance based contracts (PBC) at health facility level | 100 | DBF |
| **1.2 Management contracts: performance based management agreements with ODs and Provinces** | Establish and implement annual operational plans and performance based management agreements (PBMA) PBMA with managers at central, PHD, OD, and health facility level, as well as remote area facilities | 100 | DBF |
| **1.3 Coverage improvement planning (CIP): integrating immunization coverage improvement planning into MPA planning system to improve overall MCH** | No activities were planned for 2013 | | N/A |
| **1.4 Fixed site strategy: Implement, evaluate, and scale up fixed site strategy to improve immunization coverage through increased health center utilization** | The following activities were planned:<br>1. Consultative Workshop and 2. Dissemination Workshop/printing for development of fixed site strategy outreach guidelines<br>3. Routine community meetings with VSHG, VHV, Commune Councils in high risk areas to encourage fixed site immunizations<br>4. Supervision visits for maintenance of cold chain system | 50 | PMD<br>NIP<br>DBF |
| **2.1 Financial management system development: Develop MPA financial management system, health financing guidelines, and monitoring effective implementation** | HSS mid-year review workshop planned for all provincial and OD accountants | 100 | DBF |

| | | | |
|---|---|---|---|
| **2.2 Health planning systems: Strengthening MPA planning at OD and health centers through AOP integration** | The following activities were planned to strengthen planning at OD and health facilities for MPA services.<br><br>1. Technical support from central to OD on AOP development and AOP implementation to 24 provinces<br><br>2. Technical Support from OD planning team to RH and HCs in AOP development<br><br>3- Conduct appraisal on AOP of Health Facilities and provide feedback<br><br>4. Supervision and monitoring of appropriate implementation of outreach guidelines implementation<br><br>5. Training/workshop to PHD, ODs & HCs level of GAVI HSS by HIS Unit/MoH on data collection and reporting for HIS<br><br>6. Supervision on DQA implementation | 70 | DPHI<br>PMD<br>DBF |
| **2.3 Supervision systems: Strengthening integrated supportive supervision from central to PHD, PHD to OD and OD the health facility level through interdepartmental monitoring** | The following activities were planned:<br><br>1. Joint supervision on data validation from central to peripheral levels – 5 teams of 4 staff from central units implementing GAVI to visit 5 provinces each quarter<br><br>2. Provincial supervision visits to OD and health facility level | 80 | DBF |
| **2.4 Health systems operations research: Conducting research to support decision making for strengthening demand and delivery of MPA services** | The following study was planned: feasibility study on implementation of 24 hour at health centers in 10 HSS high risk ODs | 0 | N/A |

| | | | |
|---|---|---|---|
| **3.1 Strengthening capacity of middle level management: Strengthening financial, planning, management and monitoring capacities of middle level management at OD, and health facility level through development of guidelines, trainings and supportive supervision** | The following activities were planned for 2012:<br><br>1. Technical support & monitoring of implementation of financial management tool and revised planning manual at OD and health centers<br>2. Annual review workshop to strengthen OD and health center capacity in annual review & planning<br><br>3. Provincial on-site supervision and monitoring to strengthen OD and health center capacity in quarterly reviews & planning<br><br>4. MCH program managers training at OD level<br><br>5. Immunization training on cold change and vaccine management | 100 | DBF<br>CDC<br>NIP |
| **3.2 Child survival monitoring: Strengthening systems for child survival scorecard monitoring through Provincial Health committees, interdepartmental monitoring team, and inclusion of scorecard monitoring in AOP.** | No activities were planned for 2013 | | N/A |
| **3.3 Service delivery of IMCI: Strengthening capacity of IMCI service delivery to improve immunization and overall MCH through trainings of health center and OD staff and supportive supervision** | No activities were planned for 2013<br>The following activities were planned for 2012:<br><br>1. IMCI Clinical Training Training<br><br>2. IMCI Refresher Training Course<br><br>3. IMCI ToT Facilitators Training<br><br>4. IMCI supervisors training for IMCI Monitoring<br><br>5. Strengthen monitoring and spot-checking from national level<br><br>6. IMCI planning workshop to integrate IMCI related activities into OD planning cycle | 70 | IMCI<br>DBF |
| **3.4 Private sector collaboration: Scaling up and evaluating public/private collaboration to improve quality of immunizations and eventually MCH services in private sector** | Workshop was planned for sensitization/training of private sector on quality and government requirements of immunization/MCH service delivery. | 100 | NIP<br>DBF |

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| **3.5 Project management: Support activities to ensure effective implementation of grant activities to reach planned targets.** | The following support activities were planned:<br>1. Purchase of laptops for PHD, OD and national level key personal<br>2. Retreat and Wrap up annual progress report for HSS-Program Staff<br>3. HSS-Annual Review Workshop [2011]<br>4. Preparation of GAVI/HSS AOP 2013<br>5. Annual external audit<br>6. Cost of technical assistance<br>7. Overhead costs | 90 | DBF |

9.2.1 For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), explain the progress achieved and relevant constraints (e.g. evaluations, HSCC meetings).

| **Major Activities** (insert as many rows as necessary) | **Explain progress achieved and relevant constraints** |
|---|---|
| **1.1 Service delivery contracts** | Achievements<br>All 10 OD's established contracts and developed their AOPs with health facilities. High risk & spot check missions were also implemented<br><br>Challenges<br>The PBC scheme changed as of July 2012. The original scheme was 1USD per child immunized, however, certain health centers in less populated areas were demotivated since they were receiving low incentives, despite needing more effort to reach children in these high risk areas. For this reason a new scheme was developed based on ODs % coverage of 5MPA activities. |
| **1.2 Management contracts** | Achievements<br>All OD's developed AOPs. The new PBMA was approved in September 2012.<br><br>Challenges<br>In July 2012, the Royal Government of Cambodia's POC scheme for which the GAVI HSS PBMA was based on ended. In the absence of any new Government incentive scheme, there were challenges to ensure motivation and smooth operations for implementation of GAVI HSS activities. In response, a new PBMA scheme was developed and approved. |
| **1.3 Coverage improvement planning (CIP)** | No activities conducted for 2013 |
| **1.4 Fixed site strategy** | Achievements<br>Implement and evaluate fixed site strategy for services package of MCH and EPI.<br>• Conducted consultative workshop for development of outreach guidelines for fixed sites with 1 deputy OD director from each OD & managers from certain health centers<br>• 60% of ODs conducted most of their routine community meetings (VSHG, VHV, Commune councils) meetings to improve use of fixed sites for immunizations were conducted<br><br>Challenges<br>Not all activities were completed as planned (see section 9.2.2.).<br>• In some ODs community meetings did not take place due to competing priorities and not enough compensation for travel. This will be remedied in 2013 by providing fair compensation for these critical members of community meetings. |

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| **2.1 Financial management system development** | Achievements<br>Mid-year HSS review workshop was conducted for 76 OD and 24 PHD accountants. This review was important for information sharing and providing updates to financial management and addressing common challenges.<br><br>Challenges<br>Non HSS ODs still have issues with reporting, particularly with respect to reporting on time and providing supporting documents. This is most likely due to less training, and for this reason the mid-year workshops will continue to invite accountants from all ODs, PHDs. |
| **2.2 Health planning systems** | Achievements<br>• DPHI developed new training curriculum for new web-based HIS system. Training in new system data collection and reporting was conducted for 269 persons, 14 PHD staff from 7 provinces, 14 OD staff from 7 ODs and 240 health center staff from 97 health centers.<br>• PMD unit conducted monitoring/supportive supervision took place to all 10 ODs for implementation of outreach guidelines.<br><br>Challenges<br>• Although over 50% of planned supportive supervision/ monitoring visits took place for DQA and AOP, there was a major challenge conducting all planned visits due to lack of cars designated for GAVI projects and the restrictions for car use under HSSP2. Public transport provided limitations to certain health facilities and remote sites.<br>• With regards to planning of outreach, health staff are supposed to conduct outreach to encourage use of more health services, but because of shortage of health staff, only immunization staff go on outreach and sometimes midwife if able.<br>• During supervision visits, it was found that in some health centers not all staff knew about the guidelines because they were residing with the health center chief rather than accessible to all staff. The goal is to emphasize accessibility of guidelines for all staff in health centers during follow-up supervision/monitoring visits. |
| **2.3 Supervision systems** | Achievements<br>• Supervision visits from PHD to OD was conducted for all 10 ODs.<br>• Joint monitoring from the central level took place twice during first 2 quarters in 2012. One positive finding included confirmation that planning on improving delivery at health facilities was integrated into planning at all health centers visited.<br><br>Challenges<br>• The GAVI HSS focal point left position in Q3 2012, which created challenges to coordination of activities across units (such as joint monitoring visits).<br>• The central joint monitoring visit found a number of important challenges/gaps at OD/health facilities. For example in ODs visited:<br>• Some health centers had stock out of yellow immunization cards suggesting more focus on strengthening coordination/management between health center and OD/PHD and central level to ensure adequate stocks<br>• Data recording still quite weak at a number of health centers as well as at OD level, suggesting more focus on improving data quality |
| **2.4 Health systems operations research** | Funding was reserved to conduct a study, however, due to competing priorities and focus on new incentive scheme, studies have been postponed until 2013. |

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| **3.1 Strengthening middle level management** | Achievements<br>• DBF trained 41 OD and 91 PHD managers from all provinces, not just GAVI focused ODs, in financial management to scale up strengthening of financial management to other ODs in country<br>• Annual review workshop for annual planning conducted in all 10 ODs<br>• Supportive supervision site visits for quarterly/annual review and planning were conducted to OD and health centers in all 10 ODs<br>• CDC trained 12 MCH program managers from 5 ODs on program management<br>• NIP conducted TOT training on cold chain/vaccine management/IIP to OD and health center managers in all 10 ODs<br><br>Challenges<br>Management at non-GAVI HSS sites have faced challenges and capacity issues for financial management. For this reason financial management training has been expanded to cover all provinces. |
| **3.2 Child survival monitoring** | No activities planned or conducted for 2013 |
| **3.3 Service delivery of IMCI** | Achievements<br>Number trainings focused at new staff and capacity sustainability of current staff.<br>• 1 IMCI clinical training conducted for 20 participants from 3 ODs<br>• 2 IMCI clinical refresher trainings conducted for 40 participants from 3 ODs<br>• 1 ToT facilitators training conducted for 13 trainers from 6 ODs<br>• 1 supervisors training on IMCI monitoring for 11 supervisors from 5 ODs<br><br>IMCI review and planning workshop for IMCI and integration into AOP.<br><br>16 filed visits from central level for supervision and spot checks to 57 health centers in 9 ODs<br><br>Challenges<br>• Challenge to conduct all planned supervision visits as CDC until has no dedicated car for GAVI – affecting ability to conduct program monitoring.<br>• There was stock out of IMCI forms with no designated budget to print new forms. |
| **3.4 Private sector collaboration** | Achievements<br>Workshop was conducted for public/private collaboration on immunization and attended by private sector health practitioners.<br><br>Challenges<br>Because of HSSP2 guidelines, GAVI HSS funds could not be used to pay for private sector participants. This created challenge to ensure participation and less budget was spent as a result |
| **3.5 Project management** | Achievements<br>• Program and overhead support was provided without interruption.<br>• 1 laptop each was provided to NIP focal points at the 76 ODs and 24 PHDs, to the OD Chief for the 10 GAVI HSS ODs, and for the 6 implementing units at the central level. In addition, 1 LCD each was provided to the 10 HSS GAVI ODs.<br>• The annual HSS progress review included 45 PHD and 44 OD participants<br>• The 2011 GAVI HSS 2013 AOP preparation was attended by 45 PHD participants and 37 OD participants as well as central implementing units CDC, DPHI, and international partners (WHO, GAVI, UNICEF, PATH, and others)<br><br>Challenges<br>The position for the GAVI HSS coordinator/focal point has been vacant since mid Q3 of 2012. This has led to some challenges to coordinate activities across different implementing units. |

9.2.2 Explain why any activities have not been implemented, or have been modified, with references.

Table 9.2.1 describes briefly some of the challengesexperienced for certain activities not implemented. More details are provided for specificactivities not implemented or modified under each objective.

***OBJECTIVE 1:STRENGTHENING MPA SERVICES (SUPPLY AND DEMAND)***

*1.1 Service delivery contracts*

- Activity 6.3.3.1.0: There were changes for this activity line in2012. First, the PBC scheme changed asof July 2012. The original scheme was 1USD per child immunized, however,certain health centers in less populated areas were demotivated since they werereceiving low incentives, despite needing more effort to reach children inthese high risk areas. For this reason a new scheme was developed based on ODs% coverage of 5MPA activities. Thesecond is that high risk & spot check missions were included in this budgetline (29,800.48USD) because its part of MPA so goes under this budget.

*1.2 Management contracts*

- Activity 6.3.1.1.1 & 6.3.2.1.0 & 6.5.5.0.0 &6.5.6.0.0: The PBMA scheme was changed due to ending of Royal Government ofCambodia's POC scheme In July 2012 for which the GAVI HSS PBMA was based onended. In the absence of any new Governmentincentive scheme, there were challenges to ensure motivation and smoothoperations for implementation of GAVI HSS activities. In response, a new PBMA scheme was developedand approved and the first 3 activity lines were combined into 6.5.6.0.0 to ensureharmonization of incentives directly to staff through bank transfers.

*1.3 Coverage improvement planning (CIP)*

- Activity 6.3.1.1.1: No activity was conducted in 2013,however, commitment from 2011 was carried over into 2012.

*1.4 Fixed site strategy*

- Activity 6.1.2.4.0 & Activity6.1.2.6.0: Dissemination workshop and publication of Outreach and Fixed SiteGuidelines were not implemented as the guidelines had not yet been finalized bythe end of 2012. However, the guidelines have been finalized in 2013 and theseactivities will take place during this year.

- Activity 6.3.1.1.2: Not all community meetings for improving fixed site use were conductedsince In a few of the high risk ODs, VHSG's & VHV's didn't want to go tothe community meetings as the incentive was low (2USD with no travel fee),which did not cover the expense of attending and other priorities outweighedthe motivation/benefit to join such meetings. To remedy this, in 2013, travel costs will be included for communitymeetings to encourage participations.

- Activity 6.4.1.5.0: Notall supervision visits to 14 Provinces for maintenance of cold chain wereconducted due to competing priorities in NIP unit.

***OBJECTIVE 2:DEVELOPING AND STRENGTHENING MPA MANGEMENT SYSTEMS***

*2.2 Health planning systems*

- Activity 6.6.2.2.1: Twentyout of forty planned supervision visits for were conducted due to change inreporting structure to web-based system in 2012, which required revision oftraining curriculum and tools. Inaddition, some visits were not possible due to limitations in transportationcapacity as described in Table 9.2.1

- Activity 6.1.1.3.1: Only 50% of supervision visits for AOPdevelopment and implementation took place due to limitations in transportationcapacity as described in Table 9.2.1. Asof 2012, HSSP2 financial guidelines indicate donor money can not be used to payfor gas in government cars, and hence it was not always possible to use car toconduct site visits. In addition, DPHIwhich implements this activity does not have a car dedicated to GAVI activitiesand hence transport not always available. As many health facilities are difficult to access via public transportthis created challenge to achieve all planned visits.

*2.3 Supervision systems*

- Activity 6.1.1.6.C: Joint monitoring visits from central to peripheral leveldid not take place in Q3 and Q4 due to competing priorities of joint monitoringteam members. Part of the reason it was not a priority wasdue to attrition of GAVI HSS focal point making it difficult to plan across unitswithout a designated focal point to coordinate

*2.4 Health systems operation research*

- Activity 6.1.1.6.C: Funding was reserved to conduct astudy, however, due to competing priorities and focus on new incentive scheme,studies on fixed site/IMCI implementation is planned for 2013.

***OBJECTIVE 3. HUMANRESOURCE QUALITY IMPROVEMENT***

*3.3 IMCI*

- Activity 6.2.2.2.0: Only 25% of this activity - monitoring andspot-checks by CDC unit to ODs/health centers – was conducted due to transportlimitations as described previously. As new MoH policy under HSSP2 does notallow the use donor money to pay for gas when using government cars and thedifficulty accessing all sites with public transportation posed greatchallenges to CDC unit.

*3.5 Program management*

- Activity 6.6.2.0.0 and 6.6.2.0.3: The GAVI HSS program staff annual retreat (6.6.2.0.0)did not take place due to competing priorities. Instead, monies from thisactivity was placed into activity 6.6.2.0.3, for the workshop on thepreparation of GAVI/HSS AOP 2013.

9.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

Until July 2012 theGAVI HSS grant was providing management incentives at all GAVI implementinglevels according to the Royal Government of Cambodia's "Priority OperationalCost" or "POC" guidelines under the Ministry of Health. However, the POC sub-decree is no longer ineffect as of July 2012. Since then, theMoH approved an interim management incentive guideline for GAVI HSS grantimplementers in September 2012. Thismanagement incentive is based on a "personal performance management contract" withlump sumpayments paid directly based on **quarterly** performanceassessed by established supervisorymapping. Incentivesare provided to management at all levels and will include 41 staff at centralimplementing units, 65 staff in 9 PHDs, 52 staff in 10 ODs, and 219 staff of health centers, including remotehealth centers, in these ODs. It is hopedthat the GAVI management incentive scheme can serve as a model for the rest ofMoH programs.

The "contracting in" approach supported by the HSSP2was adopted by GAVI HSS and continues to be implemented as a strategy tostrengthen decentralization of health care management and improve coverage andquality of the Minimum Package of Activities (MPA) in 10 high risk ODs. The schematic of incentives for theseperformance-based contracts was originally based on health centers receiving1USD per child immunized. However, reviewof the scheme found some important challenges, including the disincentive forcertain health centers in less populated but high risk areas that often requiremore effort to reach adequate numbers of vaccination coverage, but received lessmoney than health centers in more populated areas. Another observed issue wasthe variation across ODs in linkages between improved performance inimmunization coverage and those of other key MPA indicators.

To address these gaps, the performance-based incentiveshave changed to reflect each OD's percent coverage of a set of several key MPAindicators. For each of the 10 ODs, anincentive ceiling and specific targets are designated in the contract based on therisk status and population. Depending onthe OD's performance on the set of indicators, a percentage of the total ceilingis provided. The table 1 provides thebreakdown in coverage per indicator that each OD needs to achieve in order toreceive 100%, 66.6% and 33.3% of the total incentive allocated for thatparticular indicator and OD (please see attachment "Tables"). For example, if the ceiling for IMCI in OD 1is 5000USD, and their achieved coverage is 60%, OD1 will be awarded 5000USD *67% or 3350USD, for that particular indicator. The total incentive disbursed to ODs for distribution to health centerstaff is the addition of the individual performance incentives for each of the5 indicators.

The hope is that thispooled indicator performance will further strengthen the health systems wideapproach and promote integrated health service delivery and move away from siloprocesses of vertical donor programs.

## 9.3. General overview of targets achieved

Please complete **Table 9.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2011 from your original HSS proposal.

**Table 9.3:** Progress on targets achieved

| Name of Objective or Indicator (Insert as many rows as necessary) | Baseline | | Agreed target till end of support in original HSS application | 2012 Target | | | | | | Data Source | Explanation if any targets were not achieved |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline value | Baseline source/date | | | 2008 | 2009 | 2010 | 2011 | 2012 | | |
| **1a. % DTP Coverage – HepB 3 [National]** | 78% | DHS 2005 | 90% | 95% | 91% | 95% | 92% | 94% | 95% | MoH HIS | Achieved |
| **1b. % DTP Coverage – HepB 3 [10 OD – HSS]** | 74% | MoH-MoP 2006 | 90% | 95% | 80% | 87% | 90% | 83% | 92% | NIP/HIS/ PHD-OD | 6 ODs have reached 2012 target, 4 ODs have not achieved |
| **2a. #/% OD Achieving >=80% DTP3 Coverage [National]** | 18 (24%) | NIP 2006 | 76 (100%) | | 62% | 68% | 66% | 64% | 67 (88%) | NIP/HIS/ PHD-OD | On track for 2015 target |
| **2b. #/% OD Achieving >=80% DTP3 Coverage [10 OD – HSS]** | 0 (0%) | DPHI/NIP 2007 | 10 (100%) | | 7% | 9% | 9% | 10% | 9 (90%) | NIP/HIS/ PHD-OD | One OD Preah Sihanouk did obtained 88% coverage for this indicator. |
| **3a. % Hepatitis Birth Dose-24 Hours [National]** | 25% | MoH-NIP 2006 | 70% | | 46% | 55% | 57% | 55% | 65% | MoH HIS | On track to achieve 2015 target. |
| **3b. % Hepatitis Birth Dose-24 Hours [10 OD – HSS]** | 25% | MoH-NIP 2006 | 70% | | 47% | 61% | 65% | 96% | 72% | NIP/HIS/ PHD-OD | Achieved, however, coverage varies greatly across 10 ODs (see section 9.4.1) |
| **4a. % Measles Coverage [National]** | 70% | MoH-NIP 2006 | 90% | | 91% | 92% | 93% | 93% | 93% | MoH HIS | Achieved |
| **4b. % Measles Coverage [10-OD-HSS]** | 70% | MoH-NIP 2006 | 90% | | 78% | 83% | 89% | 80% | 88% | NIP/HIS/ PHD-OD | On track for 2015 target |
| **5a. % Pregnant Women Attending >= 2 ANC Visits [National]** | 60% | NSRH 2005 | 90% | | 81% | 83% | 72% | 86% | 87% | MoH HIS | On track for 2015 target |
| **5b. % Pregnant Women Attending >= 2 ANC Visits [10-OD-HSS]** | 49% | MoH-HIS 2006 | 90% | | 72% | 81% | 76% | 100% | 78% | MoH HIS | High variation across 10 ODs, with 6 ODs achieving less than 80%, with 1 achieving only 29% (see section 9.4.1) |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| **6a. % Skilled Birth Attendance [National]** | 44% | DHS 2005 | 90% | | 58% | 63% | 69% | 69% | 75% | MoH HIS | Progress has been substantial since start of grant, however, 2015 target may not be reached. Main issue is large variation across geographical areas, even within provinces, with certain areas still engaging in traditional birth attendance. |
| **6b. % Skilled Birth Attendance [10-OD-HSS]** | 35% | MoH-HIS 2006 | 90% | | 47% | 58% | 67% | 67% | 52% | MoH HIS | There has been progress, but not on track to reach 2015 target. High variation across 10ODs, with 4 OD's less than 50% coverage & all less than 70%. Practice of Traditional Birth Attendants still high. |
| **7a. % Delivery at Facility [National]** | 14% | MoH-HIS 2006 | 70% | | 39% | 44% | 52% | 52% | 66% | MoH HIS | On track for 2015 target |
| **7b. % Delivery at Facility [10-OD-HSS]** | 14% | MoH-HIS 2006 | 70% | | 34% | 44% | 51% | 51% | 44% | MoH HIS | Although coverage has quadrupled since, progress towards 2015 target, is much slower than national trend. Main reason is due to 7 ODs having less than 45% coverage of health facility delivery, mainly due to their remote/high risk status. |
| **8a.% Health Centers trained/implementing IMCI [National only]** | N/A | N/A | 100% | | 69% | 78% | 100% | 100% | 100% | CDC | Achieved |
| **8b. % of Health Centers trained/implementing IMCI [10-OD-HSS]** | N/A | N/A | 100% | | N/A | 90% | 100% | 100% | 100% | CDC | Achieved |
| **9. # of ODs Reaching Performance Targets Specified in OD Contracts [10-OD-HSS]** | 1% | 10-OD-HSS 2007 | 10 | | 7 | 9 | 10 | 10 | 9 | DBF | All but 1 OD were able to achieve targets of the 5 core MPA indicators agreed in the performance contracts. Kratie OD was not able to achieve satisfactory coverage for ANC2, and hence received no performance incentive for this indicator. |

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| **10a. # Facilities Implementing Full MPA [National]** | 470 | MoH 2006 | 972 | | 967 | 984 | 997 | 1004 | 1042 | MoH HIS | Indicator has overachieved |
| **10b. # Facilities Implementing Full MPA [10-OD-HSS]** | N/A | N/A | 100% of existing HCs | | N/A | 127 | 149 | 149 | 155 | MoH HIS | Achieved, 155 of 156 (99%) HCs implement full MPA |
| **11a. % Immunization at Fixed Site [National]** | 20%-25% | 2003-2004 | 40% | | 32% | 37% | 45% | 39% | 42% | MoH HIS | Achieved |
| **11b. %] of immunization at fixed site 10 HSS ODs [10-OD-HSS]** | 20%-25% | 2003-2004 | 40% | | 37% | 48% | 41% | 45% | 47% | MoH HIS | Achieved |
| **12. % Approved Budgets Reaching Health Facilities [10-PHD/OD-HSS HCs]** | AOP-Budget Allocated | AOP-Budget Planned | 100% | | 100% | 100% | 100% | 100% | 100% | DPHI/ DBF | Achieved – all 10 GAVI HSS ODs received their planned budgets |

## 9.4. Programme implementation in 2012

9.4.1. Please provide a narrative on major accomplishments in 2012, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

**OVERALL PROGRESS**

Overall achievements of GAVI HSS funded program have been quite remarkable as measured by the trendof 12 indicators from their baselines. Alltargeted national and GAVI focused facilities are providing full MPA services,and all have been trained in IMCI. Allof the 10 GAVI HSS ODs completed their AOPs and received budgets according to their planned activities. Of these 10ODs, 9 achieved performance targets as described in the new performance basedscheme for service contracts.

The immunization indicators have performed well and either achieved or are on track to achievingtheir 2015 targets at both national and the 10 GAVI HSS OD levels. MCH indicators have more variation in their progress. The percent of immunizations that take place at fixed sites has more than double since 2004 and hasoverachieved its 2015 target.

MCH indicators are more variable in their performance. The ANC 2+ coverage indicator is on trackat national level, but is performing slower for the 10 ODs mainly because a fewof these ODs are quite remote with low or no additional donor support foroutreach and travel reimbursements creating challenge for women in these areasto the ANC centers. The same issue holds true for % receivingskilled birth attendance, however both national and 10 ODs may not reach their targets. Traditional birth practices are still quite common across Cambodia, particularly in remote areas, such as within the 10 GAVI HSS ODs. For delivery at health facility, the national coverage is on track, but coverage in the 10ODs is progressing much more slowly and may not reach its 2015 target. Again, for the 10 ODs, the majority are considered quite remote and without additional support to pregnant women forgetting to the facilities, there is a major challenge for them.

Specific Indicator achievements are described below for both national and 10 OD coverage.

***Indicator 1: % DTP Coverage – HepB 3:***

- National =95%: the current coverage has improved since the baseline of 78% in 2005 (DHS)and the 92% programmatic report of 91%. The indicator has achieved its 2012 target of 95%

- 10 HSSGAVI ODs = 92%: the current combined coverage shows considerable progress since the baseline of 74% (2006) and is on tract to reach the 2012 target of 95%. The coverage is slightly less than national coverage, but this is in line with the lower baseline figure and is mostly due to a couple of lower performing ODs. There are differences in coverage across ODs, however 6 of the 10 ODs reached their 2012 target (see below for more OD analysis)

***Indicator 2: #/% OD Achieving >=80% DTP3 Coverage***

- National =88%: the current coverage shows remarkable progress cine the baseline of 24%(2006) and is on track for 2015 target of 100%

- 10 HSSGAVI ODs = 90%: the combined current coverage shows higher achievement than national, despite a baseline of 0%. Thiscan be accredited to the focused efforts of GAVI HSS activities to scale up coverage in these ODs.

***Indicator 3: % Hepatitis Birth Dose-24 Hours***

- National =65%: national coverage for this indicator has improved significantly since the baseline25% in 2066. The indicator is on track for meeting its 2015 target 2015 of 70%.

- 10 HSSGAVI ODs = 72%: as with the national coverage, this indicator has improved greatly since the 2006 baseline of 25%. Performance has been better than national, and has overachieved the 2015target of 70%, most likely due to the sector wide approach in these ODs to improved MPA services, including service delivery at health facility, for whichthis indicator Is highly related. It isimportant to note that across the 10 ODs there is much variation in terms ofachievement for this indicator, and this is discussed in more detail below.

***Indicator 4: % Measles Coverage***

- National =93%: this indicator has overachieved its 2015 target of 90% baseline, from 2006baseline of 70%

- 10 HSSGAVI ODs = 88%: although progress has been slower than national coverage, thisindicator is on track to reaching the 90% 2015 target from the 2006 baseline of70%. There is variation across the 10ODs, however, all are on track for 2015 target (see below for more analysisacross ODs).

***Indicator 5: % Pregnant Women Attending >= 2 ANC Visits***

- National =87%: this indicator is on track nationally for reaching the 90% 2015 target,rising from baseline of 60% in 2005.

- 10 HSSGAVI ODs = 78%: for the 10 ODs, progress has been substantial since the 2005 baselineof 49%. However, not all ODs are ontrack to reach the 2015 target of 90%, with much variation across ODs, and only4 achieving coverage greater than 80% (see below for more analysis across ODs).The main reason is some of these ODs are quite remote with low or no additionaldonor support for outreach and travel reimbursements creating challenge forwomen in these areas to the ANC centers.

***Indicator 6: % Skilled Birth Attendance***

- National =75%: although nationally there is has been much progress in coverage from 2005 baselineof 44%, there maybe challenge to reach the 2015 90% target. This is most likely due to certaingeographical areas having less access to skilled birth attendance, and the useof traditional birth methods are still quite prevalent in certain parts ofCambodia.

- 10 HSSGAVI ODs = 52%: although there has been progress for the 10ODs from the 35%2006 baseline, this indicator is not on track to meet the 2015 90% target. There is much variation across ODs, but none of the ODs has a coverage value greater than 70%. These ODs were chosen for their lowperformance, and have improved, but it maybe that the national target is tooambitious for their starting point (see below for more analysis across ODs).

***Indicator 7: % Delivery at Facility***

- National =66%: this indicator has achieved remarkable coverage nationally from the 2006 baselineof 14% and is on track for the 2015 target of 70%.

- 10 HSSGAVI ODs = 44%: although the overall coverage for this indicator has quadrupledfor the 10 ODs from the baseline of 14% (2006), it has progressed slower thanthe national figure and may not reach the 2015 target of 70%. One of the reasons maybe due to fact thatthese 10 ODs were chosen for their low performance, much of which is due toaccessibility and remoteness. As 7 ODsare still less than 45% coverage, it maybe too ambitious to expect to reachnational targets by 2015 (see below formore analysis across ODs).

***Indicator 8: % Health Centers trained/implementing IMCI***

- National =100%: All health centers in the country have received training in IMCI since2010
- 10 HSSGAVI ODs = 100%: All health centers in the 10 ODs have received training inIMCI since 2010

***Indicator 9: # of ODs Reaching Performance Targets Specifiedin OD Contracts***

- 10 HSSGAVI ODs = 9 (90%): of the 10 ODs, 9 reached designated targets set out intheir service contracts. This isdescribed in more detail below under "Progress in GAVI HSS ODs"

***Indicator 10: # Facilities Implementing Full MPA***

- National =1042: this indicator has more than doubled since 2006 baseline of 470 health facilities and has overachieved the planned 2015 target of 972 health facilities.
- 10 HSSGAVI ODs = 155: almost all health centers, 99% of 156 total, are implementingfull MPA services in the 10 ODs. This is an increase of 4 health centers since last year.

***Indicator 11: % of immunization at fixed site***

- National =42%: the percent of immunizations at fixed sites has doubled nationally since2004 and overachieved the 2015 target of 40%.
- 10 HSSGAVI ODs = 47%: for the 10 ODs, this indicator has performed higher than thenational value, more than doubling from the 20% baseline in 2003, and overachieved the 40% 2015 target. Thisis most likely due to the strong focus of outreach in the 10 ODs for populations in Zone A and Zone B to use fixed sites.

***Indicator 12: % Approved Budgets Reaching Health Facilities***

- 10 HSSGAVI ODs = 100%: All 10 ODs developed their AOPs an received their budgets inaccordance to these planned activities

**PROGRESS IN GAVI HSS ODs**

In comparing progressin the 10 GAVI HSS focused ODs to national progress, it is important to keep inmind that the 10 original ODs were chosen based on their high risk or low performance and paucity of support from development partners and local NGOs. In addition, there have been anumber of changes since start of grant, including 2 new ODs being introduced in2010. Summary of indicator trends forboth national and the 10 ODs has already been described above.

***Indicator data***

In addition to comparing the 10ODs to national level and whether they are on track to reaching2015 targets, it is important to look at progress across the 10 ODs and understand differences in performance. Please seethe attachment "Tables_Figures_GAVI_HSS_2012" Figures 1 to 5.

It is clear from the figures thatfor most indicators there is variation across the ODs, even with high performing indicators such as DTP3. Some of the under performance is related to the remoteness of the OD. For example, Kratie under performs on 4 of the5 indicators presented in the figures. This is most likely due to the remoteness ofcertain populations and their access to health centers. As these ODs were chosen for their under performance and lack of additional NGO/donor support,there isn't the complimentary client based incentives to ensure pregnant women get to health centers for ANC and delivery and mothers can get to facilities for immunization. For this reason, it will be important to collaborate with donors that can provide complimentary activities that are outside the scope of the GAVI HSS.

In addition, it is important to note that the high over achievement in Mongkul Borei OD is most likely due to underestimate of the denominator, the population of children under 1. This is also the case for a couple of theother indicators that reached over 100%. The ODs report on the population using the figures from the PHD, which in general seems to be an underestimate of the true population. This issue will need to be addressed more aggressively by DPHI and individual units.

***Service contracts***

In July 2012, a new scheme was designed to reward incentives for the service-based contracts to ODs. Previously, ODs were awarded basedon number of children vaccinated, with 1USD per child. However, internal review found this scheme tobe a disincentive for some health centers for which population levels were low,leading to low incentive rewards, but need was nevertheless high because of the remoteness and risk environment of these areas. For this reason a new scheme was developed (please see section 9.2.3 fordetailed description). This new scheme is based on combined performance of 5 indicators, which reflect 5 core MPAservices. The combined performance ofthese indicators and the subsequent awarded incentive are provided in Table 2 (please see attachment "Tables_Figures_GAVI_HSS_2012") related to linkage of this vaccination to level of delivery at health facility, for which the level of coverage varies geographically. From the table it is clear that all ODs achieved incentive targets withthe exception of Kratie.

In addition, the DQAS has shown that quality of data has improved over time. Since 2008 staff pay more attention to quality of data because of the scale up of the DQAS as well as incentives which provide motivation for recording and cross validation.

9.4.2. Please describe problems encountered and solutions found or proposed to improve future performance of HSS funds.

A few important challenges and gaps are highlighted for 2012

- *Support to pregnantwomen to improve MCH indicators*: As described in section 9.4.1, the MCH indicatorsare struggling to reach their 2015 targets in the 10ODs. The main issue is thatthese indicators rely on pregnant women having access to facilities, and mostof these ODs are remote with little or no additional donor support to thesewomen to cover travel costs, etc. Itwill be important to work with partners to ensure in future there iscomplimentary support to pregnant women in these ODs.
- *Issue of denominators*: Since 2008, all Provincial Health Departmentsuse their own methods of estimating their populations include the value forpopulation of infants and pregnant women. Almost all ODs in the country use thepopulation rate reported by the province. However there are a number of issues that arise. There is inconsistency across Provinces inmethods of population estimation including the source data they use for theirestimates. This can be problematic asseveral assessments have shown that estimates across different sources are notconsistent with some underestimating or other overestimating. At the OD level another layer of complexityis added. ODs are MoH specific, while other ministries rely on AdministrativeDistricts (ADs) for which Census data is available. Obtaining valid OD level denominators is notstraightforward since not all ODs and ADs are geographically equally, and oftenhave overlapping areas. Thesedenominator issues can skew percent coverage, even if numerators are validatedthrough DQAS methods. An underestimated denominator can overestimate the coverage and vice versa. It will be criticalfor a comprehensive review to takeplace in next year that compares all denominator data sources in the 10 ODs using2010 CDHS, 2008 Census, and other sources. In addition, this exercise should recommenda common method for consistency and valid estimation across ODs.
- *High staff turnover*: In general there has been experience of highstaff turnover despite existing incentives for GAVI HSS ODs. The lowergovernment salaries loose staff to higher paying private sector. This creates issues of sustainability for AOPcapacity strengthening, as new staff that come in are unclear on how to conductplanning and it sets back momentum established by previous efforts.
- *Challenges to supervision visits*: Most of the units experienced difficulty incompleting all their planned supervision visits. There were a number of reasons, which havebeen mentioned in section 9.2. These include transport limitations, competingpriorities, and difficulties coordinating across units for joint visits. For2013 and beyond the Program Management Team will institute a supervision/monitoring plan across the grant which will take into account limitations and realistic schedules, ensuring that the most needed sites are visited as priority.
- *Challenges to engagingprivate sector*: As the grant management follows the HSSP2 financial policy,it is not possible for Government to pay for private sector staff to attendworkshops and trainings. This limitation creates a challenge to motivate private sector to engage in coordination activities.

9.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

Monitoring and evaluation the progress of the GAVI grant cuts across multiple levels. Most of the monitoring relies on existing AOP feedback process. Data is collected to inform planning and target setting and mechanisms such as quarterly and monthly meeting reviews, supervision and monitoring visits, periodic audits and operations research provide the needed strategic information on progress of contractual activities and quality of data.

***Central Level***

- Technical Working Group for Health (TWGH) provides oversight on major grant decisions and progress. The TWGH sits under the MoH and is comprised of key MoH staff, including representatives from GAVI implementing units, international and national non-governmental partners, and multi and bi-lateral donors.
- The Program Monitoring Team is responsible for the general oversight and day to day management of GAVI grant. Monitoring activities include:
  - Coordination of annual GAVI review, including compilation of APR and annual HSS AOP workshop
  - Integrated supervision to all 10 ODs on quarterly basis by the Joint Program Monitoring team, which is comprised of all implementation units (DBF, NIP, CDC, DPM, and DPHI). These visits are to ODs and health centers with comprehensive checklist to spot check performance of grant activities. These include but are not limited to financial records, management practices, MPA implementation, and data quality checks. In addition, the team provides supportive supervision to the field staff, discussing/trouble shooting challenges and gaps as well as following up on findings from annual audits and previous monitoring visits.
  - Assessing eligibility and level of incentive based on the performance based management agreements and service delivery contracts performances with ODs.
  - Coordinates external annual audits by independent private audit firms and ensures recommendations are addressed and implemented.
  - Oversight/coordination on several planned operational/special studies
- Department of Budget and Finance monitors financial processes and verifies expenditures for all grant implementing units, including PHDs and ODs.
- The Internal Audit Division (IAD) of MoH is responsible for conducting audits on GAVI HSS grants. The audits are conducted on rotational basis, conducted annually for provinces with 4 or less ODs and every three years for provinces with 5 or more ODs.

- Implementing units of GAVI HSS also conduct routine monitoring which include:

o DPHI – responsible unit for the Data Quality Audit System, which includes unannounced "spot checks" to health centers (see attachment "DQA Final Report". In addition, they conduct supportive supervision and monitoring to ODs to for strengthening PHD/OD DQA spot checks as well as PHD/OD and health center operational planning

o CDC - Supportive supervision "spot checks" are conducted to ODs and health centers to monitor IMCI services

o DPM – supervision visits are conducted to all 10 ODs which focus on whether health center staff understand and are complying with outreach guidelines, particularly with regards to increasing use of fixed sites for immunization

***Provincial Level:***

Monitoring at the provincial level takes place as part of nationally mandated activities as well as those initiated by GAVI HSS grant. These include:

o Integrated supervision visits from province to the 10 GAVI HSS ODs, which include provincial health accountant and provincial focal points from Technical Bureau, Expanded Program on Immunization, Health Information System, and Maternal Child Health. As with the integrated visits by the central level, these visits provide comprehensive checks and feedback on implementation of MPA services, finance and management.

o Provincial supervision and monitoring to ODs and Health Centers on the annual and quarterly operational planning and review processes

o Unannounced DQA spot checks by provincial monitoring team to health facilities

o Quarterly meetings at provincial level to monitor progress of activities as described in AOP and reaching targets as described in service contracts with ODs an health centers

***Operational District Level:***

Monitoring at the provincial level takes place as part of nationally mandated activities as well as those initiated by the GAVI HSS grant. These include:

o Integrated supervision visits from 10 ODs to the health centers, which include the Director/Deputy OD health

manager, OD health accountant and provincial focal points from Technical Bureau, Expanded Program on Immunization, Health Information System, and Maternal Child Health. As with the integrated visits by the central level, these visits provide comprehensive checks and feedback on implementation of MPA services, finance and management.

- Monthly meetings at OD level to monitor progress of activities as described in AOP and reaching targets as described in service contracts with ODs an health centers
- Unannounced DQA spot checks by OD monitoring team to health facilities

9.4.4. Please outline to what extent the M&E is integrated with country systems (such as, for example, annual sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more organization with existing reporting systems in your country. This could include using the relevant indicators agreed in the sector-wide approach in place of GAVI indicators.

The GAVI HSS M&Ewas designed from its onset to be integrated with Cambodia's national systems. Grant activities were planned to strengthenthe existing National annual operational structures and processes, includingthose for monitoring (as described above), which then feed into M&E needsfor the GAVI HSS grant. Morespecifically, GAVI M&E activities and requirements are integrated with theNational system in the following ways:

- *Monitors national indicators*: most of the impact and outcome indicators monitored forthe GAVI HSS grant are drawn from the National Health Strategic Plan 2(HSP2). In addition, indicator targetsare based on those set out in the HSP2 and those described in the MoH, specifichealth programs and provincial/OD health Annual Operational Plans. Hence measuring progress of the GAVI HSS isdrawn from measuring progress of nationally and sub-nationally set targets.
- *Based on existing systems:* since the GAVI HSS indicators and targets are based onnational and sub-national plans, the means for collecting and reporting onthese indicators are also part of the national and sub-national HIS/M&Esystems. There is no parallel structurefor monitoring and reporting on GAVI HSS progress, and all indicator data aredrawn from existing National or sub-national data sources.
- *Builds on and strengthens existing M&E structures*: Further many activities in the GAVI HSS grant have beendesigned to strengthen the national M&E structures. These include but are not limited to the followingfunded and planned activities:

- Coordinatedsupervision across units to sub-national and health facility levels in line withthe interdepartmental strategy for M&E to provide oversight and directmonitoring of the of the integrated package of services (MPA)
- Training on HISindicator data collection and reporting, including the new online reportingsystem
- Data Quality Audit trainings,supervision visits and spot checks
- Trainings andsupportive supervision and monitoring for AOP at OD where indicators arereviewed and inform planning process

- *Compliments routine monitoring: the grant has planned a series of operational research and special studies that will inform the national level. For example, the latest study in 2011 looked at contribution of availability of 24-hour services for MPA in health centers to increased accessand utilization of health services in the 10 GAVI HSS ODs. The findings provided valuable strategic information on what is working and continued challenges in implementing 24-hourservices that can be applied to rest of country.*

9.4.5. Please specify the participation of key stakeholders in the implementation of the HSS proposal (including the EPI Programme and Civil Society Organisations). This should include organisation type, name and implementation function.

The Department of Budget & Finance MoH manages and coordinates the GAVI HSS grant.

There are 4 implementing units under the Ministry ofHealth receiving funds under GAVI HSSS. These include:

- National Immunization Program(NIP)
- Department of Planning and HealthInformation (DPHI)
- Preventive Medicine Department(PMD)
- Center for Disease Control (CDC)

The GAVI HSS activities are predominantly focused on10 high risk ODs in 9 provinces. These provinces and ODs receive funds for activities as well as incentives, which then get disbursed to the health centers.

Funds are also channelled to non-GAVI ODs and provinces for certain capacity strengthening activities.

Development partners include WHO, UNICEF, and donor partners under funding of HSSP2. These partners provide technical support to specific implementing units and are members of the Technical Working Groupfor Health which serves as the coordinating/oversight mechanism for HSS GAVI grant decisions.

There were no NGO/CSOco-implementers under for 2012 GAVI-HSS, however these organizations do play important role in health system strengthening under other donor funding, such as Global Fund.

9.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.

There were no NGO/CSOco-implementers under GAVI-HSS, however these organizations do play important role in health system strengthening under other donor funding, such as Global Fund.

9.4.7. Please describe the management of HSS funds and include the following:

- Whether the management of HSS funds has been effective
- Constraints to internal fund disbursement, if any
- Actions taken to address any issues and to improve management
- Any changes to management processes in the coming year

## 1. 1. EFFECTIVE MANAGEMENT OF HSS FUNDS

All financial management andprocesses of GAVI HSS funds follow HSSP2 Financial Guidelines. As described in Section 9.1.3, funds from HSSGAVI grant are managed by the MoH's Department of Budget and Finance. Funds are disbursed to provinces on a yearlybasis, who then disburse to ODs on monthly basis. These funds are based on the annual approvedAOPs.

In addition, specific performancecontracts have been developed for each of the 10 focused ODs. These contracts describe the expected targetsin coverage of MPA services for each OD in order to receive performance-basedfunds. Departments at national levelrequest for cash advance for workshops and trainings. For other activities such as supervision andmonitoring visits, they staff are reimbursed with a check to the person whosigned the MoU with DBF.

At the time of submission for this APR,the 2012 external audit report was not finalized, however, the 2011 auditreported some internal control weaknesses which have been addressed by GAVI HSSproject team. These included thefollowing:

- Maintenance of advanceregister in 2 ODs
- No procedure fortimeframe of advance liquidation
- Quality and dataverification of performance indicators for MPA incentives weak in 6 ODs.
- PHDs not providingexplanation of variance between allocated and spent budgets and more oversightneeded from central level

## 2. CONSTRAINTS TO INTERNAL FUND DISBURSEMENT

Disbursements to the10 ODs have experienced no major issues since money is disbursed once a year toprovince. However, other disbursement mechanisms do experience challenges. Forexample, providing advances to departments at central level fortrainings/workshops can experience delays in supporting documents, which arerequired within 10 days of implementation of training/workshop. In addition, sometimes support documents haveincorrect information and additional time is required to control forvalidity. This is particularlychallenging since there is not enough staff to verify all supporting documentsin a timely manner.

## 3. ACTIONS TAKEN TO ADDRESS ANY ISSUES AND TO IMPROVEMANAGEMENT

For issues identifiedin the 2011 audit, 50% have been addressed/resolved, while the others are inprogress. The more challenging is thatof verification of performance indicators for the MPA incentives. Since the incentive scheme has changed to include 5 MPA indicators, this issue is even more critical. However, DPHI hasstarted to implement a web-based data entry system for core national indicators, including the 5 performance MPA indicators. As part of this system,DQA training and supervision, as well as spot checks will take place. A web-based system facilitates verification and quality control, and the hope is this will improve the validity of reporting under the performance-based system.

## 4. ANY CHANGES TO MANAGEMENT PROCESSES IN 2013

The management of Activity1.1 has changed. The criteria for performance based contracts and performance based management was changed in mid 2012 and is described in section 9.2.3 Forthe 10 ODs, previously payouts were based on number of children immunized. However, now the scheme has changed topercent coverage of a set of 5 MPA indicators with incentive award based on previously determined targets achievement.

The management for Activity 1.2 has also been changed with MoH developing guidelines for performance base to motivate health professionals managing activities under GAVI HSS. Incentives are provided to management at alllevels including the central units, the 9 PHDs, the 10 ODs, & managers of remote Health Centers in theseODs. A lump sum payment is provided to managers based on quarterly performance evaluations (see attachment GAVI_HSS_Incentive_Guidelines).

Some minor changes based on HSSP2 Financial guidelines have been experienced under GAVI. One example is that of per diems supervision monitoring visits to the field, which is now shortened from 5 nights to 4 nights in the field, and from 5 people to 3people per visit.

## 9.5. Planned HSS activities for 2013

Please use **Table 9.5** to provide information on progress on activities in 2013. If you are proposing changes to your activities and budget in 2013 please explain these changes in the table below and provide explanations for these changes.

**Table 9.5:** Planned activities for 2013

| **Major Activities** (insert as many rows as necessary) | **Planned Activity for 2013** | **Original budget for 2013** (as approved in the HSS proposal or as adjusted during past annual progress reviews) | **2013 actual expenditure** (as at April 2013) | **Revised activity** (if relevant) | **Explanation for proposed changes to activities or budget** (if relevant) | **Revised budget for 2013** (if relevant) |
|---|---|---|---|---|---|---|
| 1.1 Service delivery contracts: performance based contracts with health centers | Establish and implement annual operational plans and performance based contracts (PBC) at health facility level | 539035 | 186852 | This activity has been revised per new PBC scheme based on OD specific targets to reach certain % coverage on 5 critical MPA services | Previous scheme was based on number of children immunized. Based on internal review, it was found this approach could be demotivating for less populated (yet still high risk) areas. Further it was focused on immunizations with assumption linkages are strong enough between immunization coverage and other MPA services for improvement of further to have impact. By basing performance on OD specific % coverage for group of critical MCH services, it is hoped staff will be motivated to improve all these services. (please see Attachment #)<br><br>(please note the 2013 expenditures are for January to March, or Q1 (3 months), not January to April) | 427650 |
| 1.2 Management contracts | Establish and implement annual operational plans and performance based management agreements (PBMA) with ODs and Provinces | 136220 | 58034 | This activity has been revised per approval by Ministry of Economy and Finance 9/2012 on a new PBA scheme. | Since former POC scheme was abolished, new PBMA scheme was developed through consultative review providing incentives to 41 Central, 65 PHD, and 52 OD management staff (219 Total) who implement (please see Attachment #) | 235600 |
| 1.3 Coverage improvement planning (CIP) | Integrating immunization coverage improvement planning into MPA planning system to improve overall MCH | 50000 | 0 | No activities planned for 2013 | For 2013, 95,076USD has been earmarked for CIP activities, however to be drawn from the ISS budget. This is due to shortage of funds in the HSS grant to fully cover the planned activities under CIP. | 0 |
| 1.4 Fixed site strategy | Implement, evaluate, and scale up fixed site strategy to improve immunization coverage through increased health center utilization | 25000 | 0 | No changes in activities | Minor adjustments to budget lines to reflect actual costs and 2012 revised budget | 38792 |

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|---|---|---|---|---|---|---|
| 2.1 Financial management system development | Develop MPA financial management system, health financing guidelines, and monitoring effective implementation | 10000 | 0 | Mid-term workshop will be revised to conduct HSS review with OD and provinces | The 2012 workshop proved to be a valuable forum for review of financial management/health financing issues and provided opportunity OD and PHD managers to share challenges and lessons learned | 15000 |
| 2.2 Health planning systems | Strengthening MPA planning at OD and health centers through AOP integration | 45000 | 12056 | A number of activities are planned including training to ODs on HIS collection and reporting of MPA service data and routine DQA and HIS spot checks | Capacity strengthening activities for planning at OD and health facility level are crucial for successful delivery of MPA services. For this reason supportive supervision and training will be scaled up from the original plan. Following external DQA and audit findings, recommendations included refresher trainings on data collection and DQA as well as more frequent DQA site visits. | 110589 |
| 2.3 Supervision systems | Strengthening integrated supportive supervision from central to PHD, PHD to OD and OD the health facility level through interdepartmental monitoring | 69776 | 8779 | No changes in activities planned, just adjustment of budget per actual costs | Adjustment per pervious year expenditure | 51999 |
| 2.4 Health systems operations research | Conducting research to support decision making for strengthening demand and delivery of MPA services | 20000 | 0 | Operational research study is planned to explore challenges and strategies to better implement fixed sites, particularly from demand side | No changes to original planned budget | 20000 |
| 3.1 Strengthening capacity of middle level management | Strengthening financial, planning, management and monitoring capacities of middle level management at OD, and health facility level through development of guidelines, trainings and supportive supervision | 50000 | 5914 | Refresher trainings to middle level management will be provided in financial management with follow up supervision. In addition, the new HIS web-based system requires training to these staff | Strong management and planning skills in managers at OD and health facility level are crucial for quality service delivery of MPA and for ODs to meet the new performance targets set out in Activity 1.1. For this reason scale up capacity strengthening of middle level management to ensure they can provide leadership and oversight to performance of health facilities. | 123749 |

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|---|---|---|---|---|---|---|
| 3.2 Child survival monitoring | Strengthening systems for child survival scorecard monitoring through Provincial Health committees, interdepartmental monitoring team, and inclusion of scorecard monitoring in AOP. | 0 | 0 | No activities planned for 2013 | N/A | 0 |
| 3.3 Service delivery of IMCI | Strengthening capacity of IMCI service delivery to improve immunization and overall MCH through trainings of health center and OD staff and supportive supervision | 0 | 13173 | Refresher trainings on IMCI to clinicians is planned with follow-up monitoring through site spot-checks. In addition workshop for integration of IMCI planning into AOPs will take place. | It is important to maintain skill level through refresher trainings and follow-up. | 60000 |
| 3.4 Private sector collaboration | Scaling up and evaluating public/private collaboration to improve quality of immunizations and eventually MCH services in private sector | 10000 | 5288 | Scale up of monitoring to private sector sites through supportive supervision is planned | As follow-up to 2012 workshop with private health sector providers, and to respond to growing proportion of private health sector providers, it is critical to maintain collaboration, capacity and implementation through close monitoring of these facilities to ensure compliance to national guidelines and standards | 20000 |
| 3.5 Project management | Support activities to ensure effective implementation of grant activities to reach planned targets. | 68652 | 18019 | Internal audit review on 2012 will take place and inform implementation strategy for 2013 to end of grant period. Contingency funds have been tripled. Cold chain maintenance and other equipment will be procured at PHD/OD/HC | After 4 years of implementation of GAVI HSS grant, it is important for the grant to be reviewed internally to assess quality of implementation and adapt strategies as needed. Previous implementation challenges has shown that additional contingency funds are needed to adapt to change in strategy and implementation needs. Procurement of cold chain equipment and maintenance activities are needed to ensure quality of immunizations | 211435 |
| | | 1023683 | 308115 | | | 1314814 |

## 9.6. Planned HSS activities for 2014

Please use **Table 9.6** to outline planned activities for 2014. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval the revised budget and activities.

**Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval with the evidence for requested changes**

**Table 9.6:** Planned HSS Activities for 2014

| **Major Activities** (insert as many rows as necessary) | **Planned Activity for 2014** | **Original budget for 2014** (as approved in the HSS proposal or as adjusted during past annual progress reviews) | **Revised activity** (if relevant) | **Explanation for proposed changes to activities or budget** (if relevant) | **Revised budget for 2014** (if relevant) |
|---|---|---|---|---|---|
| **.1 Service delivery contracts** | Establish and implement annual operational plans and performance based contracts (PBC) at health facility level | 462030 | Same as 2013 | Same as 2013 | 427,650 |
| **1.2 Management contracts** | Establish and implement annual operational plans and performance based management agreements (PBMA) with ODs and Provinces | 136220 | Same as 2013 | Same as 2013 | 235,600 |
| **1.3 Coverage improvement planning (CIP)** | Integrating immunization coverage improvement planning into MPA planning system to improve overall MCH | 50000 | Reprogramming is planned for 2014 based on review in 2013 | | 0 |
| **1.4 Fixed site strategy** | Implement, evaluate, and scale up fixed site strategy to improve immunization coverage through increased health center utilization OBJECTIVE 2: DEVELOPING AND STRENGTHENING MPA MANAGEMENT SYSTEMS Develop MPA financial management system, health financing guidelines, and monitoring effective implementation | 25000 | Reprogramming is planned for 2014 based on review in 2013 | | 38,792 |
| **2.1 Financial management system development** | Develop MPA financial management system, health financing guidelines, and monitoring effective implementation | 10000 | Reprogramming is planned for 2014 based on review in 2013 | | 15,000 |

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| **2.2 Health planning systems** | Strengthening MPA planning at OD and health centers through AOP integration | 45000 | Reprogramming is planned for 2014 based on review in 2013 | | 110,589 |
| **2.3 Supervision systems** | Strengthening integrated supportive supervision from central to PHD, PHD to OD and OD the health facility level through interdepartmental monitoring | 69776 | Reprogramming is planned for 2014 based on review in 2013 | | 51,999 |
| **2.4 Health systems operations research** | Conducting research to support decision making for strengthening demand and delivery of MPA services | 20000 | Reprogramming is planned for 2014 based on review in 2013 | | 20,000 |
| **3.1 Strengthening capacity of middle level management** | Strengthening financial, planning, management and monitoring capacities of middle level management at OD, and health facility level through development of guidelines, trainings and supportive supervision | 50000 | Reprogramming is planned for 2014 based on review in 2013 | | 123,749 |
| **3.2 Child survival monitoring** | Strengthening systems for child survival scorecard monitoring through Provincial Health committees, interdepartmental monitoring team, and inclusion of score card monitoring in AOP. | 0 | Reprogramming is planned for 2014 based on review in 2013 | | 0 |
| **3.3 Service delivery of IMCI** | Strengthening capacity of IMCI service delivery to improve immunization and overall MCH through trainings of health center and OD staff and supportive supervision | 0 | Reprogramming is planned for 2014 based on review in 2013 | | 60,000 |

| | | | | | |
|---|---|---|---|---|---|
| **3.4 Private sector collaboration** | Scaling up and evaluating public/private collaboration to improve quality of immunizations and eventually MCH services in private sector | 10000 | Reprogramming is planned for 2014 based on review in 2013 | | 20,000 |
| **3.5 Project management** | Support activities to ensure effective implementation of grant activities to reach planned targets. | 64301 | Reprogramming is planned for 2014 based on review in 2013 | | 211,435 |
| | | 942327 | | | |

## 9.7. Revised indicators in case of reprogramming

Countries planning to submit reprogramming requests may do so any time of the year. Please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org

## 9.8. Other sources of funding for HSS

If other donors are contributing to the achievement of the country's objectives as outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:

Table 9.8: Sources of HSS funds in your country

| Donor | Amount in US$ | Duration of support | Type of activities funded |
|---|---|---|---|
| Royal Government of Cambodia | 20500000 | 2012-2015 | The Ministry of Health budget for Program 4 Health Sector Strengthening in the Health Strategic Plan has allocated budget for the following linked inputs:<br>4.1 Services delivery<br>4.2 Health care financing<br>4.3 Human resources development<br>4.4 Health information<br>4.5 Supportive supervision/monitoring |
| Global Fund for HIV, Malaria and TB | 7968903 | 2013 - 2015 | Activities are geared to two objectives, increasing demand for health services at the community level and improving quality of maternal health services at health centers. Specific activities include technical and management support to health centers and commune meetings with VHSGs through trainings, supportive supervision visits and incentives (not currently active since POC abolished). Budget presented includes entities implementing these activities, NGOs: CARE, CRS, HACC< KHANA, MEDICAM and Government: NMCHC, DPHI |

| | | | |
|---|---|---|---|
| Second Health Sector Support Program | 149671414 | 2009-2013 | The Second Health Sector Support Program (HSSP2) operates across 21 of the 24 Provinces in Cambodia, which contracts Operational Districts as “special operating agencies” or SOAs. However, none of the 10 GAVI HSS funds is and SOA. HSSP2 program involves infrastructure development, capacity building programs and extension of health contracting and health equity fund schemes. The activities are linked to HSS GVI goals and objectives, with all inputs coordinated through the annual operational planning system of the Ministry of Health. There are 2 ODs under HSSP2 that have reproductive health equity funds supported through HSSP 2, and some of the 10 ODs have had infrastructure investment support under HSSP2. |

9.8.1. Is GAVI’s HSS support reported on the national health sector budget? **No**

## 9.9. Reporting on the HSS grant

9.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 9.9: Data sources

| Data sources used in this report | How information was validated | Problems experienced, if any |
|---|---|---|
| Financial records, Department of Budget and Finance, MoH | Financial data was obtained from DBF who manages the HSS GAVI grant. These data have been crosschecked and validated against supporting documents with appropriate reporting units. | The 2011 and previous external audits have outlined certain risks and issues with data validity. These audit reports with planned resolutions have been included in previous APRs. The 2012 audit report will be available and uploaded to GAVI APR portal end of June 2013. |

| | | |
|---|---|---|
| National Health Information System, Department of Planning and Health Information, MoH | Data quality assurance has become increasingly important in Cambodian's health system as the Annual Operational Plans (AOP) rely on National HIS (NHIS) data for situational analysis. Incorrect data could lead to inappropriate planning. There are a number of internal established measures from facility to central level that assess and validate indicator data that are drawn from the NHIS.<br>NHIS is managed by DPHI who implement a Data Quality Audit System (DQAS) (see Attachment "DQA Final Report"). The DQAS uses a set of tools that validates reported data down to the service delivery level. The DQA exercise is part of the routine monitoring activities of DPHI, a portion of which is funded under GAVI HSS for the 10 high risk ODs.<br>At all levels, from health center to central, indicator data reported to NHIS are reviewed on quarterly basis to determine progress as outlined in AOP. This exercise serves to question and validate the data. In addition, at the central level, data is validated through consultative review as part of the Joint Annual Program Review (JAPR), which takes place on yearly basis as part of the overall National AOP process. During the JAPR, data is triangulated across different sources and official values are derived through consensus. These data values are published yearly for public access and placed on the public website for access by programs and relevant partners.<br>Beyond internal routine DQA processes, several data assessments have been conducted to inform quality of data.<br>An external assessment of health facility data quality was undertaken in 2011 by WHO. The assessment was mainly focused on immunization coverage data. Significant positive findings included:<br>• Completeness of reporting: excellent; 99.8% of facilities submitted monthly reports for the year and there were no missing/zero values at the provincial and district level for four tracer indicators (Antenatal care second visit–ANC2–, measles immunization, institutional deliveries, and outpatient department – OPD–).<br>• Internal consistency of the reported data: extreme outlying values from provinces were very rare, consistency over time was good, consistency between ANC1 and DTP1 was good, only 25% of provinces had DTP3 reported higher than DTP1<br>An internal DQA was conducted for the assessment of performance in the 24 provinces. Overall positive findings showed:<br>• Registers, case definitions, tally sheets, etc. filled as per MoH guidelines<br>• 93% validity in random selection of health centers in their reported number of cases for non-immunization indicators such as ANC monitored under GAVI HSS. | No major issues were experienced in obtaining the data. However it is important to note there are known risks to the validity of data. These issues have been highlighted in the assessments and may also be reflected in the inconsistent trends observed as described in Section 4.1.<br>One of the most common issues and most difficult to resolve is the "denominator" issue. At the district level it is difficult to reconcile denominators (population sizes) due to different categorizations of Operational Districts under MoH and Administrative Districts under other Ministries, which also provide such population statistics. Several reviews have suggested that OD figures underestimate the denominators for immunization indicators (child populations) and would hence overestimate the indicator coverage.<br>In addition, the past annual external program audits on GAVI HSS found that consistency across different sources of reported immunization data (registers versus quarterly reports, versus tally sheets, etc.) to be highly variable across health centers and ODs. This variation in quality may explain some of the unexpected trends described in section 4.1 and 4.2.<br>The external WHO 2011 assessment found:<br>• Consistency of population denominators: fair, but varies highly across provinces; the survey findings however suggest that the national population denominators for diphtheria-tetanus-pertussis vaccine (DTP) is too low, especially for Phnom Penh<br>• External comparison of coverage rates: poor correspondence; coverage of measles immunization based on facility reporting were much higher than that from the survey data, with some provinces having greater differences.<br>. The internal DQA report found:<br>• Cases reported that did not actually exist, which constituted 67% of unverified cases |

9.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

There were some challenges faced during the development of theAPR for GAVI HSS activities.

1. Loss of grant historical information: in the past there hasalways been a dedicated focal point to coordinate and manage the differentunits as well as monitoring and reporting activities under the HSS GAVI, while the financial management has been under DBF. However, over the last 6 months, this position has been vacant and some of the institutional history of the grant, particularly for non-financial issues, has been lost. Since the development of the 2012 APR was under the leadership of the Grant Manager and responsibility of DBF, there were some gaps in availability of non-financial information, such as which indicators and targets of the M&E Framework werethe most recent, as there was inconsistency across different GAVI documents. While the grant team recognizes areas of improvement for ensuring continuity if there is staff turnover, it is hoped that the GAVI country team would be able to serve as a backup reference ongrant information when such incidents occur.

2. The APR form can be quite repetitive and several tables could be condensed into one table (eg. Table 9.2 and 9.2.1 or 9.3.1 and 9.8.1).

3. A number of challenges with the online system including inability to login if own a MAC as system does notwork on Safari, being booted out during data entry, difficulty saving dataentered, challenges by staff during initial attempts to login. Overall the online system presents technical challenges, especially if internet connectivity and speed are sub-optimal.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2012?2

Please attach:

1. The minutes from the HSCC meetings in 2013 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

# 10. Strengthened Involvement of Civil Society Organisations (CSOs) : Type A and Type B

## 10.1. TYPE A: Support to strengthen coordination and representation of CSOs

Cambodia **has NOT received GAVI TYPE A CSO support**

Cambodia is not reporting on GAVI TYPE A CSO support for 2012

## 10.2. TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP

Cambodia **has NOT received GAVI TYPE B CSO support**

Cambodia is not reporting on GAVI TYPE B CSO support for 2012

## 11. Comments from ICC/HSCC Chairs

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review. These could be in addition to the approved minutes, which should be included in the attachments

# 12. Annexes

## 12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS **FOR IMMUNISATION SERVICES SUPPORT (ISS)** AND **NEW VACCINE INTRODUCTION GRANTS**

I. All countries that have received ISS /new vaccine introduction grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2012, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, based on ***your government's own system of economic classification.*** This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2012 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2012 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

## 12.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR **ISS** AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS 1

*An example statement of income & expenditure*

| **Summary of income and expenditure – GAVI ISS** | | |
|---|---|---|
| | **Local currency (CFA)** | **Value in USD *** |
| **Balance brought forward from 2011** (balance as of *31Decembre 2011*) | 25,392,830 | 53,000 |
| **Summary of income received during 2012** | | |
| Income received from GAVI | 57,493,200 | 120,000 |
| Income from interest | 7,665,760 | 16,000 |
| Other income (fees) | 179,666 | 375 |
| **Total Income** | 38,987,576 | 81,375 |
| **Total expenditure during 2012** | 30,592,132 | 63,852 |
| **Balance as of 31 December 2012** (balance carried forward to 2013) | 60,139,325 | 125,523 |

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

| **Detailed analysis of expenditure by economic classification ** – GAVI ISS** | | | | | | |
|---|---|---|---|---|---|---|
| | **Budget in CFA** | **Budget in USD** | **Actual in CFA** | **Actual in USD** | **Variance in CFA** | **Variance in USD** |
| **Salary expenditure** | | | | | | |
| Wedges & salaries | 2,000,000 | 4,174 | 0 | 0 | 2,000,000 | 4,174 |
| Per diem payments | 9,000,000 | 18,785 | 6,150,000 | 12,836 | 2,850,000 | 5,949 |
| **Non-salary expenditure** | | | | | | |
| Training | 13,000,000 | 27,134 | 12,650,000 | 26,403 | 350,000 | 731 |
| Fuel | 3,000,000 | 6,262 | 4,000,000 | 8,349 | -1,000,000 | -2,087 |
| Maintenance & overheads | 2,500,000 | 5,218 | 1,000,000 | 2,087 | 1,500,000 | 3,131 |
| **Other expenditures** | | | | | | |
| Vehicles | 12,500,000 | 26,090 | 6,792,132 | 14,177 | 5,707,868 | 11,913 |
| **TOTALS FOR 2012** | 42,000,000 | 87,663 | 30,592,132 | 63,852 | 11,407,868 | 23,811 |

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

## 12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I. All countries that have received HSS grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2012, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, based on your government's own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2012 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2012 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

## 12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

*An example statement of income & expenditure*

| **Summary of income and expenditure – GAVI HSS** | | |
|---|---|---|
| | **Local currency (CFA)** | **Value in USD *** |
| **Balance brought forward from 2011** (balance as of *31Decembre 2011*) | 25,392,830 | 53,000 |
| **Summary of income received during 2012** | | |
| Income received from GAVI | 57,493,200 | 120,000 |
| Income from interest | 7,665,760 | 16,000 |
| Other income (fees) | 179,666 | 375 |
| **Total Income** | 38,987,576 | 81,375 |
| **Total expenditure during 2012** | 30,592,132 | 63,852 |
| **Balance as of 31 December 2012** (balance carried forward to 2013) | 60,139,325 | 125,523 |

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

| **Detailed analysis of expenditure by economic classification ** - GAVI HSS** | | | | | | |
|---|---|---|---|---|---|---|
| | **Budget in CFA** | **Budget in USD** | **Actual in CFA** | **Actual in USD** | **Variance in CFA** | **Variance in USD** |
| **Salary expenditure** | | | | | | |
| Wedges & salaries | 2,000,000 | 4,174 | 0 | 0 | 2,000,000 | 4,174 |
| Per diem payments | 9,000,000 | 18,785 | 6,150,000 | 12,836 | 2,850,000 | 5,949 |
| **Non-salary expenditure** | | | | | | |
| Training | 13,000,000 | 27,134 | 12,650,000 | 26,403 | 350,000 | 731 |
| Fuel | 3,000,000 | 6,262 | 4,000,000 | 8,349 | -1,000,000 | -2,087 |
| Maintenance & overheads | 2,500,000 | 5,218 | 1,000,000 | 2,087 | 1,500,000 | 3,131 |
| **Other expenditures** | | | | | | |
| Vehicles | 12,500,000 | 26,090 | 6,792,132 | 14,177 | 5,707,868 | 11,913 |
| **TOTALS FOR 2012** | 42,000,000 | 87,663 | 30,592,132 | 63,852 | 11,407,868 | 23,811 |

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

## 12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **CIVIL SOCIETY ORGANISATION (CSO)** TYPE B

I. All countries that have received CSO 'Type B' grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2012, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2012 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2012 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

## 12.6. Annex 6 – Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR **CSO 'Type B'** FINANCIAL STATEMENTS

*An example statement of income & expenditure*

| **Summary of income and expenditure – GAVI CSO** | | |
|---|---|---|
| | **Local currency (CFA)** | **Value in USD *** |
| **Balance brought forward from 2011** (balance as of *31Decembre 2011*) | 25,392,830 | 53,000 |
| **Summary of income received during 2012** | | |
| Income received from GAVI | 57,493,200 | 120,000 |
| Income from interest | 7,665,760 | 16,000 |
| Other income (fees) | 179,666 | 375 |
| **Total Income** | 38,987,576 | 81,375 |
| **Total expenditure during 2012** | 30,592,132 | 63,852 |
| **Balance as of 31 December 2012** (balance carried forward to 2013) | 60,139,325 | 125,523 |

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

| **Detailed analysis of expenditure by economic classification ** - GAVI CSO** | | | | | | |
|---|---|---|---|---|---|---|
| | **Budget in CFA** | **Budget in USD** | **Actual in CFA** | **Actual in USD** | **Variance in CFA** | **Variance in USD** |
| **Salary expenditure** | | | | | | |
| Wedges & salaries | 2,000,000 | 4,174 | 0 | 0 | 2,000,000 | 4,174 |
| Per diem payments | 9,000,000 | 18,785 | 6,150,000 | 12,836 | 2,850,000 | 5,949 |
| **Non-salary expenditure** | | | | | | |
| Training | 13,000,000 | 27,134 | 12,650,000 | 26,403 | 350,000 | 731 |
| Fuel | 3,000,000 | 6,262 | 4,000,000 | 8,349 | -1,000,000 | -2,087 |
| Maintenance & overheads | 2,500,000 | 5,218 | 1,000,000 | 2,087 | 1,500,000 | 3,131 |
| **Other expenditures** | | | | | | |
| Vehicles | 12,500,000 | 26,090 | 6,792,132 | 14,177 | 5,707,868 | 11,913 |
| **TOTALS FOR 2012** | 42,000,000 | 87,663 | 30,592,132 | 63,852 | 11,407,868 | 23,811 |

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

## 13. Attachments

| Document Number | Document | Section | Mandatory | File |
|---|---|---|---|---|
| 1 | Signature of Minister of Health (or delegated authority) | 2.1 | ✓ | GAVI APR 2013 Signatures.pdf<br>File desc:<br>Date/time: 5/21/2013 3:43:57 AM<br>Size: 17127 |
| 2 | Signature of Minister of Finance (or delegated authority) | 2.1 | ✓ | GAVI APR 2013 Signatures.pdf<br>File desc:<br>Date/time: 5/21/2013 3:44:15 AM<br>Size: 17127 |
| 3 | Signatures of members of ICC | 2.2 | ✓ | TWGH Participants Signatures for APR 2012.pdf<br>File desc:<br>Date/time: 5/2/2013 10:35:23 PM<br>Size: 2015110 |
| 4 | Minutes of ICC meeting in 2013 endorsing the APR 2012 | 5.7 | ✓ | Minutes for TWGH meeting - April 11 2013.doc<br>File desc:<br>Date/time: 5/2/2013 10:37:44 PM<br>Size: 203264 |
| 5 | Signatures of members of HSCC | 2.3 | ✗ | HSCC Update.pdf<br>File desc:<br>Date/time: 5/8/2013 6:18:59 AM<br>Size: 26507 |
| 6 | Minutes of HSCC meeting in 2013 endorsing the APR 2012 | 9.9.3 | ✓ | HSCC Update.pdf<br>File desc:<br>Date/time: 5/8/2013 6:19:13 AM<br>Size: 26507 |
| 7 | Financial statement for ISS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health | 6.2.1 | ✗ | Financial Statement ISS Funds 2012.jpg<br>File desc:<br>Date/time: 4/23/2013 11:06:33 PM<br>Size: 144642 |
| 8 | External audit report for ISS grant (Fiscal Year 2012) | 6.2.3 | ✗ | External Audit Explanation.pdf<br>File desc:<br>Date/time: 4/30/2013 11:11:09 PM<br>Size: 14514 |
| 9 | Post Introduction Evaluation Report | 7.2.2 | ✓ | Penta Vaccine PIE August 2011 - Cambodia.pdf<br>File desc:<br>Date/time: 3/27/2013 8:50:42 PM<br>Size: 73103 |

| | | | | |
|---|---|---|---|---|
| 10 | Financial statement for NVS introduction grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health | 7.3.1 | ✓ | Financial Statement VIG 2012.jpg<br>File desc:<br>Date/time: 4/23/2013 11:14:55 PM<br>Size: 209074 |
| 11 | External audit report for NVS introduction grant (Fiscal year 2012) if total expenditures in 2012 is greater than US$ 250,000 | 7.3.1 | ✓ | External Audit Explanation.pdf<br>File desc:<br>Date/time: 4/30/2013 11:11:52 PM<br>Size: 14514 |
| 12 | Latest EVSM/VMA/EVM report | 7.5 | ✓ | EVM_report-Cambodia - July 2012 Update.pdf<br>File desc:<br>Date/time: 3/27/2013 8:55:22 PM<br>Size: 1959094 |
| 13 | Latest EVSM/VMA/EVM improvement plan | 7.5 | ✓ | EVM-imp-plan-Cambodia-2012 - Final.pdf<br>File desc:<br>Date/time: 3/27/2013 8:56:12 PM<br>Size: 8128 |
| 14 | EVSM/VMA/EVM improvement plan implementation status | 7.5 | ✓ | EVM Improvement Plan Progress Report 2012.pdf<br>File desc:<br>Date/time: 4/23/2013 11:18:27 PM<br>Size: 316502 |
| 19 | Financial statement for HSS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health | 9.1.3 | ✗ | HSS_2012_Financial_Statement.pdf<br>File desc:<br>Date/time: 5/16/2013 4:55:20 PM<br>Size: 2726918 |
| 20 | Financial statement for HSS grant for January-April 2013 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health | 9.1.3 | ✗ | HSS_Q1_2013_Financial_Statement.pdf<br>File desc:<br>Date/time: 5/16/2013 4:58:27 PM<br>Size: 1878056 |
| 21 | External audit report for HSS grant (Fiscal Year 2012) | 9.1.3 | ✗ | External Audit Explanation.pdf<br>File desc:<br>Date/time: 5/21/2013 3:46:32 AM<br>Size: 14514 |
| | | | | IFAPER Cambodia Dec 11_Chapter_4_HSS_review.pdf |

| | | | | |
|---|---|---|---|---|
| 22 | HSS Health Sector review report | 9.9.3 | ✗ | File desc: MId-term Review of HSSP 2 is currently taking place. Latest related health sector review can be found in Chapter 4 of World Bank 2011 Public Expenditure Review.<br>Date/time: 5/17/2013 6:48:53 AM<br>Size: 2503471 |
| 26 | Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2012 on (i) 1st January 2012 and (ii) 31st December 2012 | 0 | ✓ | Statement of Account 01 Dec 12 to 01 Jan 13.pdf<br>File desc: Consolidated bank statements for all existing cash programs<br>Date/time: 5/17/2013 6:37:52 AM<br>Size: 408132 |