GAVI Alliance

Annual Progress Report 2013

Submitted by

The Government of

Cambodia

Reporting on year: **2013**

Requesting for support year: **2015**

Date of submission: **17/05/2014**

Deadline for submission: 22/05/2014

Please submit the APR 2013 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: **2013**

Requesting for support year: **2015**

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
Preventive Campaign Support	MR, 10 dose(s) per vial, LYOPHILISED	MR, 10 dose(s) per vial, LYOPHILISED	2013
Routine New Vaccines Support	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	2015

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 2013	Request for Approval of	Eligible For 2013 ISS reward
ISS	Yes	next tranche: N/A	Yes
HSS	Yes	next tranche of HSS Grant Yes	N/A
VIG	Yes	Not applicable	N/A
COS	Yes	Not applicable	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2012 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 BUNHENG	**Name**	H.E. Dr. AUN PORN MONIROTH
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 THE 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 LIST IN ATTACHMENT NO. xx	FULL LIST PROVIDED IN ATTACHMENT NO. xx		

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 06 March, 2014. Note that the Technical Working Group for Health 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), N/A , 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 the HSCC functions are performed by the Technical Working Group for Health, formal communication of this change was provided to GAVI in 2013.

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 2014

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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)			
	2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2013	Current estimation
Total births	354,407	354,614	350,142	350,142	343,968	343,968
Total infants' deaths	0	0	0	0	0	0
Total surviving infants	354407	354,614	350,142	350,142	343,968	343,968
Total pregnant women	354,407	383,043	350,142	350,142	343,968	343,968
Number of infants vaccinated (to be vaccinated) with BCG	354,407	328,373	350,142	350,142	343,968	343,968
BCG coverage	100 %	93 %	100 %	100 %	100 %	100 %
Number of infants vaccinated (to be vaccinated) with OPV3	336,496	273,306	332,634	332,634	326,769	326,769
OPV3 coverage	95 %	77 %	95 %	95 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with DTP1	340,230	338,160	336,136	336,136	330,209	330,209
Number of infants vaccinated (to be vaccinated) with DTP3	336,496	326,716	332,634	332,634	326,769	326,769
DTP3 coverage	95 %	92 %	95 %	95 %	95 %	95 %
Wastage*[1]* rate in base-year and planned thereafter (%) for DTP	5	2	5	5	5	5
Wastage*[1]* factor in base-year and planned thereafter for DTP	1.05	1.02	1.05	1.05	1.05	1.05
Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib	377,302	338,160	336,136	336,136	330,209	330,209
Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib	377,302	326,716	336,136	336,136	326,769	326,769
DTP-HepB-Hib coverage	106 %	92 %	96 %	96 %	95 %	95 %
Wastage*[1]* rate in base-year and planned thereafter (%)	5	2	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
Maximum wastage rate value for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	5 %	5 %	5 %	5 %	5 %	5 %
Number of infants vaccinated (to be vaccinated) with 1 dose of Pneumococcal (PCV13)		0		0	330,209	330,209
Number of infants vaccinated (to be vaccinated) with 3 dose of Pneumococcal (PCV13)		0		0	326,769	326,769

Pneumococcal (PCV13) coverage		0 %		0 %	95 %	95 %
Wastage*[1]* rate in base-year and planned thereafter (%)		0		0	5	5
Wastage*[1]* factor in base-year and planned thereafter (%)		1		1	1.05	1.05
Maximum wastage rate value for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	0 %	5 %	0 %	5 %	5 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	377,302	320,013	332,634	332,634	326,769	326,769
Number of infants vaccinated (to be vaccinated) with 2nd dose of Measles	336,496	225,087	332,634	332,634	326,769	326,769
Measles coverage	95 %	63 %	95 %	95 %	95 %	95 %
Wastage*[1]* rate in base-year and planned thereafter (%) *{0}*	50	40	40	40	50	40
Wastage*[1]* factor in base-year and planned thereafter (%)	2	1.67	1.67	1.67	2	1.67
Maximum wastage rate value for Measles second dose, 10 dose(s) per vial, LYOPHILISED	40.00 %	40.00 %	40.00 %	40.00 %	50.00 %	40.00 %
Pregnant women vaccinated with TT+	318,966	215,796	315,127	315,127	309,571	309,571
TT+ coverage	90 %	56 %	90 %	90 %	90 %	90 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0	0	0
Vit A supplement to infants after 6 months	0	0	0	0	0	0
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	1 %	3 %	1 %	1 %	1 %	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 2013 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2013.** The numbers for 2014 - 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 2014 and 2015 are consistent with the latest census projections (Census Report Number 12 - January 2011, National Institute of Statistics) and is provided as an attachment. Target populations for 2013 and birth estimates for 2014 and 2015 are also consistent with that reported to WHO/UNICEF in the 2013 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 2013

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 2013 and how these were addressed:

The DTP-HepB-Hib3 (Penta3) coverage target of 95% in 2013 was not fully achieved, with final coverage of 92% reported, which the National Immunization Program still considers a commendable result, and reflects the incremental challenges of reaching those most remote and socially and economically isolated communities. The MR SIA and the focus of implementing this in the final quarter of 2013 is also considered to have reduced final coverage figures for 2013, as the final quarter of each year is traditionally used as a time for catch up coverage of routine immunization. Despite not meeting full coverage targets with DTP3, the high level of equity in immunization coverage in Cambodia, with 62 out of 80 districts (78%) reporting Penta3 coverage of greater than 80%, and only one district reporting Penta3 coverage of less than 50% should been seen as a positive indicator of the performance of EPI service delivery in 2013.

While coverage of measles first dose is high (90%), measles 2nd dose coverage is significantly less (64%) and reflects different challenges of reaching children in their 2nd year of life with immunization services, and ensuring high awareness of the population, especially mothers of the need for them to bring their child to health centres in the 2nd year of life. This issue will be a key theme of the Measles 2nd Dose Post Introduction Evaluation that will be conducted in mid 2014 and will develop strategies and recommendations to address this issue and ensure that measles 2nd dose coverage tracks upwards.

Key achievements for the immunization program in 2013 include:

1. The country continues to remain free of measles virus, with the last case reported in November 2011. Cambodia is on track to achieve measles elimination in late 2014 or early 2015.
2. Rubella vaccine, as MR was introduced in late 2013 with a large SIA conducted that vaccinated over 4.5 million children, the largest public health intervention in Cambodia's history
3. Cambodia successfully hosted the GAVI Board meeting in November 2013, which was opened by the

Prime Minister of Cambodia and has greatly increased the visibility and success of the immunization program in this country.

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

DTP3 coverage has been addressed above.

Cambodia experienced stock outages of Government procured vaccines in 2013, namely BCG, HepB birth dose and OPV vaccines, due to complexities with the need for prepayment of vaccines orders to UNICEF and the timely release of funds by the Ministry of Economy and Finance. This appears to have mostly affected OPV3 coverage in 2013, which is lower than in previous years. At present these issues appear to be resolved.

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 2013 will only be available in July 2014 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2012 to the present? **Yes**

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

Assessment of health facility data quality: Data quality report card – Cambodia, 2012 conducted by WHO Geneva in 2013

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2011 to the present.

WHO undertook an assessment of health facility data quality in 2011 and 2012 and are attached to this report.

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 2013**	**Source of funding**						
		Country	**GAVI**	**UNICEF**	**WHO**	**GAVI HSS**	**N/A**	**N/A**
Traditional Vaccines*	1,355,102	1,315,472	0	0	39,630	0	0	0
New and underused Vaccines**	6,975,853	681,818	6,294,035	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	1,907,131	1,493,563	413,568	0	0	0	0	0
Cold Chain equipment	0	0	0	0	0	0	0	0
Personnel	40,558	20,158	20,400	0	0	0	0	0
Other routine recurrent costs	752,524	258,670	35,703	31,014	134,000	293,137	0	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	3,206,973	0	2,818,301	107,346	232,000	49,326	0	0
N/A		0	0	0	0	0	0	0
Total Expenditures for Immunisation	14,238,141							
Total Government Health		3,769,681	9,582,007	138,360	405,630	342,463	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 2014 and 2015

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?
Planning, Budgeting and Coordination: 3 action points, all implemented	Yes
Budget Execution: 4 action points, all implemented	Yes
Procurement: 4 action points, three points implemented one outstanding to be implemented in 2014	No
Accounting and Reporting: 8 action points, all implemented	Yes
Internal Audit: 1 action point, all implemented	Yes
External Audit: 5 action points, all implemented	Yes
Bank Accounts for the Management of GAVI HSS and ISS Funds: 2 action points, all implemented	Yes
Compliance with GAVI's Grant Terms and Conditions: 2 action points, all implemented	Yes

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

A total of 34 points are detailed in the Aid Memoire, of these 29 are action points to be implemented. The 29 action points to be implemented are ordered into eight sections as detailed above. In 2013 all but one action point was implemented.

The outstanding action point not implemented in 2013 is point 16 in the procurement section of the Aid Memorie, it states:
16. An APP shall be prepared on the basis of the AWPB's.

This action point could not be implemented in 2013 due to timing, as this relates to the Annual Operational Planning (AOP) process which had already passed. This action point will be implemented in 2014.

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 2013? **12**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2014 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

TWGH met on the 06 March to review the GAVI support for 2013 and endorse the report. Meeting minutes and list of participants attached.

EPI was discussed as a topic at TWGH meeting X times. Copies of the minutes of these meetings are attached.

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

If Yes, which ones?

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

5.8. Priority actions in 2014 to 2015

What are the country's main objectives and priority actions for its EPI programme for 2014 to 2015

1. To achieve measles and MNTE elimination validation in 2014.

2. To expand the NIP high risk community strategy throughout Cambodia linked to measles 2nd dose and ensure continued improvement in measles 2nd dose coverage

3. To successfully introduce PCV13 and IPV(single dose) vaccine in 2015

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

5. To update the cMYP in 2014 that includes a long term plan for new vaccine introduction (HPV, rotavirus, JE) in line with the overall objections and focuses of the next Health Sector Plan 3 (2016-2020)

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 2013

Vaccine	Types of syringe used in 2013 routine EPI	Funding sources of 2013
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 2013 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 2013

	Amount US$	Amount local currency
Funds received during 2013 *(A)*	0	0
Remaining funds (carry over) from 2012 *(B)*	312,081	312,081
Total funds available in 2013 *(C=A+B)*	312,081	312,081
Total Expenditures in 2013 *(D)*	69,000	69,000
Balance carried over to 2014 *(E=C-D)*	243,081	243,081

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.

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 2013

- Coverage Improvement Planning (CIP) for additional immunization rounds in high risk areas/communities
- Fixed Site Immunization meetings between health centre staff & Village Health Support Groups
- Supervision by National/Provincial staff of immunization performance at the health centre level

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 2013 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2013 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

Request for ISS reward achievement in 2013 is applicable for Cambodia

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

7.1. Receipt of new & under-used vaccines for 2013 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2013 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2013 vaccinations against approvals for 2013

	[A]	[B]		
Vaccine type	**Total doses for 2013 in Decision Letter**	**Total doses received by 31 December 2013**	**Total doses of postponed deliveries in 2013**	**Did the country experience any stockouts at any level in 2013?**
DTP-HepB-Hib	1,195,400	1,195,400	0	No
Measles	759,000	759,000	0	No
Pneumococcal (PCV13)		0	0	No

**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? ...)

  N/A

- 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 2013

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2013, 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	01/01/2010
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	02/01/2012
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	

Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID		
Phased introduction	No	
Nationwide introduction	Yes	01/01/2015
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? **July 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))

N/A

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? **No**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **No**

Does your country conduct special studies around:

a. rotavirus diarrhea? **No**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **No**

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? **No**

Do you plan to use these sentinel surveillance and/or special studies data to monitor and evaluate the impact of vaccine introduction and use? **Yes**

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

Cambodia currently conducts sentinel surveillance for rotavirus disease at the National Pediatric Hospital in Phnom Penh, in collaboration with WHO. These results (including the genotyping of rotavirus) are being used to gain further visibility of the impact of rotavirus disease in Cambodia and prepare the case for vaccine introduction. This will be further explored during the updating of the cMYP in 2014 and reported to the TWGH.

7.3. New Vaccine Introduction Grant lump sums 2013

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2013 (A)	298,500	298,500
Remaining funds (carry over) from 2012 (B)	70,690	70,690
Total funds available in 2013 (C=A+B)	369,190	369,190
Total Expenditures in 2013 (D)	43,743	43,743
Balance carried over to 2014 (E=C-D)	325,447	325,447

Detailed expenditure of New Vaccines Introduction Grant funds during the 2013 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2013 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

Development and printing of guidelines for MR vaccine introduction
Training activities for national, provincial, district and health centre staff on MR vaccine
General Training on Immunization for new health staffs
Surveillance and Investigation of Measles and Rubella cases

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 2014 onwards

Further supervision of MR vaccine introduction, especially in high risk communities where coverage is lowest.

7.4. Report on country co-financing in 2013

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2013?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID		
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED	0	0
Awarded Vaccine #3: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID		
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2013 from the following sources?	
Government	100%	
Donor	0	
Other	0	
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ 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		
Awarded Vaccine #3: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID		
	Q.4: When do you intend to transfer funds for co-financing in 2015 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2015	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	September	Government Budget
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED	September	GAVI
Awarded Vaccine #3: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID		
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	N/A	

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? **February 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? **February 2015**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2013

7.6.1. Vaccine Delivery

Did you receive the approved amount of vaccine doses for MR Preventive Campaigns that GAVI communicated to you in its Decision Letter (DL)?

[A]	[B]	[C]
Total doses approved in DL	**Campaign start date**	**Total doses received (Please enter the arrival dates of each shipment and the number of doses of each shipment)**
5884800	21/10/2013	12 Oct - 1,806,000 doses, 26 October - 2,577,600 doses, 14 Nov - 1,461,200

If numbers [A] and [C] above are different, what were the main problems encountered, if any?

N/A

If the date(s) indicated in [C] are after [B] the campaign dates, what were the main problems encountered? What actions did you take to ensure the campaign was conducted as planned?

Over 5.8 million doses of MR vaccine from Serum Institute of India (SII) were supplied to Cambodia and received over three batches of shipment. Originally the SIA was scheduled to start on 16 October 2013 but due to delay in receiving the vaccines, the SIA was postponed to 21 October (the first batch of vaccine that contained 1.8 million doses arrived in country on 12 October), second batch (2.6 million doses) arrived on 26 October and the third batch (1.5 million doses) arrived on 14 November 2013.

7.6.2. Programmatic Results of MR preventive campaigns

Geographical Area covered	Time period of the campaign	Total number of Target population	Achievement, i.e., vaccinated population	Administrative Coverage (%)	Survey Coverage (%)	Wastage rates	Total number of AEFI	Number of AEFI attributed to MenA vaccine

National	Oct to Dec 2013	4345392	4576633	105	0	3	0	0

*If no survey is conducted, please provide estimated coverage by indepenent monitors

Has the campaign been conducted according to the plans in the approved proposal?” **Yes**

If the implementation deviates from the plans described in the approved proposal, please describe the reason.

no

Has the campaign outcome met the target described in the approved proposal? (did not meet the target/exceed the target/met the target) If you did not meet/exceed the target, what have been the underlying reasons on this (under/over) achievement?

yes, pleas see detailed MR SIA report as an attachment

What lessons have you learned from the campaign?

please see detailed MR SIA report as an attachment

7.6.3. Fund utilsation of operational cost of MR preventive campaigns

Category	Expenditure in Local currency	Expenditure in USD
see full expenditure in MR SIA Report attached	2818301	2818301
Total	**2818301**	**2818301**

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 2014

Renewal of multi-year vaccines support for Cambodia is not available in 2014

7.9. Request for continued support for vaccines for 2015 vaccination programme

In order to request NVS support for 2015 vaccination do the following

Confirm here below that your request for 2015 vaccines support is as per 7.11 Calculation of requirements
Yes

If you don’t confirm, please explain

N/A

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply are not disclosed

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes	No Threshold	200,000$		250,000$	
			<=	>	<=	>
DTP-HepB	HEPBHIB	2.00 %				
HPV bivalent	HPV	3.50 %				
HPV quadrivalent	HPV	3.50 %				
Measles second dose	MEASLES	14.00 %				
Meningococcal type A	MENINACONJUGATE	10.20 %				
MR	MR	13.20 %				
Pneumococcal (PCV10)	PNEUMO	3.00 %				
Pneumococcal (PCV13)	PNEUMO	6.00 %				
Rotavirus	ROTA	5.00 %				
Yellow Fever	YF	7.80 %				

Vaccine Antigens	VaccineTypes	500,000$		2,000,000$	
		<=	>	<=	>
DTP-HepB	HEPBHIB				
DTP-HepB-Hib	HEPBHIB	25.50 %	6.40 %		
HPV bivalent	HPV				
HPV quadrivalent	HPV				
Measles second dose	MEASLES				
Meningococcal type A	MENINACONJUGATE				
MR	MR				
Pneumococcal (PCV10)	PNEUMO				
Pneumococcal (PCV13)	PNEUMO				
Rotavirus	ROTA				
Yellow Fever	YF				

7.11. Calculation of requirements

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

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	354,407	350,142	343,968	1,048,517
	Number of children to be vaccinated with the first dose	Table 4	#	377,302	336,136	330,209	1,043,647
	Number of children to be vaccinated with the third dose	Table 4	#	377,302	336,136	326,769	1,040,207
	Immunisation coverage with	Table 4	%	106.46 %	96.00 %	95.00 %	

	the third dose						
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.05	1.05	1.05	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	1,195,400			
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	1,195,400			
	Number of doses per vial	Parameter	#		1	1	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.40 %	6.40 %	
fd	**Freight cost as % of devices value**	Parameter	%		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 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

N/A

For pentavalent vaccines, GAVI applies a benchmark of 4.5 months of buffer + operational stocks. Countries should state their buffer + operational stock requirements when different from the benchmark up to a maximum of 6 months. For support on how to calculate the buffer and operational stock levels, please contact WHO or UNICEF. By default, a buffer + operational stock of 4.5 months is pre-selected.

6

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

Co-financing group	Low

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

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

		2014	**2015**
Number of vaccine doses	#	899,800	629,700
Number of AD syringes	#	1,041,400	712,400

Number of re-constitution syringes	#	0	0
Number of safety boxes	#	11,475	7,850
Total value to be co-financed by GAVI	$	1,890,000	1,338,000

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

		2014	**2015**
Number of vaccine doses	#	97,400	67,300
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value to be co-financed by the Country <i>[1]</i>	$	199,500	139,500

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

		Formula	2013	2014		
				Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	9.76 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	377,302	336,136	32,823	303,313
B1	Number of children to be vaccinated with the third dose	*Table 4*	377,302	336,136	32,823	303,313
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	1,131,906	1,008,408	98,468	909,940
E	Estimated vaccine wastage factor	*Table 4*	1.05	1.05		
F	Number of doses needed including wastage	*D X E*		1,058,829	103,392	955,437
G	Vaccines buffer stock	*((D - D of previous year) x 0.5) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.5)*		- 61,749	- 6,029	- 55,720
H	Stock to be deducted	*H1 - F of previous year x 0.5*				
H1	Calculated opening stock	*H2 (2014) + H3 (2014) - F (2014)*				
H2	Reported stock on January 1st	*Table 7.11.1*	0	1,195,400		
H3	Shipment plan	*UNICEF shipment report*		719,700		
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*		997,100	97,364	899,736
J	Number of doses per vial	*Vaccine Parameter*		1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*		1,041,325	0	1,041,325
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*		11,455	0	11,455
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		1,919,418	187,425	1,731,993
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		46,860	0	46,860
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)*		58	0	58
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		122,843	11,996	110,847
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)*		2,089,179	199,420	1,889,759
U	Total country co-financing	*I x country co-financing per dose (cc)*		199,420		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*		9.76 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

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

		Formula	2015		
			Total	Government	GAVI
A	Country co-finance	*V*	9.64 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	330,209	31,847	298,362
B1	Number of children to be vaccinated with the third dose	*Table 4*	326,769	31,515	295,254
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	985,777	95,073	890,704
E	Estimated vaccine wastage factor	*Table 4*	1.05		
F	Number of doses needed including wastage	*D X E*	1,035,066	99,827	935,239
G	Vaccines buffer stock	*((D - D of previous year) x 0.5) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.5)*	- 11,315	- 1,091	- 10,224
H	Stock to be deducted	*H1 - F of previous year x 0.5*	326,858	31,524	295,334
H1	Calculated opening stock	*H2 (2014) + H3 (2014) - F (2014)*	856,272	82,583	773,689
H2	Reported stock on January 1st	*Table 7.11.1*			
H3	Shipment plan	*UNICEF shipment report*			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*	696,900	67,212	629,688
J	Number of doses per vial	*Vaccine Parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	712,365	0	712,365
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	7,837	0	7,837
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	1,358,259	130,997	1,227,262
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	32,057	0	32,057
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)*	40	0	40
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	86,929	8,384	78,545
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)*	1,477,285	139,380	1,337,905
U	Total country co-financing	*I x country co-financing per dose (cc)*	139,380		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.64 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

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

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	354,407	350,142	343,968	1,048,517
	Number of children to be vaccinated with the first dose	Table 4	#	377,302	332,634	326,769	1,036,705
	Number of children to be vaccinated with the second dose	Table 4	#	336,496	332,634	326,769	995,899
	Immunisation coverage with the second dose	Table 4	%	94.95 %	95.00 %	95.00 %	
	Number of doses per child	Parameter	#	1	1	1	
	Estimated vaccine wastage factor	Table 4	#	2.00	1.67	1.67	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	901,400			
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	901,400			
	Number of doses per vial	Parameter	#		10	10	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		Yes	Yes	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	Country co-financing per dose	Co-financing table	$		0.00	0.00	
ca	AD syringe price per unit	Table 7.10.1	$		0.0450	0.0450	
cr	Reconstitution syringe price per unit	Table 7.10.1	$		0	0	
cs	Safety box price per unit	Table 7.10.1	$		0.0050	0.0050	
fv	Freight cost as % of vaccines value	Table 7.10.2	%		14.00 %	14.00 %	
fd	Freight cost as % of devices value	Parameter	%		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 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

N/A

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

Co-financing group	Low

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

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

		2014	2015
Number of vaccine doses	#	- 357,000	- 218,200
Number of AD syringes	#	- 637,900	- 480,900
Number of re-constitution syringes	#	- 39,200	- 24,000
Number of safety boxes	#	- 7,425	- 5,550
Total value to be co-financed by GAVI	$	- 131,500	- 88,000

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

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

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

		Formula	2013	2014		
				Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	0.00 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	377,302	332,634	0	332,634
C	**Number of doses per child**	*Vaccine parameter (schedule)*	1	1		
D	**Number of doses needed**	*B x C*	377,302	332,634	0	332,634
E	**Estimated vaccine wastage factor**	*Table 4*	2.00	1.67		
F	**Number of doses needed including wastage**	*D X E*		555,499	0	555,499
G	**Vaccines buffer stock**	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*		- 11,167	0	- 11,167
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*				
H2	**Reported stock on January 1st**	*Table 7.11.1*	0			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		- 357,000	0	- 357,000
J	**Number of doses per vial**	*Vaccine Parameter*		10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*		- 637,926	0	- 637,926
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*		- 39,270	0	- 39,270
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*		- 7,449	0	- 7,449
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		- 87,465	0	- 87,465
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		- 28,706	0	- 28,706
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*		- 157	0	- 157
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*		- 37	0	- 37
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		- 12,245	0	- 12,245
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*		- 2,890	0	- 2,890
T	**Total fund needed**	*(N+O+P+Q+R+S)*		- 131,500	0	- 131,500
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	2015		
			Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	326,769	0	326,769
C	**Number of doses per child**	*Vaccine parameter (schedule)*	1		
D	**Number of doses needed**	*B x C*	326,769	0	326,769
E	**Estimated vaccine wastage factor**	*Table 4*	1.67		
F	**Number of doses needed including wastage**	*D X E*	545,705	0	545,705
G	**Vaccines buffer stock**	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*	- 1,466	0	- 1,466
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*	762,525	0	762,525
H2	**Reported stock on January 1st**	*Table 7.11.1*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	- 218,200	0	- 218,200
J	**Number of doses per vial**	*Vaccine Parameter*	10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	- 480,945	0	- 480,945
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	- 24,002	0	- 24,002
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*	- 5,554	0	- 5,554
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	- 56,513	0	- 56,513
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	- 21,642	0	- 21,642
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	- 96	0	- 96
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	- 27	0	- 27
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	- 7,911	0	- 7,911
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	- 2,176	0	- 2,176
T	**Total fund needed**	*(N+O+P+Q+R+S)*	- 88,365	0	- 88,365
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 7.11.1: Specifications for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	354,407	350,142	343,968	1,048,517
	Number of children to be vaccinated with the first dose	Table 4	#	0	0	330,209	330,209
	Number of children to be vaccinated with the third dose	Table 4	#			326,769	326,769
	Immunisation coverage with the third dose	Table 4	%	0.00 %	0.00 %	95.00 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.00	1.00	1.05	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	0			
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	0			
	Number of doses per vial	Parameter	#		1	1	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Co-financing table	$		0.00	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		0.00 %	6.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		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 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

N/A

Co-financing tables for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

Co-financing group	Low

	2013	2014	2015
Minimum co-financing	0.00	0.00	0.20
Recommended co-financing as per Proposal 2013			0.20
Your co-financing			0.20

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

		2014	2015
Number of vaccine doses	#	0	1,228,600
Number of AD syringes	#	0	1,375,800
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	15,150
Total value to be co-financed by GAVI	$	0	4,451,000

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

		2014	2015
Number of vaccine doses	#	0	72,900
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value to be co-financed by the Country <i>[1]</i>	$	0	260,500

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID (part 1)

		Formula	2013	2014		
				Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	0.00 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	0	0	0	0
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B x C*	0	0	0	0
E	Estimated vaccine wastage factor	*Table 4*	1.00	1.00		
F	Number of doses needed including wastage	*D X E*		0	0	0
G	Vaccines buffer stock	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*		0	0	0
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*				
H2	Reported stock on January 1st	*Table 7.11.1*	0			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*		0	0	0
J	Number of doses per vial	*Vaccine Parameter*		1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*		0	0	0
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*		0	0	0
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		0	0	0
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		0	0	0
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)*		0	0	0
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		0	0	0
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)*		0	0	0
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 Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID (part 2)

		Formula	2015		
			Total	Government	GAVI
A	Country co-finance	*V*	5.60 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	330,209	18,488	311,721
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B x C*	990,627	55,464	935,163
E	Estimated vaccine wastage factor	*Table 4*	1.05		
F	Number of doses needed including wastage	*D X E*	1,040,159	58,237	981,922
G	Vaccines buffer stock	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*	260,040	14,560	245,480
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*	0	0	0
H2	Reported stock on January 1st	*Table 7.11.1*			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*	1,301,400	72,863	1,228,537
J	Number of doses per vial	*Vaccine Parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	1,375,734	0	1,375,734
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	15,134	0	15,134
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	4,385,718	245,548	4,140,170
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	61,909	0	61,909
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)*	76	0	76
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	263,144	14,733	248,411
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)*	4,710,847	260,281	4,450,566
U	Total country co-financing	*I x country co-financing per dose (cc)*	260,280		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	5.60 %		

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 <u>and</u> received HSS funds before or during January to December 2013**. All countries are expected to report on:

   a. Progress achieved in 2013

   b. HSS implementation during January – April 2014 (interim reporting)

   c. Plans for 2015

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

For countries that received HSS funds within the last 3 months of 2013, or experienced other delays that limited implementation in 2013, 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 2013 fiscal year starts in January 2013 and ends in December 2013, HSS reports should be received by the GAVI Alliance before **15th May 2014**. 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 2014, the HSS reports are expected by GAVI Alliance by September 2014.

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 2013

   b. Minutes of the HSCC meeting in 2014 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2013 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 2013 and request of a new tranche

For countries that have previously received the final disbursement of all GAVI approved funds for the HSS grant and have no further funds to request: Is the implementation of the HSS grant completed ? **No**

If NO, please indicate the anticipated date for completion of the HSS grant.

2015

Please attach any studies or assessments related to or funded by the GAVI HSS grant.

Please attach data disaggregated by sex, rural/urban, district/state where available, particularly for immunisation coverage indicators. This is especially important if GAVI HSS grants are used to target specific populations and/or geographic areas in the country.

If CSOs were involved in the implementation of the HSS grant, please attach a list of the CSOs engaged in grant implementation, the funding received by CSOs from the GAVI HSS grant, and the activities that they have been involved in. If CSO involvement was included in the original proposal approved by GAVI but no funds were provided to CSOs, please explain why not.

N/A

Please see http://www.gavialliance.org/support/cso/ for GAVI's CSO Implementation Framework

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

Please attach the latest reported National Results/M&E Framework for the health sector (with actual reported figures for the most recent year available in country).

9.1.1. Report on the use of HSS funds in **2013**

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: **938000** US$

These funds should be sufficient to carry out HSS grant implementation through December 2015.

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)$

	2008	2009	2010	2011	2012	2013
Original annual budgets (*as per the originally approved HSS proposal*)	987043	1010070	1032260	1052865	1071540	1088545
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	337500	1524793	1532900	1498472	1452639	1314270
Total funds received	337500	1509500	1464000	1228000	1121000	1314270

from GAVI during the calendar year (*A*)						
Remaining funds (carry over) from previous year (*B*)	1703013	711280	1085434	1378898	1436496	1454218
Total Funds available during the calendar year (*C=A+B*)	2040513	2220780	2549434	2606898	2557496	2768488
Total expenditure during the calendar year (*D*)	1329233	1136703	1170536	1170402	1103378	1123338
Balance carried forward to next calendar year (*E=C-D*)	711280	1084077	1378898	1436496	1454118	1645150
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	1524793	1532900	1498472	1452639	1214270	1314270

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)	1104205	1118980		
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	1791165	1524340		
Total funds received from GAVI during the calendar year (*A*)	938000	553238		
Remaining funds (carry over) from previous year (*B*)	1645150	971102		
Total Funds available during the calendar year (*C=A+B*)	2583150	1524340		
Total expenditure during the calendar year (*D*)	1612049	1524340		
Balance carried forward to next calendar year (*E=C-D*)	971102	0		
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	1404830	0	0	0

Table 9.1.3b (Local currency)

	2008	2009	2010	2011	2012	2013
Original annual budgets (*as per the originally approved HSS proposal*)	987043	1010070	1032260	1052865	1071540	1088545
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	337500	1524793	1532900	1498472	1452639	1314270
Total funds received from GAVI during the calendar year (*A*)	337500	1509500	1464000	1228000	1121000	1314270
Remaining funds (carry over) from previous year (*B*)	1703013	711280	1085434	1378898	1436496	1454218
Total Funds available during the calendar year (*C=A+B*)	2040513	2220780	2549434	2606989	2557496	2768488
Total expenditure during the calendar year (*D*)	1329233	1136703	1170536	1170402	1103378	1123338
Balance carried forward to next calendar year (*E=C-D*)	711280	1084077	1378898	1436496	1454188	1645150
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	1524793	1532900	1498472	1452639	1214270	1314270

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)	1104205	1118980		
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	1791165	1524340		
Total funds received from GAVI during the calendar year (*A*)	938000	553238		
Remaining funds (carry over) from previous year (*B*)	1645150	971102		
Total Funds available during the calendar year (*C=A+B*)	2583150	1524340		
Total expenditure during the calendar year (*D*)	1612049	1524340		
Balance carried forward to next calendar year (*E=C-D*)	971102	0		
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	1404830	0	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	2008	2009	2010	2011	2012	2013
Opening on 1 January	3992	4077	4165	4051	4039	3995
Closing on 31 December	4077	4165	4051	4039	3995	3995

Detailed expenditure of HSS funds during the 2013 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2013 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 2014 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.

The Aide-Memoire dated 17 January, 2013 described financial arrangements for the remainder of the GAVI HSS Grant cycle, for which there were some minor changes to grant agreement and processes. These adjustments have been followed during the reporting period.

Bank account: The GAVI HSS funds are received into a government USD bank account set up specifically for GAVI and used for GAVI funds only.

Budget approval: Budget for use on GAVI activities is approved by the Technical Working Group for Health (TWGH) following the Ministry of Health's (MoH) Annual Operational Plan (AOP) process which is led annually by the Department of Planning and Health Information (DPHI). This process plans and approves budgets for activities for the forthcoming year at all levels of implementation including central program units, provincial health departments, operational districts, and health centres.

Midterm and annual HSS workshops take place to review 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 integrated into the AOPs of the Provinces and Districts. For the 10 Operational Districts (OD) which receive additional focus and support from the GAVI HSS funds, targets and conditions are negotiated into contracts between OD and the MoH's 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.

Fund transfers: Fund transfers are made annually to each MoH department implementing activities under GAVI HSS and at the sub-national level to the 10 ODs that receive additional focus and support from GAVI HSS funds. The OD 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 release the funds to the 10 ODs on a monthly basis into safety boxes. The amount is based on the health centre performance on the Minimum Package of Activities (MCH and EPI service package) during the previous month. At the national level departments receive cash advances for workshops and trainings, for other activities, such as supervision and monitoring visits, staff are reimbursed with a check to the person who signed the MoU with DBF.

There have been no delays in the transfer of funds to the national or sub-national level following the receipt of funds into the government USD account designated for GAVI funds. GAVI HSS financial processes and procedures follow those described in the financial guidelines of the Ministry of Health's (MoH) Health Sector Support Program II, 2009-2013, (HSSP 2). The MoH's DBF manages the disbursements to and coordinates the use of funds of all implementing levels of GAVI HSS.

Financial reporting: Health Centres report to 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 report monthly to Provinces and Provinces report quarterly to DBF at national level. DBF compile the reports to produce quarterly and annual reports for all GAVI HSS expenditure that has taken place.

Overall role of the TWGH: the Technical Working Group for Health (TWGH) has taken over the role from the National Health Sector Coordinating Committee (HSCC) as the Interagency Coordinating Committee (ICC) for the GAVI HSS grant. The TWGH meets monthly and addresses all health programs and issues, immunization is a regular topic of the forum and all group minutes are annexed to this report. The TWGH provides oversight on major grant decisions and progress, approval for GAVI HSS budgets and review and endorsement of GAVI HSS reports.

Has an external audit been conducted? No

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 2013 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 2013 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**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	Coverage improvement planning activities planned.		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: 1. Dissemination Workshop on Outreach Guidelines and Fixed Site Guidelines. 2. Supervision and monitoring of outreach guidelines implementation 3. Routine community meetings with VSHG, VHV, Commune Councils in high risk areas to encourage fixed site immunizations 4. Supervision visits for maintenance of cold chain system	90	PMD NIP
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	0	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. 1. Technical support on AOP development and AOP implementation from central to PHD /OD/ HC 2. Training on AOP Web-Based planning 3- Conduct appraisal on AOP of Health Facilities and provide feedback 5. Training/workshop to PHD, ODs & HCs level of GAVI HSS by HIS Unit/MoH on data collection and reporting for HIS 6. Supervision on DQA implementation	80	DPHI PMD 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: 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 2. Provincial supervision visits to OD and health facility level	80	DBF
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 2013: 1. Technical support & monitoring the implementation of financial management tool and revised planning manual at OD and health centres 2. Annual review workshop to strengthen OD and health center capacity in annual review & planning 3. Provincial on-site supervision and monitoring to strengthen OD and health center capacity in quarterly reviews & planning	100	DBF CDC 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	The following activities were planned for 2013: 1. IMCI Clinical Training 2. IMCI supervisors training for IMCI Monitoring	90	CDC DBF

and OD staff and supportive supervision	3. Strengthen monitoring and spot-checking from national level 4. IMCI planning workshop to integrate IMCI related activities into OD planning cycle		
3.4 Private sector collaboration: Scaling up and evaluating public/private collaboration to improve quality of immunizations and eventually MCH services in private sector	A follow up workshop for sensitization/training of private sector on quality and government requirements of immunization/MCH service delivery.	0	NIP DBF
3.5 Project management: Support activities to ensure effective implementation of grant activities to reach planned targets.	The following support activities were planned: 1. Retreat and Wrap up annual progress report for HSS-Program Staff 2. HSS-APR workshop (Progress Report 2013) 3. HSS Mid-year and Annual Review Workshop (2013) 4. Preparation of GAVI/HSS AOP 2014 5. Cost of technical assistance 6. Overhead costs 7. Technical support and monitoring the implementation of financial management by DBF and IAD 8. Annual external audit 9. Internal audit review of 2012	70	NIP DBF IAD

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 - All 10 OD's established contracts and developed their AOPs with health facilities. High risk & spot check missions were also implemented Challenges - The PBC scheme continues to be based on ODs % coverage of 5MPA activities following the change in 2012. In addition during 2013 two of the 5 MPA indicators changed: Measles M9 changed to Measles M18 and ANC2 changed to ANC4.
1.2 Management contracts	Achievements - All OD's developed AOPs. Challenges - The new PBMA scheme developed and approved in 2012 continued during the reporting period with no changes to report on.
1.3 Coverage improvement planning (CIP)	Planned CIP activities were not implemented due to the coincidence with the MR SIA during the last quarter of the year which was planned for improving the immunization coverage.

1.4 Fixed site strategy	Achievements - Outreach Guidelines completed - Outreach Guidelines Dissemination Workshop/printing and Fixed Site Guidelines - 80% of ODs conducted most of their routine community meetings (VSHG, VHV, Commune councils) meetings to improve use of fixed sites for immunizations were conducted Challenges - Slow adoption of guidelines in 2013 due to timing of the dissemination - Limited functioning of VHSGs and HCMC in some areas
2.1 Financial management system development	This activity was not conducted. A mid-tem review took place but not for financial accountants specifically, for all relevant national level, OD and PHD staff.
2.2 Health planning systems	Achievements - DPHI developed new training curriculum for new web-based HIS system. Training in new system data collection and reporting was conducted for 254 persons, 14 PHD staff from 6 provinces, 14 OD staff from 7 ODs and 226 health centre staff. - The PMD conducted monitoring visits to evaluate the implementation of the new outreach guidelines at 5 HCs per OD. Challenges - Almost all HCs monitored still conducting outreach activities for villages under 5km from HC - Outreach sessions in communities are not always happening as planned due to shortage of health staf. Mostly, only immunization staff go on outreach and very occassionally a midwife. - Lack of transport (e.g. motos), of budget (for transport and per diem) and of material (e.g. loudspeakers) affects the implementation of outreach activities - The trainning on AOP Web-Based planning could not take place because the curriculum for HCs was not completed
2.3 Supervision systems	Achievements - Supervision visits from PHD to OD were conducted for all 10 ODs. - Joint monitoring from the central level took place during 2013. One positive finding is that the compliance rate with IMCI guidelines is greater than 95%. Challenges - The central joint monitoring visit found a number of important challenges OD/health facilities for example in ODs visited - There was not enough focus on technical improvement and quality of care by program managers - IMCI training is not provided to RH staff, limited quality of health care at RH; and it is not possible to monitor C-IMCI at community level - Data recording still weak at a number of health centrse as well as at OD level, suggesting more focus on improving data quality
2.4 Health systems operations research	No activities planned or conducted for 2013
3.1 Strengthening middle level management	Achievements - DBF provided technical support and monitoring to 10 ODs in a total of 25 visits to strengthen financial management. - Annual review workshop for annual planning conducted in all 10 ODs - Supportive supervision site visits for quarterly/annual review and planning were conducted to OD and health centres in all 10 ODs Challenges - Limited staff capacity for data analysis & interpretation (can in part be attributed to staff turnover)
3.2 Child survival monitoring	No activities planned or conducted for 2013
3.3 Service delivery of IMCI	Achievements - 3 IMCI clinical training conducted for 69 participants from 7 ODs - IMCI review and planning workshop for IMCI and integration into AOP. - 16 Field visits from central level for supervision and spot checks to 10 ODs/ 75 HCs

	Challenges - Limited utilization of health facilities by sick children and care-takers. - Not all HC staff treating sick children have been trained in IMCI (i.e. if those trained not at the HC and/or few staff at HC trained due budget constrains and staff turnover).
3.4 Private sector collaboration	Achievements Workshop did not take place Challenges - Because of HSSP2 guidelines, GAVI HSS funds can not be used to pay for private sector participants. This continues to create challenge to ensure participation and less budget was spent as a result. - Limited data in HIS from the private sector (although efforts being made to increase the number of private facilities contributing data)
3.5 Project management	Achievements - Program and overhead support was provided without interruption - The annual HSS progress review included 45 PHD and 44 OD participants - The GAVI HSS 2014 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) - Internal audit was conducted successfully. External audit will be conducted in Apr-May 2014 Challenges - Making the arrangement for the joint supervision visits

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

Further to Table 9.2.1 describing achievements and challenges experienced during the reporting period, please find to follow details for specific activities not implemented or modified under each objective.

Objective 1: Strengthening MPA Services (Supply and Demand)

1.4 Fixed site strategy

Activity 6.3.1.1.2: Not all community meetings for improving fixed site use were conducted during the reporting period. It is challenging to get VHSG's & VHV's to go to meetings due what are perceived to be low incentives (2USD).

Activity 6.3.1.3.1: Private sector: the private sector workshop was not conducted in 2013 as planned and no activity took place in this activity line. 22% expenditure is booked against this activity line; expenditure is booked against this activity as it was committed in 2012 but not paid until 2013.

Objective 2: Developing and Strengthening MPA Management Systems

2.1 Financial management systems: The HSS mid-year review workshop planned for all provincial and OD accountants under this activity line was not conducted. A mid-term review took place but not for financial accountants specifically. The mid-term review that took place was attended by all relevant national level, OD and PHD staff and is detailed below in the project management activity line.

2.2 Health planning systems: Strengthening MPA planning at OD and health centres through AOP integration

Activity 6.2.1.1.0: Training on AOP Web-Based planning. The training on AOP Web-Based planning could not take place because the curriculum for HCs was not completed. This activity has been moved to 2014.

Objective 3: Human Resource Quality Improvement

3.5 Project management

Activity 6.6.2.0.0: Retreat and Wrap up annual progress report for HSS-Program Staff did not take place in 2012 as planned because of time constraints. Time was spent by program staff to wrap up the annual progress report during the HSS-APR workshop and mid-year review workshop which was conducted at the same time as detailed below to be more efficient and cost effective.

Activity 6.6.2.0.1: HSS-APR Workshop (Progress Report 20130). This activity was conducted in 2013 but the expense was made against activity 6.6.2.0.1 because the two activities were conducted at the same time to be more efficient and cost effective.

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?

The GAVI management incentive scheme described in the 2012 report continued to be employed unchanged during the reporting period. This management incentive is based on a “personal performance management contract” with lump sum payments paid directly based on quarterly performance assessed by established supervisory mapping. Incentives are provided to management at all levels and include 41 staff at central implementing units, 65 staff in 9 PHDs, 52 staff in 10 ODs, and 219 staff of health centres, including remote health centres, in these ODs.

The “contracting in” approach, supported by the HSSP2, was adopted by GAVI HSS and continues to be implemented as a strategy to strengthen decentralization of health care management and improve coverage and quality of the Minimum Package of Activities (MPA) in 10 high risk ODs. The schematic of incentives for these performance-based contracts was originally based on health centres receiving 1USD per child immunized. However, review of the scheme found some important challenges, including the disincentive for certain health centres in less populated but high risk areas that often require more effort to reach adequate numbers of vaccination coverage, but received less money than health centres in more populated areas. Another observed issue was the variation across ODs in linkages between improved performance in immunization coverage and those of other key MPA indicators.

To address these gaps, the performance-based incentives have changed to reflect each OD’s percent coverage of a set of several key MPA indicators. For each of the 10 ODs, an incentive ceiling and specific targets are designated in the contract based on the risk status and population. Depending on the OD’s performance on the set of indicators, a percentage of the total ceiling is provided. The hope is that this pooled indicator performance will further strengthen the health systems wide approach and promote integrated health service delivery and move away from silo processes 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 2012 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	2013 Target						Data Source	Explanation if any targets were not achieved

	Baseline value	Baseline source/date			2009	2010	2011	2012	2013		
1a. % DTP Coverage – HepB 3 [National]	78%	DHS 2005	90%	97%	95%	92%	94%	95%	95%	MoH HIS	Due to MoH personnel being occupied during the reporting period conducting the MRSIA campaign.
1b. % DTP Coverage – HepB 3 [10 OD – HSS]	74%	MoH-MoP 2006	90%	95%	87%	90%	83%	92%	96%	NIP/HIS/ PHD-OD	N/A
2a. #/% OD Achieving >=80% DTP3 Coverage [National]	18 (24%)	NIP 2006	76 (100%)	80%	68%	66%	64%	67 (88%)	77%	NIP/HIS/ PHD-OD	N/A
2b. #/% OD Achieving >=80% DTP3 Coverage [10 OD – HSS]	0 (0%)	DPHI/NIP 2007	10 (100%)	80%	9%	9%	10%	9 (90%)	100%	NIP/HIS/ PHD-OD	In remote areas a higher proportion of deliveries occur at home, although this is gradually reducing. However in these cases it is very difficult to provide DTP3 at 24 hours.
3a. % Hepatitis Birth Dose-24 Hours [National]	25%	MoH-NIP 2006	70%	70%	55%	57%	55%	65%	60%	MoH HIS	As above in remote areas a higher proportion of deliveries occur at home, although this is gradually reducing. However in these cases it is very difficult to provide Hepatitis dose at 24 hours.
3b. % Hepatitis Birth Dose-24 Hours [10 OD – HSS]	25%	MoH-NIP 2006	70%	70%	61%	65%	96%	72%	61%	NIP/HIS/ PHD-OD	In remote areas a higher proportion of deliveries occur at home, although this is gradually reducing. However in these cases it is very difficult to provide Hepatitis dose at 24 hours.
4a. % Measles Coverage [National]	70%	MoH-NIP 2006	90%	95%	92%	93%	93%	93%	93%	MoH HIS	N/A
4b. % Measles Coverage [10- OD-HSS]	70%	MoH-NIP 2006	90%	95%	83%	89%	80%	88%	89%	NIP/HIS/ PHD-OD	N/A
5a. % Pregnant Women Attending >= 4 ANC Visits [National]				68%					56%	MoH HIS	This indicator was changed in 2013 from ANC2 to ANC4, therefore baseline data from the start of the proposal and annual achievement beyond 2013 are not provided here. 2013 data for achievement

												from the MoH HIS will be used as baseline data and achievements will be stated each following year.
5b. % Pregnant Women Attending >= 2 ANC Visits [10- OD-HSS]										65%	MoH HIS	As above, this indicator has changed from ANC2 to ANC4, therefore no baseline data is included here. 2013 data for achievement from the MoH HIS will be used as baseline data and achievements will be stated each following year.
6a. % Skilled Birth Attendance [National]	44%	DHS 2005	90%	80%	63%	69%	69%	75%	75%	MoH HIS	In remote areas a higher proportion of deliveries occur at home, although this is gradually reducing. However in these cases it can be difficult to ensure that a skilled birth attendant is in attendance.
6b. % Skilled Birth Attendance [10-OD-HSS]	35%	MoH-HIS 2006	90%		57%	67%	67%	52%	52%	MoH HIS	No target agreed with ODs for this indicator.
7a. % Delivery at Facility [National]	14%	MoH-HIS 2006	70%	66%	44%	52%	52%	66%	70%	MoH HIS	N/A
7b. % Delivery at Facility [10-OD- HSS]	14%	MoH-HIS 2006	70%		44%	51%	51%	44%	39%	MoH HIS	No target agreed with ODs for this indicator.
8a.% Health Centres trained/implementing IMCI [National only]	N/A	N/A	100%	100%	78%	100%	100%	100%	100%	CDC	N/A
8b. % of Health Centres trained/implementing IMCI [10- OD-HSS]	N/A	N/A	100%	100%	90%	100%	100%	100%	100%	CDC	N/A
9. # of ODs Reaching Performance Targets Specified in OD Contracts [10- OD-HSS]	1%	10-OD-HSS 2007	10%		9%	10%	10%	9%	1%	DBF	Koh Thom OD in Kandal reached all of it's targets.
10a. # Facilities Implementing Full MPA [National]	470	MoH 2006	972		984	997	1004	1042	1088	MoH HIS	N/A
10b. # Facilities Implementing Full MPA [10- OD-HSS]	N/A	N/A	100% of existing HCs		127	149	149	155	161	MoH HIS	N/A
11a. % Immunization at Fixed Site [National]	20%-25%	2003-2004	40%		37%	45%	39%	42%	48%	MoH HIS	N/A
11b. %] of immunization at fixed site 10 HSS ODs [10- OD-HSS]	20%-25%	2003-2004	40%		48%	41%	45%	47%	56%	MoH HIS	N/A

12. % Approved Budgets Reaching Health Facilities [10-PHD/OD-HSS HCs]	AOP- Budget Allocated	AOP- Budget Allocated	100%		100%	100%	100%	100%	100%	DPHI/ DBF	N/A

9.4. Programme implementation in 2013

9.4.1. Please provide a narrative on major accomplishments in 2013, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

Overall achievements of GAVI HSS funded program have been significant as measured by the trend of 12 indicators from their baselines.

All targeted national and GAVI focused facilities are providing full MPA services and all have been trained in IMCI.

All of the 10 GAVI HSS ODs completed their AOPs and received budgets according to their planned activities.

The immunization indicators have performed well however there has been some under achievement which is attributed to MoH personnel being occupied during the reporting period conducting the MRSIA campaign and to the challenge of providing immuinzation at 24 hours in remote ares where a proportion of births take place in homes. However the 2013 indicator achievement is not far below the 2013 targets and they are on track to achieving their 2015 targets at both national and the 10 GAVI HSS OD levels. The percent of immunizations that take place at fixed sites has more than double since 2004 and has overachieved its 2015 target. MCH indicators have more variation in their progress.

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

Challenges affecting implementation in 2013:

- Population denominators: There continues to be is inconsistency across Provinces in methods of population estimation including the source data they use for their estimates. This is problematic as several assessments have shown that estimates across different sources are not consistent with some underestimating or other overestimating. At the OD level another layer of complexity is added. ODs are MoH specific, while other ministries rely on Administrative Districts (ADs) for which Census data is available. Obtaining valid OD level denominators is not straight forward since not all ODs and ADs are geographically equal, and often have overlapping areas. These denominator issues skew percent coverage, even if numerators are validated through DQAS methods. An underestimated denominator can overestimate the coverage and vice versa. It continues to be critical for a comprehensive review to take place as soon as possible to compares all denominator data sources in the 10 ODs using2010 CDHS, 2008 Census, and other sources. In addition, this exercise should recommend a common method for consistency and valid estimation across ODs countrywide
- High staff turnover and capacity problems: is still an issue despite existing incentives for GAVI HSS ODs. The lower government salaries contribute to the turnover with staff lost due to the higher paying private sector. Another significant reason for this is the movement of staff back to their home province having done an initial three years out of their home province. This creates issues of sustainability for AOP capacity strengthening and for IMCI service delivery. New staff coming into remote and hard to reach ODs are primarily inexperienced and therefore unclear on how to conduct planning which sets back momentum established by previous efforts or to provide basic services which means they require training. Once they have done three years, during which they are likely to have been the recipient of training/ capacity building staff may then move on to the private sector or to another province. This again reduces the limited number of staff trained on IMCI. It is important to explore how to hire and retain staff in the remote and hard to reach facilities to aid service continuity and improvement. It is also important to stress the importance of coaching as a long term strategy, not just supervision
- Health service delivery issues: there are still some problems with health service delivery for example that there is no 24 hour service provided by all health centres. There are significant concerns regarding security for women staying in HCs in the evening, especially in rural places. A limited

number of referral hospital staff are trained on IMCI; IMCI training is not provided at RH level, so there is a limited quality of IMCI care in RHs. There is not enough focus in some cases on technical improvement and quality of care by program managers, and compliance with IMCI needs to be further improved

- Health service utilisation issues: there is still very low health service utilisation in a number of cases, particularly for care of sick children with treatable diseases by care-takers. It is not easy to check C-IMCI, which is the responsibility of the National Centre for Health Promotion, however the training of villages level community health workers is a key linkage which needs to be strengthened to bridge the gap between the health facility and community level
- Challenges to engaging the private sector: it is very important to expand working with the private sector but there are challenges in doings so as under the HSSP2 financial policy which the grant management follows it is not possible for the Government to pay for private sector staff to attend workshops 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 of the GAVI grant takes place at 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
- 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.

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:

- 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
- Provincial supervision and monitoring to ODs and Health Centres on the annual and quarterly operational planning and review processes
- Unannounced DQA spot checks by provincial monitoring team to health facilities
- 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 centres.

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:

- Integrated supervision visits from 10 ODs to the health centres, 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
- 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 centres
- 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&E was designed to be integrated with Cambodia's national systems. Grant activities were planned to strengthen the existing National annual operational structures and processes, including those for monitoring (as described above), which feed into M&E needs for the GAVI HSS grant.

GAVI M&E activities and requirements are integrated with the National system in the following ways:

- Monitors national indicators: most of the impact and outcome indicators monitored for the GAVI HSS grant are drawn from the National Health Strategic Plan 2 (HSP2). In addition, indicator targets are based on those set out in the HSP2 and those described in the MoH, specific health programs and provincial/ OD health Annual Operational Plans
- Based on existing systems: since the GAVI HSS indicators and targets are based on national and sub-national plans, the means for collecting and reporting on these indicators are also part of the national and sub-national HIS/ M&E systems
- Builds on and strengthens existing M&E structures: many activities in the GAVI HSS grant have been designed to strengthen the national M&E structures for example coordinated supervision across units to sub-national and health facility levels and trainings and supportive supervision and monitoring for AOP at OD where indicators are reviewed and inform planning process

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.

Overall coordination was provided by the grant manager who provides as interface between the country and GAVI and programmatic oversight for the grant.

The Technical Working Group (TWG) Health serves as the oversight mechanism for HSS GAVI grant decisions. The Department of Budget & Finance (DBF) provides support for managing and coordinating the financial side of the GAVI HSS grant.

There are 6 implementing units under the Ministry of Health receiving funds under GAVI HSSS. These include:
- Department of Internal Audit
- Department of Budget & Finance (DBF)
- National Immunization Program (NIP)
- Department of Planning and HealthInformation (DPHI)
- Preventive Medicine Department(PMD)
- Centre for Disease Control (CDC)

The GAVI HSS activities are predominantly focused on 10 high risk ODs in 9 provinces. These 10 high risk provinces and ODs receive funds for activities as well as incentives, which then get disbursed to the health centres. Funds are also channelled to non-GAVI ODs and provinces for certain capacity strengthening activities and other ODs benefit from activities for example the development of new countrywide guidelines funded under the GAVI HSS grant.

Key stakeholders include WHO, UNICEF, and donor partners under funding of HSSP2. These partners provide technical support to specific implementing units and are members of the TWG for Health. There were no NGO/CSO co-implementers under for 2013 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/CSO co-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

The management of HSS funds has been effective during the reporting period and there have been no constraints to internal fund disbursement. There has continued to be no internal HSS Officer during the reporting period which has some effect on the management of the grant.

All financial management and processes of GAVI HSS funds follow HSSP2 Financial Guidelines. As described in Section 9.1.3, funds from HSS GAVI grant are managed by the MoH's Department of Budget and Finance. Funds are disbursed to provinces on a yearly basis, who then disburse to ODs on monthly basis. These funds are based on the annual approved AOPs. In addition, specific performance contracts have been developed for each of the 10 focused ODs. These contracts describe the expected targets in coverage of MPA services for each OD in order to receive performance-based funds.

At the time of submission for this APR, the 2013 external audit was not undertaken. For issues identified in the 2012 audit all have been addressed/ resolved.

No changes to management processes are planned for the coming year.

9.5. Planned HSS activities for 2014

Please use **Table 9.5** to provide information on progress on activities in 2014. If you are proposing changes to your activities and budget in 2014 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned 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)	**2014 actual expenditure** (as at April 2014)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
1.1 Service delivery contracts: performance based contracts with health centres	Establish and implement annual operational plans and performance based contracts (PBC) at health facility level	385025		This activity has been revised per new PBC scheme based on OD specific targets to reach certain % coverage on 5 critical MPA services	Changing OD BAKAN to OD SAMPEUVMEAS (OD Bakan moved to SOA)	487175
1.2 Management contracts	Establish and implement annual operational plans and performance based management agreements (PBMA) with ODs and	136220		This activity has been revised per approval by Ministry of Economy and Finance 9/2012 on a new PBA scheme.	Changing OD BAKAN to OD SAMPEUVMEAS (OD Bakan moved to SOA)	196300

	Provinces					
1.3 Coverage improvement planning (CIP)	Integrating immunization coverage improvement planning into MPA planning system to improve overall MCH	31300		No activities planned for 2013		384750
1.4 Fixed site strategy	Implement, evaluate, and scale up fixed site strategy to improve immunization coverage through increased health center utilization	25000		No changes in activities		
2.1 Financial management system development	Develop MPA financial management system, health financing guidelines, and monitoring effective implementation	10000		Mid-term workshop will be revised to conduct HSS review with OD and provinces		25880
2.2 Health planning systems	Strengthening MPA planning at OD and health centers through AOP integration	45000		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		26315
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		No changes in activities planned, just adjustment of budget per actual costs		60994
2.4 Health systems operations research	Conducting research to support decision making for strengthening demand and delivery of MPA services	20000		Operational research study is planned to explore challenges and strategies to better implement fixed sites, particularly from demand side		
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	46000		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		83614
3.2 Child survival monitoring	Strengthening systems for child survival scorecard monitoring through			No activities planned for 2013		

	Provincial Health committees, interdepartme ntal monitoring team, and inclusion of scorecard monitoring in AOP.					
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			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.		4750
3.4 Private sector collaboration	Scaling up and evaluating public/private collaboration to improve quality of immunizations and eventually MCH services in private sector			Scale up of monitoring to private sector sites through supportive supervision is planned		
3.5.Project management	Support activities to ensure effective implementatio n of grant activities to reach planned targets.	350659		Internal/External audit, Contingency funds, other equipments management Incentive and performance incentive (Central /PHDs/ODs/ Remote HCs)		433678
		1118980	0			1703456

9.6. Planned HSS activities for 2015

Please use **Table 9.6** to outline planned activities for 2015. 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 2015

Major Activities (insert as many rows as necessary)	**Planned Activity for 2015**	**Original budget for 2015** (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 2015** (if relevant)
1.1 Service delivery contracts	Establish and implement annual operational plans and performance based contracts (PBC) at health facility level	385025	Same as 2014	Due to the available funds for 2015, the budget for each activity needs to be reduced by 5% compared to the budget 2014	487175
1.3 Coverage improvement planning (CIP)	Integrating immunization coverage improvement planning into MPA planning	31300	Same as 2014	Due to the available funds for 2015, the budget for each activity needs to be reduced by 5% compared to the budget 2014	384750

	system to improve overall MCH (High Risk)				
1.2 Management contracts	Establish and implement annual operational plans and performance based management agreements (PBMA) with ODs and Provinces and Central	136220	Same as 2014	Due to the available funds for 2015, the budget for each activity needs to be reduced by 5% compared to the budget 2014	196300
1.4 Fixed site strategy	Implement, evaluate, and scale up fixed site strategy to improve immunization coverage through increased health centre utilization	25000	Reprogramming is planned for 2014 based on review in 2013	The activities are included in the Services Delivery Contracts (Activity 1.1)	
2.1 Financial management system development	Monitoring effective implementation, Workshop/ Training	10000	Reprogramming is planned for 2014 based on review in 2013	Due to the available funds for 2015, the budget for each activity needs to be reduced by 5% compared to the budget 2014	25880
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	Due to the available funds for 2015, the budget for each activity needs to be reduced by 5% compared to the budget 2014	26315
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	Due to the available funds for 2015, the budget for each activity needs to be reduced by 5% compared to the budget 2014	60994
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	This activities are included in the budget of project management (3.5)	
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	46000	Reprogramming is planned for 2014 based on review in 2013	Due to the available funds for 2015, the budget for each activity needs to be reduced by 5% compared to the budget 2014	
3.2 Child survival monitoring	Strengthening systems for child survival scorecard monitoring through Provincial Health committees, interdepartmental monitoring team		Reprogramming is planned for 2014 based on review in 2013	Due to the available funds for 2015, the budget for each activity needs to be reduced by 5% compared to the budget 2014	

	and inclusion of score card monitoring in AOP.				
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		Reprogramming is planned for 2014 based on review in 2013	Due to the available funds for 2015, the budget for each activity needs to be reduced by 5% compared to the budget 2014	
3.4 Private sector collaboration	Scaling up and evaluating public/private collaboration to improve quality of immunizations and eventually MCH services in private sector		Reprogramming is planned for 2014 based on review in 2013	Due to the available funds for 2015, the budget for each activity needs to be reduced by 5% compared to the budget 2014	4750
3.5 Project management	Support activities to ensure effective implementation of grant activities to reach planned targets, Auditing (external audit & Internal Audit)	350659	Reprogramming is planned for 2014 based on review in 2013	Supports Activities: Internal/External audit, Contingency, Health system operations research, other equipments management Incentive and performance incentive (Central /PHDs/ODs/Remote HCs)	433678
		1118980			

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
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 centres. Specific activities include technical and management support to health centres 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
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: 4.1 Services delivery 4.2 Health care financing

			4.3 Human resources development 4.4 Health information 4.5 Supportive supervision/monitoring
Second Health Sector Support Program	149671414	2009-2014	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? **Yes**

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.	No problems experienced
National Health Information System, Department of Planning and Health Information, MoH	At all levels, from health centre to central, indicator data is reported to the National Health Information System. This is reviewed on quarterly basis to determine progress as outlined in AOP. This exercise serves to question and validate the data. Each year a Data Quality Audit (DQA) is undertaken which 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. 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	No major problems experienced. The main issue highlighted by the Data Quality Audit 2012 is the issue of the consistency of population denominators.

	placed on the public website for access by programs and relevant partners.	

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.

The main challenge faced in putting this report together is the lack of clarity among implementing partners for report preparation responsibilities. There is also currently no internal HSS Officer. The Department for Budget and Finance provide a coordinating role for the GAVI HSS grant, but this does not equip them to complete the report from a programmatic point of view. As there are many different implementers each has a detailed understanding of their activities, but not as in-depth an understanding of the progress of the activities of other departments. In addition each department has other non GAVI HSS activities to complete and all have busy schedules.

In addition the report format can be repetitive and it may be possible to consolidate some tables to reduce the overall number.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2013?12

Please attach:

1. The minutes from the HSCC meetings in 2014 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 2013

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 2013

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

N/A

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 2013 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 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 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, 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						
Wages & 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 2013	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 2013 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 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 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, 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						
Wages & 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 2013	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 2013 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 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 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, 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						
Wages & 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 2013	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	✔	Signatures_Attachments 1+2.pdf **File desc:** **Date/time :** 09/05/2014 03:35:24 **Size:** 26 KB
2	Signature of Minister of Finance (or delegated authority)	2.1	✔	Signatures_Attachments 1+2.pdf **File desc:** **Date/time :** 09/05/2014 03:36:07 **Size:** 26 KB
3	Signatures of members of ICC	2.2	✔	Participation List of TWGH meeting on March 6, 2014.pdf **File desc:** **Date/time :** 01/04/2014 03:25:30 **Size:** 2 MB
4	Minutes of ICC meeting in 2014 endorsing the APR 2013	5.7	✔	TWGH minutes endorsing APR_06.03.14.pdf **File desc:** **Date/time :** 07/05/2014 02:13:11 **Size:** 6 MB
5	Signatures of members of HSCC	2.3	✔	HSCC.pdf **File desc:** **Date/time :** 31/03/2014 11:33:58 **Size:** 20 KB
6	Minutes of HSCC meeting in 2014 endorsing the APR 2013	9.9.3	✔	HSCC.pdf **File desc:** **Date/time :** 31/03/2014 11:34:14 **Size:** 20 KB
7	Financial statement for ISS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✔	ISS Expenditure 2013.pdf **File desc:** **Date/time :** 31/03/2014 09:21:05 **Size:** 65 KB
8	External audit report for ISS grant (Fiscal Year 2013)	6.2.3	✔	External Audit.pdf **File desc:** **Date/time :** 31/03/2014 11:35:45 **Size:** 20 KB
9	Post Introduction Evaluation Report	7.2.2	✔	PIE MCV2.pdf **File desc:** **Date/time :** 31/03/2014 11:37:24

				Size: 23 KB
10	Financial statement for NVS introduction grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✔	VIG Expenditure 2013.pdf **File desc:** **Date/time :** 31/03/2014 09:21:44 **Size:** 79 KB
11	External audit report for NVS introduction grant (Fiscal year 2013) if total expenditures in 2013 is greater than US$ 250,000	7.3.1	✔	External Audit.pdf **File desc:** **Date/time :** 31/03/2014 11:37:51 **Size:** 20 KB
12	Latest EVSM/VMA/EVM report	7.5	✔	EVM_report-Cambodia - July 2012 Update.pdf **File desc:** **Date/time :** 31/03/2014 09:22:39 **Size:** 1 MB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✔	EVM-imp-plan-Cambodia-2012 - Final.pdf **File desc:** **Date/time :** 31/03/2014 09:24:06 **Size:** 8 KB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✔	EVM Improvement Plan Progress Report 2013.pdf **File desc:** **Date/time :** 31/03/2014 09:24:38 **Size:** 55 KB
16	Valid cMYP if requesting extension of support	7.8	✘	UPDATED cMYP NIP [2011] 2008-2015.pdf **File desc:** **Date/time :** 31/03/2014 11:38:46 **Size:** 718 KB
17	Valid cMYP costing tool if requesting extension of support	7.8	✘	cMYP Costings Cambodia - PCV 2013-2015 [Final].xlsx **File desc:** **Date/time :** 31/03/2014 09:25:09 **Size:** 132 KB
18	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✘	No file loaded
19	Financial statement for HSS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent	9.1.3	✔	HSS Expenditure 2013.pdf **File desc:** **Date/time :** 02/04/2014 12:12:19 **Size:** 11 MB

	Secretary in the Ministry of Health			
20	Financial statement for HSS grant for January-April 2014 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✔	Financial statement for Q1 2014.pdf **File desc:** **Date/time :** 07/05/2014 02:25:57 **Size:** 12 MB
21	External audit report for HSS grant (Fiscal Year 2013)	9.1.3	✔	HSS External Audit.pdf **File desc:** **Date/time :** 03/04/2014 11:48:19 **Size:** 15 KB
22	HSS Health Sector review report	9.9.3	✔	MOH JAPR 2013 final.pdf **File desc:** **Date/time :** 05/05/2014 02:26:49 **Size:** 2 MB
23	Report for Mapping Exercise CSO Type A	10.1.1	✕	No file loaded
24	Financial statement for CSO Type B grant (Fiscal year 2013)	10.2.4	✕	No file loaded
25	External audit report for CSO Type B (Fiscal Year 2013)	10.2.4	✕	No file loaded
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 2013 on (i) 1st January 2013 and (ii) 31st December 2013	0	✔	Bank Statement_Jan+Dec_2013.pdf **File desc:** **Date/time :** 07/05/2014 02:19:32 **Size:** 1 MB
27	Minutes ICC meeting endorsing change of vaccine prensentation	7.7	✕	No file loaded

	Other		×	TWGH [ICC] 2013 Minutes.zip **File desc:** **Date/time :** 01/04/2014 09:24:52 **Size:** 7 MB
				Report 12 Population-Projection.pdf **File desc:** Census Population Projections 2012 **Date/time :** 24/03/2014 06:46:43 **Size:** 4 MB
				fwdcentralvaccinestorestemperaturemonitoring2013.zip **File desc:** EVM Progress - Cold Chain Store Temperature Study **Date/time :** 01/04/2014 09:29:12 **Size:** 6 MB
				Cold_Chain_Impact_Assessment_for_IPV -Draft _12 March.pdf **File desc:** EVM Progress Report - Cold Chain Assessment 2013 IPV **Date/time :** 31/03/2014 11:29:02 **Size:** 1 MB
				CAM_CC_Inventory Analysis PCV13 introduction Final.xlsx **File desc:** EVM Progress Report - Cold Chain Assessment 2013 PCV13 **Date/time :** 31/03/2014 11:25:35 **Size:** 201 KB
				MR-SIA Report - Final + Preface 24 Jan.pdf **File desc:** MR SIA Report 2013 **Date/time :** 01/04/2014 07:16:02 **Size:** 1 MB
				KH_DataQualityReportCard_2011.pdf **File desc:** WHO Data Quality Assessment 2011 **Date/time :** 24/03/2014 06:46:11 **Size:** 1 MB
				KH_DataQualityReportCard_2012_fin.pdf **File desc:** WHO Data Quality Assessment 2012 **Date/time :** 24/03/2014 06:46:25 **Size:** 2 MB