Cambodia Cash Support for

HEALTH SYSTEMS STRENGTHENING (HSS)

This Decision Letter sets out the Programme Terms of a Programme.

1. **Country:** Cambodia
2. **Grant number:** 1519-KHM-10a-Y
3. **Date of Decision Letter:** 13 July 2015
4. **Date of the Partnership Framework Agreement:** 16 November 2013
5. **Programme Title:** Health Systems Strengthening (HSS)
6. **HSS terms:**

The ultimate aim of HSS support is to ensure increased and sustained immunisation coverage through addressing health systems barriers in Country, as specified in:

- The relevant Gavi HSS guidelines – please contact your SCM at rajkumar@gavi.org for the guidelines.
- The relevant Gavi HSS application form - please contact your SCM at rajkumar@gavi.org for the form.
- Country's approved grant proposal and any responses to the HSS IRC's request for clarifications.

Any disbursements under Gavi's HSS cash support will only be made if the following requirements are satisfied:

- Gavi funding being available;
- Submission of satisfactory Annual Progress Reports (APRs), or equivalent, by the Country;
- Approval of the recommendation by a High Level Alliance Review Panel for continued support by Gavi after the second year;
- Compliance with any TAP requirements pursuant to the TAP Policy and under any Aide Memoire concluded between Gavi and the Country;
- Compliance with Gavi's standard terms and conditions (as set out in the PFA); and
- Compliance with the then-current Gavi requirements relating to financial statements and external audits, including the requirements set out for annual external audit applicable to all Gavi cash grants as set out in Gavi's grant terms and conditions.

The HSS cash support shall be subject to Gavi's performance-based funding (PBF). Under this, the HSS support will be split into two payments: the programmed payment (based on implementation of the approved HSS grant) and the performance-based payment (based on improvements in immunisation outcomes). This means that in the first year, Country will receive 100% of the approved ceiling, or programme budget, if different (the initial Annual Amount), as an upfront investment. After the first year, countries will receive 80% of the ceiling, or programme budget, if different, based on implementation of the grant, and additional payments will be based on performance on immunisation outcome indicators. Note that countries whose total grant budget would fall below US$3 million are exempt from this 80% rule.

Country will have the opportunity to receive payments beyond the programme budget amount, for exceptional performance on the same immunisation outcomes. The maximum

programmed payment plus performance payment may be up to 150% of the country ceiling.

Performance payments for a given year will be made the following year, based on performance of the indicators listed and data verification.

If a Country's DTP3 coverage is **at or above 90%** at baseline* based on WHO/UNICEF estimates, Country will be rewarded for sustaining high coverage with:

- 20% of programme budget for maintaining DTP3 coverage at or above 90%; and
- 20% of programme budget ensuring that 90% of districts have at or above 80% DTP3 coverage.

** The baseline is defined as the year prior to the first year of HSS grant implementation. For example, if a country begins grant implementation in February 2015, then their baseline is 2014. Even if a country begins grant implementation in December 2015, their baseline would still be 2014.*

7. **Programme Duration[1]:** 2015 to 2019

8. **Programme Budget (indicative) (subject to the terms of the Partnership Framework Agreement, if applicable):**

Note that with PBF, annual disbursements may be more or less than these endorsed amounts after the first year (see section 6 above).

	2015	2016	2017	2018	2019	Total[2]
Programme Budget (US$)	4,299,456	3,439,458	3,439,978	3,439,158	3,439,998	18,058,048

9. **Indicative Annual Amounts (indicative) (subject to the terms of the Partnership Framework Agreement):**

The following disbursements are subject to the conditions set out in sections 6, 10, 11 and 12:

Programme Year	**2015**	**2016**	**Total[3]**
Annual Amount (US$)	4,299,456	3,439,458	7,738,914

10. **Financial Clarifications:** The Country shall provide the following clarifications to Gavi[4]: Not Applicable

If the bank account information most recently provided to Gavi has changed or changes prior to disbursement, the country will need to complete a bank account information form. Please contact gavihss@gavi.org for the form.

[1] This is the entire duration of the programme.
[2] This is the total amount endorsed by Gavi for the entire duration of the programme.
[3] This is the amount approved by Gavi.
[4] Failure to provide the financial clarifications requested may result in Gavi withholding further disbursements.

11. Documents to be delivered for future HSS cash disbursements:

The Country shall deliver the following documents by the specified due dates as part of the conditions for approval and disbursements of the future Annual Amounts.

Reports, documents and other deliverables	Due dates
Annual Progress Reports (APRs), or equivalent. The APRs, or equivalent, shall provide detail on the progress against milestones and targets against baseline data for indicators identified in the proposal, as well as the PBF indicators as listed in section 6 above. The APRs, or equivalent, should also include a financial report on the use of Gavi support for HSS (which could include a joint pooled funding arrangement report, if appropriate), and use of performance payments, which have been endorsed by the Health Sector Coordination Committee (HSCC) or its equivalent.	15 May 2016 or as negotiated with Secretariat
Interim unaudited financial reports. Unless stated otherwise in the existing Aide Memoire between Gavi and the Country, the Country shall deliver interim unaudited financial reports on the HSS cash support no later than 45 days after the end of each 6-month reporting period (15 February for the period covering 1 July – 31 December and 15 August for the period covering 1 January – 30 June). Failure to submit timely reports may affect future funding.	15 February and 15 August
In order to receive a disbursement for the second approved year of the HSS grant (YEAR 2), Country shall provide Gavi with a request for disbursement, which shall include the most recent interim unaudited financial report.	As necessary

12. Other conditions: The following terms and conditions shall apply to HSS support.

Cash disbursed under HSS support may not be used to meet Gavi's requirements to co-finance vaccine purchases.

In case the Country wishes to alter the disbursement schedule over the course of the HSS programme, this must be highlighted and justified in the APR, or equivalent, and will be subject to Gavi approval. It is essential that Country's Health Sector Coordination Committee (or its equivalent) be involved with this process in both its technical process function and its support during implementation and monitoring of the HSS programme proposal. Utilisation of Gavi support stated in this letter will be subject to performance monitoring.

Signed by,
On behalf of Gavi

Hind Khatib-Othman
Managing Director, Country Programmes
13 July 2015

Appendix A

Independent Review Committee (IRC) Country Report

GAVI Secretariat, Geneva • 16 - 27 March 2015

Country: Cambodia

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1. Type of support requested

Table 1

Planned start date *(Month, Year)*	Duration of support	Vaccine presentation(s) *(1st, 2nd, and 3rd choice)*
HSS	2015 – 2019	

2. In-country governance mechanisms (ICC/HSCC) and participatory proposal development process

Proposal development was led by the National Immunisation Programme with inputs from some other departments of the MoH and support from WHO and UNICEF. It is not clear whether staff from provincial and district levels were involved.

The Minister of Health and the Minister of Finance signed off on the proposal and budget. The proposal was presented to and endorsed by the Technical Working group for Health (TWGH) -- the main forum for dialogue between government, donor partners and NGOs (represented by Medicam). When the revised proposal was presented to the TWGH on 15 January, 2015 a representative of one bilateral donor "… raised concerns about the issue of incentive payments and asked that the MOH and development partners conduct a general review of incentive payments later this year."

3. Situation analysis – Status of the National Immunisation Programme

Coverage and data quality: WHO/UNICEF (WUENIC) have consistently endorsed administrative estimates of DPT3 coverage of 91% to 95% for the last five years. Administrative estimates have been largely consistent with findings from DHS surveys in 2005 and 2010. A DHS is currently under way and preliminary results should be available sometime in 2015. Nationwide, the average drop out between first and third dose for Pentavalent vaccine is estimated to be less than 3%. A rigorous 2012 assessment of data quality found excellent completeness of data and good internal consistency.

Bottleneck analysis: The proposal is accompanied by a collection of documents which demonstrate a good understanding of health system constraints for immunisation outcomes:

Demand side: The 2010 EPI review presented findings from a household survey on reasons for non-vaccination. Of note, 22% of respondents said that they feared vaccinations. "... currently, there is no government budget source to finance village based social mobilization of health education. Demand creation is an area of priority and urgency..."

Supply side: As noted by the NIP Strategic Plan, 2008-2015, "Major barriers to improving immunisation coverage" include

- Many communities are far from any health facility. As a result, expensive outreach activities remain key for the achievement of high immunization coverage.
- "The salaries of staff are highly dependent on health equity funds and contracting mechanisms and NGO supplements. This is clearly non-sustainable in the longer term..."
- "Outreach activities conducted with limited support ...(with exception of areas where there are NGOs support)."

The 2010 EPI Review identified a complementary health system bottleneck: "Lack of village level analysis... the tendency to implement "standardized" approaches..."

The NIP has done a lot of work to locate 1,832 "high risk communities" (coverage <80%) and characterize the unimmunized. "The high-risk groups fall into 4 categories: mobile workers and their families; ethnic minorities with different languages and belief systems from the Khmer majority; the urban poor and poor households within settled communities; and unofficial or remote settlements...."

4. Overview of national health documents

There is good consistency between documents (the proposal, the Health Strategic Plan, the cMYP, the National Immunization Program Strategic Plan and the 2010 EPI Review) in the emphasis on equity and the identification of bottlenecks. A new 5 year Health Strategic Plan and a new 5 year Immunization Strategic Plan are now being prepared.

The MOH's Health Strategic Plan 2008-2015 has 4 cross-cutting themes: service quality improvement, accountability, efficiency and equity. It cautions against vertical programming: *"Fragmented aid architecture prevents a broader systemic approach to health sector management and drives health service delivery towards more non-integrated vertical approaches and project approaches. This makes the overall stewardship role of the Ministry of Health difficult and limits integration of financing systems"*

5. Gender and Equity

The 2010 DHS showed no significant difference in DPT3 coverage between boys (84.6%) and girls (85.1%). The same survey found disparities in immunisation coverage between urban and rural population (90.4% and 83.7% respectively) and among wealth quintiles (ranging from 73.5% and 92.6%). Eighteen districts have coverage of less than 80%.

The NIP developed Implementation Guidelines for High Risk Communities which set out a 5-step process to target hard-to-reach groups. The process, comparable to a reach every community approach, focuses on the development and implementation of micro-plans for identified high risk communities.

6. Proposed activities, budgets, financial planning and financial sustainability

Lessons learnt from existing HSS: The Joint Appraisal notes that the immunisation coverage is higher in the 10 districts supported by the existing HSS grant than in other districts of the country. Unfortunately, there has been no evaluation of activities supported under this grant and the lessons learned section of the proposal provides only limited description of what has actually taken place in the 10 districts. A report is provided of a 2012 evaluation following 3 months of implementation of the high risk strategy. While the evaluation concluded that the approach appeared to be working well it also noted that "… there was low demand for services among the under-served minorities…" and recommended that the NIP "…work with NGO communication specialists…".

Proposed HSS objectives and budget

The overall budget for the HSS proposal is US$ 18,055,250 for the following 5 objectives:

Objective 1 (US$ 6.6M)**: "Increase immunization coverage in high risk communities"**. Of the total allocated to this objective, 36% of the budget would directly support increased coverage through outreach immunization activities. The remaining 64% of funds would go for what was described in the original proposal as collection of data ("This activity will ensure that the database of high-risk communities contains up to date and accurate information"); meetings to support data collection ("The meetings will update data on high-risk communities, and collect surveillance forms, immunization coverage data, and update registers. The output will be better quality data."), supervision visits to high risk communities and a central review workshop.

The original proposal did not explain how data collection, supervision and review meetings would result in increased coverage in high risk communities. The revised proposal clearly explains that, in addition to data collection and supervision, funds for objective 1 would support some demand creation efforts in high risk communities and support the development and implementation of local micro-plans ("The meetings will be used to identify key problems at community level in getting high-risk households to take up immunization and attend immunization outreach visits, and how these obstacles might be addressed.")

Objective 2 (US$ 2.8M): **"Strengthen cold chain system through improved equipment and management".**

The proposal notes that "...two-thirds of cold chain equipment is now over 10 years old and ... A major challenge is insufficient government funding for maintenance and repair ...." The November IRC questioned whether sufficient funds were to be allocated for maintenance from the new HSS grant. The revised proposal calls attention to the fact that the budget includes US$ 575,000 for spares and repairs but notes that the challenge of strengthening government allocations and HR for this purpose will have to be addressed in the longer term. In 2015 UNICEF/NIP will assess repair and maintenance for health systems generally to ascertain longer term HR needs and financing strategy.

The proposal is well articulated and transparent with respect to strengthening the cold chain and Cambodia is well positioned to implement the activities if certain specific issues are addressed. An EVMA conducted in 2012 indicated good supply chain performance with the notable exception of maintenance standards where a low score (50%) was awarded. An EVM improvement plan progress report from Aug 2014 notes that progress in implementing the EVM recommendations is modest.

The HSS budget allocates US$ 1,783,000 for cold chain equipment: 1410 refrigerators and 4 cold rooms.

- The November IRC asked for clarification regarding the source of funds for 2 additional cold rooms. The revised proposal adequately specifies the source.

- The cold chain inventory of 2013 lists 1,072 Gas/Electric absorption refrigerators. These are notorious for freezing vaccines if not well maintained and regulated. Cambodia reports major improvements in the availability of electrical power, so future procurement of absorption refrigerators can (and should) be avoided.
- There is no specific reference to the new equipment being WHO/PQS prequalified. Since the unit costs are US$ 1060 and no stabilisers are planned, this suggests that equipment may not be WHO/PQS prequalified. In the Nov 2014 review of Cambodia, the IRC noted that *the Secretariat should monitor refrigerator procurement requests to ensure that appropriate WHO/PQS prequalified equipment is procured with HSS funding.*
- The November IRC asked for clarification regarding the allocation of supply chain equipment specifically to high risk communities. Adequate clarification is provided in the revised proposal.
- The November IRC suggested revision of the target for the intermediate results indicator regarding refrigerators < 10 years old. A more appropriate target is now specified in the revised proposal.

Objective 3 (increased from US$ 0.4 M to US$ 1.5 M): "**Increase community awareness of, and demand for, immunization".** The original proposal noted the limited effectiveness of current print-based communication activities but budgeted very little to implement alternative strategies. The November IRC wrote that "The strategy for reaching the hard-to-reach will have limited success unless a larger budget is allocated to communication / demand creation activities." No funds were to be allocated for NGOs which now are widely engaged in Cambodia in demand generation activities (not yet focused on immunization). The revised proposal points out that some of the work performed under objective 1 (e.g. "Support VHSG to get data...") would involve support for demand creation. More importantly, the revised proposal allocates an extra US$ 1M for objective 3. Most of this is to support implementation of new communication activities that have yet to be defined and developed. This is discussed further in the below section on CSO activities.

Objective 4 (US$ 1.9 M): "**Strengthen the surveillance of vaccine-preventable diseases".** The activities involve support for training and coordination meetings at various levels. Limited information is provided on the curriculum but it appears that it would be limited to surveillance for vaccine preventable diseases.

Objective 5 (decreased from US$ 6.1 M to US$ 5.0 M): **Strengthen management capacity to support EPI.** Of the budget for Objective 5, the original proposal called for US$ 2.5 M) to be allocated to quarterly supervision visits" "This will allow supervision that focuses specifically on immunization, and especially coverage in high-risk communities." Together with the supervision budgeted for under Objective 1.7, the proposal would thus allocate a total of US$ 4.0 M to supervision activities. The November IRC asked whether economies could be achieved through

integration of the two supervision activities. The revised proposal reduced the total amount budgeted for supervision to US$ 3.7 M and noted that the supervision to be conducted under Objective 1.7 would focus on high risk communities while the supervision to be conducted under Objective 5 would support routine immunization nationwide.

Both the original and the revised proposals call attention to the fact that this supervision would focus exclusively on immunization services. The November 2014 IRC appealed to the authors of the proposal: "In collaboration with other units involved with primary health care, consider how the outreach, supervision, data collection and incentive activities might help to improve access to at least a few other essential community health services beyond immunization." In response, the revised proposal notes that "There are strong links between the activities under this proposal and service delivery for maternal and child health. The visits of immunization staff to villages and the work of Village Health Support Groups at community level provide opportunities [to support] ... maternal and child health, reproductive health and health insurance for the poor.... narrative has been added to sections 10, 11 and 12 of the proposal to note these linkages."

Another US$ 1.7 M (reduced from US$ 1.8 M in the original proposal) of the funds for Objective 5 would pay Incentives for "NIP staff, cooperating departments in MOH, and key NIP staff at PHD, OD and HC levels". The November 2014 IRC asked that new guidelines be developed for such incentives and that these be discussed by the TWFH. The revised proposal is accompanied by a document entitled "Gavi incentive scheme guidelines." The TWGH has agreed to a joint review by MOH and donor partners of the role of incentive payments for health staff.

Procurement

The November 2014 IRC asked the NIP to "Please provide details regarding the US$ 0.66 M of management equipment to be procured." The revised budget reduces the budget for this line to US$ 140,000 and the revised proposal lists the equipment to be purchased.

Financial management of the grant

For the proposed new grant, funds for the NIP and the 25 provinces will be transferred to a designated Gavi account in the National Maternal and Child Health Center (NMCHC -- the administrative unit to which NIP belongs). Gavi's Program Fiduciary Oversight team have raised concerns that "This may increase the fiduciary risk as NMCHC's FM capacity has never been assessed..." The revised proposal invites Gavi to perform another FMA and notes that "NMCHC has strong capacity to manage external funds, having experience with managing funds for US-CDC, Global Fund, UNICEF, WHO, UNFPA, JICA and HSSP2."

Financial sustainability of activities to be funded under the HSS grant

The section of the proposal devoted to sustainability notes only that "... financial sustainability will require long-term commitment from government". The revised proposal adds only that "Village Health Support Groups [VHSGs] are ... being increasingly linked to the government's D&D [Decentralization & Deconcentration] strategy ... As the D&D system is rolled out, Commune Councils and District Councils are likely to play an increasingly important role in funding the work of VHSGs..."

M&E and the results chain

The proposal draws a clear link between objectives, activities and immunization outcomes with a strong emphasis on supervision and micro-plans. The results chain and the M&E framework are well aligned. The results chain has been revised from the original submission to include the incentives for immunization program staff (US$ 1.9M = 10% of the budget). The 6 indicators required by Gavi have been included in the M&E framework. In response to IRC comment on the original submission, the revised M&E framework includes "intermediate results" indicators which measure progress with implementation.

Total expenditure on M&E is approximately 9% of the overall budget. Cambodia has included plans to conduct each year an EPI coverage survey and a data quality assessment. An EPI review is planned for 2015 and an external evaluation of the HSS grant is also budgeted for (US$ 90,000) in year 5. Cambodia's application indicated it will use administrative data to verify outcomes for PBF in its alternative data verification form.

7. Specific comments related to requested support

Community Sensitisation & Mobilisation

Activities pertaining to community sensitisation are generally adequately described although they do not really differentiate between the different types of so called high risk communities (e.g. urban and rural communities would have very different challenge in terms of communication and social mobilisation).

Financial sustainability of immunization

The country finances all its traditional vaccines needs, has paid Gavi co-financing and has never been a default. It is estimated that 67% of the budget for the NIP is provided by Gavi.

Engagement of civil society, including for implementation:

The proposal and accompanying documents repeatedly note the important roles played by NGOs in social mobilization/health promotion, incentives for facility staff and support for

outreach. Yet no consultations were held with NGOs when developing the proposal and none of the budget is allocated to them. The November 2014 IRC asked for a more complete justification of this decision. The revised proposal responded carefully and thoughtfully to this request, saying that "It is not known how many or which NGOs currently work in the communities listed as high-risk ... or whether their activities relate to ... immunization education and awareness raising. In collaboration with NIP, UNICEF will therefore undertake an assessment and mapping exercise in 2015 which will detail the NGOs working in these locations ... the results will allow NIP to identify NGOs with which it can work... If NGOs are active in high-risk locations but not supporting health-related activities, it might still be possible to supply them with support materials through the VHSG... There is a substantially increased budget (from 3% to 8%) to allow for communication and demand-creation work in cooperation with NGOs under Activity 3.4."

8. Country document quality, completeness, consistency and data accuracy

There is good consistency between key documents. Assessments have found that administrative data are reasonably accurate.

9. Overview of the proposal

Strengths:

1. Cambodia has achieved high levels of immunization coverage (DPT3 roughly 90%);
2. Data quality appears to be good;
3. Various official documents (including the HSS proposal) document that the NIP wants to focus on equity as a top priority;
4. "High risk communities" and "high risk groups" have been identified;
5. The NIP has developed robust "Implementation Guidelines for High Risk Communities" that feature micro-planning to develop locally appropriate approaches;
6. The revised proposal has responded thoughtfully and appropriately to each of the concerns with the original proposal that were identified by the IRC of November 2014. This has clarified the logic of the planned activities and strengthened their content (e.g. increased funding for demand-side activities);
7. In particular, US$1 M has been added to the budget for demand creation.

Weaknesses:

1. The MoH and its partners (TWGH) have yet to reach consensus on the guidelines for incentives. As noted by the new Gavi Operational Guidelines, existing norms (e.g. national plan or policy) should govern the payment of salaries, top ups and incentives.

2. Both the incentives and the vertical approach to supervision of immunization activities are unlikely to be sustained after GAVI HSS funding comes to an end.

Table 2

Comments for consideration
1. Development of district capacity for effective, integrated approaches to supervision will take time and resources but will pay off in the long run and be much more sustainable.
2. Considering the high cost of reaching out to high risk communities, it would be more cost-effective for outreach sessions to deliver a broader range of health services in addition to immunization. Such an approach should be developed and piloted.
3. A freeze risk study (WHO/IVB 5.01 protocol) is needed (or a report from such a study) to assess the potential during storage and transportation
4. Assure that the WHO/PQS pre-qualified vaccine refrigerators that are procured are carefully matched with the quality and availability of energy available.

10. Conclusions

Cambodia is to be commended for the progress it has made, nearly doubling immunization coverage since 2000. With DPT3 coverage now about 90%, the NIP is now appropriately focused on immunizing the remaining 10%. They have made progress identifying the unreached and developing a strategy to reach them.

The "Implementation Guidelines for High Risk Communities" provide a focus on equity and a strategy that matches well with GAVI priorities. The revised proposal has clarified the logic of the planned activities, strengthened their content and improved their chances of success.

11. Recommendation:

Approval

Table 3

Issue to be addressed	Action points
1. Sector-wide guidelines for payment of incentives and salary top ups	The NIP has already taken a big step in discussing with the TWGH the guidelines for "GAVI incentive scheme guidelines." An important next step is the planned joint review by the members of the TWGH of incentive guidelines for health workers. Please update Gavi on when this review will likely tak place.
2. Make/models of refrigerators proposed	Indicate the make/models of refrigerators proposed, and if thes are compression refrigerators, why voltage stabilisers are not required.
3. WHO/PQS compliance of col chain equipment	Supply chain equipment (Cold rooms and vaccine refrigerators are to be WHO/PQS prequalified and supplied with voltage stabilizers as may be appropriate.

Approved budget for HSS

Table 4

	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
	July – Dec 2015	*Jan – Dec 2016*	*Jan – Dec 2017*	*Jan – Dec 2017*	*Jan – Dec 2018*	
5-year annual ceilings provided by Gavi (US$) *[country annual budget cannot exceed this amour*	4,300,000	3,440,000	3,440,000	3,440,000	3,440,000	18,060,000
Budget request from Country Proposal (US$)	4,299,456	3,439,458	3,439,978	3,439,158	3,439,998	18,058,048
Budget approved by IRC - different from proposal budget (US$)	4,299,456	3,439,458	3,439,978	3,439,158	3,439,998	18,058,048