



Application Form for Country Proposals

Providing approximately two years of support for an HPV Vaccination Demonstration Programme

Deadlines for submission of application:
25 January, 8 September 2015

Submitted by:

The Government of the Kingdom of Cambodia

Date of submission: x September 2015

Please submit the Proposal using the form provided.

Enquiries to: proposals@gavi.org or representatives of a Gavi partner agency. Unless otherwise specified, the documents will be shared with Gavi partners, collaborators and the general public. The Proposal and attachments must be submitted in English, French, Spanish, or Russian.

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

The Gavi Secretariat is unable to return submitted documents and attachments to countries. Gavi

1. Application specification

Q1a. Please specify vaccine preference.

Preferred vaccine Bilavent (GSK) or Quadrivalent (Merck) See <i>below</i> for more information	Month and year of first vaccination	Preferred presentation ¹ second
Cervarix (GSK)	December 2016	Quadrivalent (Merck)

Q1b. Please summarize the rationale for choice of preferred vaccine. Also, please clarify whether the vaccine is licensed for use in the country.

Both vaccines are licensed for use in Cambodia.

Cervarix has less impact on the cold chain since the product comes as a 2-dose presentation in a single vial.

Gardasil provides additional protection against infections from HPV types 6 and 11 and thus prevents anogenital warts. Gardasil's single dose presentation reduces wastage.

2. Executive summary

Q2. Please summarize the rationale and the expected outcome of the HPV vaccination demonstration programme Plan.

Cambodia is applying for Gavi support to conduct a 2-year HPV vaccine demonstration project because cervical cancer is the leading cause of cancer for Cambodian women. HPV vaccine is a valuable primary prevention for a disease that causes significant morbidity and mortality and for which secondary prevention through screening and treatment is very limited in the country. However, the challenge of routinely delivering a multi-dose schedule of this new vaccine to a new target population, 9-13 year old girls, is one that has not previously been addressed by the Cambodian immunization program.

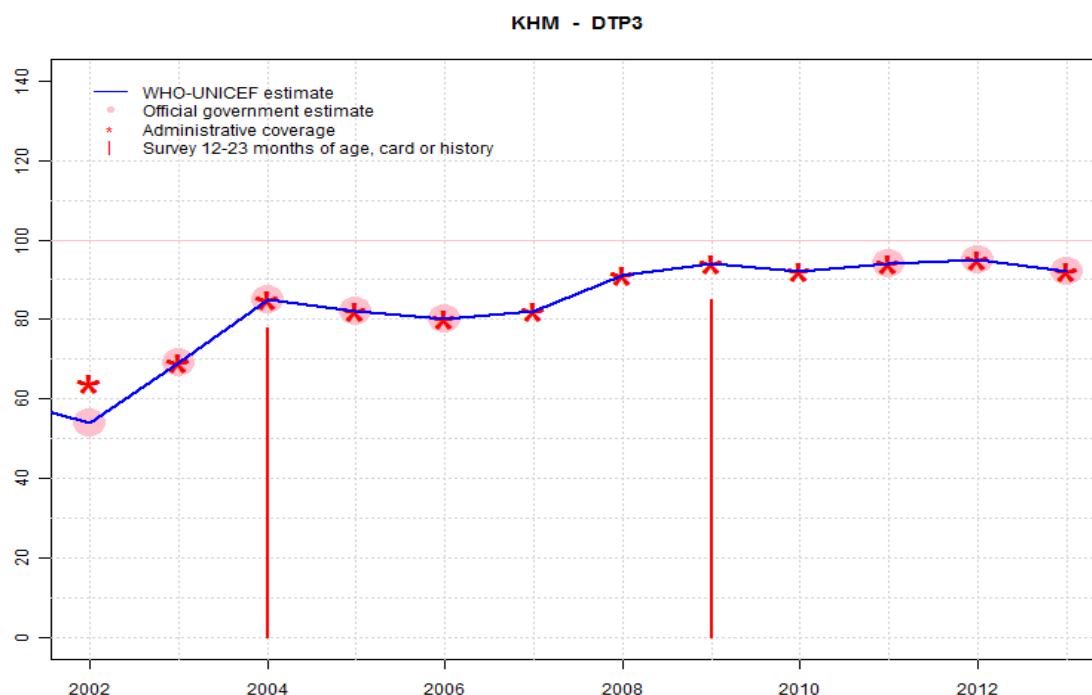
The Gavi HPV vaccine demonstration programme offers an important opportunity not only to gain experience with successfully delivering HPV vaccine in Cambodia but also to evaluate the vaccine delivery to understand coverage, programme issues, and costs, together with the potential opportunities to integrate with other adolescent health activities and how the vaccination fits into a national cervical cancer strategy. The implementation and the evaluation components of the demonstration project will allow Cambodia to gather valuable in-country experience and evidence. These will be used to inform the program and policy discussions which are needed to make a government decision on whether, when, and how to pursue national scale-up of HPV vaccine introduction. The expected outcome of the HPV vaccination programme is to generate the evidence of how to affordably and sustainably solve the programmatic challenges of routinely delivering 2 HPV vaccine doses to girls with the highest coverage possible. In the longer term, the expected outcome is that the evidence will lead to a decision for national HPV vaccine introduction followed by significant reduction of cervical cancer in Cambodia.

3. Immunisation programme data

Q3. Please provide national coverage estimates for DTP3 for the two most recent years from the WHO/UNICEF Joint Reporting Form in the table below. If other national surveys of DTP3 coverage have been conducted, these can also be provided in the table below.

NOTE: Applications for the HPV vaccination demonstration programme will be open to any Gavi-eligible country with at least 70% DTP3 coverage at the national level, based on the latest available WHO/UNICEF estimates.

Trends of national DTP3 coverage (percentage)				
Vaccine	Reported		Survey	
	2014 year	2013 year	2014 year	2010 year
DTP 3	97 %	92 %	84%	85%



Q4. If survey data is included in the table above, please indicate the years the surveys were conducted, the full title, and if available the age groups the data refer to.

The above DTP3 coverage survey data are from the 2010 and 2014 reports of the Cambodia Demographic and Health Survey (DHS) which were conducted in 2010 and in 2014, respectively. DHS collects data on children <60 months of age. Questions regarding immunization status are asked of caregivers for children 12-23 months old; the number of 12-23 month old children is the denominator for calculating vaccination coverage. In some countries, the availability of these data vary and vaccination data are collected on older children.

Note: The IRC may review previous applications to Gavi for a general history of a country's capacities and challenges.

4. HPV vaccination demonstration programme plan

1.1 Province profile

Q5. Please describe which district or districts have been selected for the HPV vaccination demonstration programme, completing all components listed in the table below. Also, kindly provide a province level map of the country.

For further information on factors to consider when selecting the districts, please refer to Annex D of the HPV Demo Supplementary Guidelines.



Above is a map of The Kingdom of Cambodia which depicts all the provinces. The two provinces that have been selected for this HPV vaccine demonstration project are Kampong Thom and Svay Rieng.

It should be noted that for estimates in the responses included in the table below, we used total population data for girls based on projections from the 2008 National Census and we used data from public and private school enrolment from the Ministry of Education, Youth, and Sports. Projections based on the 2008 National Census appear to provide somewhat lower population numbers than are evident in the actual 2014-2015 school enrolment data and will account for occasional discrepancies when one sums the numbers from these 2 different data sources.

Component	Province 1: Kampong Thom	Province 2: Svay Rieng
Topography (% urban, % semi-urban, % remote, etc.)	8 % urban and 92% rural. Data source: National Institute of Statistics, Ministry of Planning.	3.53%Urban and 96.47 rural. Data source: National Institute of Statistics, Ministry of Planning.
Number and type of administrative subunits, e.g., counties, towns, wards, villages		4 Operational districts (OD):Svay Rieng;Chipou,Svay Teab and Romeashek, each OD has 2-3 administrative districts; 2 towns, 80 wards,

		690 villages in the province, data source: Provincial Health Department.
Total population (estimated for 2016)	688,305, data source for this row and next 2 rows: Population Projections of Cambodia from 2008 Census, January 2011, National Institute of Statistics, Ministry of Planning.	504,905, data source: Population Projections of Cambodia from 2008 Census, January 2011, National Institute of Statistics, Ministry of Planning.
Total female population (%)	50.6%, data source: see above, National Institute of Statistics	51.3%, data source: see above, National Institute of Statistics
Total female population aged 9-13 years by age (% of total female population) 9 years 10 years 11 years 12 years 13 years	data source: see above, National Institute of Statistics 9 years old girls = 6,958, 2.14% 10 yrs old girls = 6,892, 2.29% 11 yrs old girls = 6,850, 2.04% 12 yrs old girls = 6,891, 1.94% 13 yrs old girls = 7,050, 1.64%	data source: see above, National Institute of Statistics 9 years old girls = 4,606, 1.97% 10 yrs old girls = 4,553, 1.97% 11 yrs old girls = 4,525, 1.95% 12 yrs old girls = 4,565, 1.96% 13 yrs old girls = 4,700, 1.99%
Number and type of public health facilities	3 referral hospitals; 52 health centers, 3 health posts; data source: Provincial Health Department.	4 referral hospitals, 43 health centers, 1 health posts; data source: Provincial Health Department.
Number and type of health workers in all district public health facilities	69 doctors, 154 secondary nurses, 135 primary nurses, 104 midwives, 256 other health workers; data source: Provincial Health Department.	50 doctors, 7 Pharmacists, 6 dentist, 16 medical assistant, 137 secondary nurses, 166 primary nurses, 65 secondary midwives, 81 primary midwives, 38 other health workers; data source: Provincial Health Department.
Number and type of private health facilities	3 private general clinics; data source: Provincial Health Department.	7 private general clinics, data source Provincial Health Department.
Number and type of health workers in private health facilities in the district	11 private doctors, 9 secondary nurses; 1 secondary midwife; data source: Provincial Health Department.	14 private doctors, 30 secondary nurses; 20 secondary midwife; data source: Provincial Health
Number and type of public and private primary and secondary schools	468 public primary schools; 14 public disadvantaged schools; 92 public secondary schools; 2 public disadvantaged secondary schools; 3 private primary schools; 2 private secondary schools; 2 primary school age classes in pagoda; data source: Ministry of Education, Youth, and Sports, Education Statistics & Indicators, 2013-14; Tables 4, 8	261 public primary schools; 1 public disadvantaged school; 54 public secondary schools; 0 public disadvantaged secondary schools; 1 private primary schools; 11 primary school age classes in pagoda; data source: Ministry of Education, Youth, and Sports, Education Statistics & Indicators, 2014-15; Tables 5,6,7,8
Estimate the number and percent of girls in school for each of the following ages:	9 year old girls – 7005; 96.3% 10 year old girls – 7515; 96.2%	9 year old girls– 4957; 96.3% 10 year old girls–5112; 96.2% 11 year old girls–4755; 94.7%

9 year old girls 10 year old girls 11 year old girls 12 year old girls 13 year old girls	11 year old girls –6689; 94.7% 12 year old girls –6360; 88.1% 13 year old girls –5385; 76.6% data source: Ministry of Education, Youth, and Sports, Education Statistics & Indicators, public and private school enrolment for 2014-2015; estimation of % in-school based on UNESCO analysis of 2010 data	12 year old girls–4806: 88.1% 13 year old girls–3963; 76.6% data source: provincial department of Education, Youth, and Sports, Education Statistics & Indicators, public and private school enrolment for 2014-2015; estimation of % in-school based on UNESCO analysis of 2010 data
Estimate the number and percent of girls out of school for each of the following ages: 9 year old girls 10 year old girls 11 year old girls 12 year old girls 13 year old girls	9 year old girls–241 10 year old girls–259 11 year old girls–230 12 year old girls–219 13 year old girls–185 data source: Ministry of Education, Youth, and Sports, Education Statistics & Indicators,	9 year old girls– 507 10 year old girls–508 11 year old girls–503 12 year old girls–505 13 year old girls–513 data source: provincial department of Education, Youth, and Sports, Education Statistics & Indicators,

Q6. Please give a brief description of why these provinces were selected to participate in the HPV vaccination demonstration programme.

The Provincial Health Department (PHD) and the Operational District (OD) Managers for Kampong Thom and Svay Rieng are good managers, having strong leadership and high commitment for the immunization program. Communication and collaboration with the national level is strong. Human resources at the health facility levels in these provinces are sufficient. Collaboration between the Health Department and the Education Department at the provincial levels works well.

The communities and the populations in these 2 provinces are typical of Cambodia. Approximately 80% of Cambodia's 15.2 million residents reside in rural areas. Both provinces have extensive rural areas and examples of high risk communities such as migrant populations, poor, and minority populations. The population makes their living working in garment factories, fishing, and in agriculture.

For supervision and monitoring, the provinces are accessible and can be reached within 2 hours from Phnom Penh.

Q7. Please describe the operations of the EPI programme in the district(s) selected for the HPV vaccination demonstration programme.

Component	Province 1: Kampong Thom	Province 2: Svay Rieng
Number and type of administrative subunits (e.g. health facilities) used for routine vaccine delivery	3 referral hospitals, 52 health centers, 3 health posts	4 referral hospitals, 43 health centers, 1 health posts
Number and type of outreach sessions in a typical month used for routine vaccine delivery	746 routine outreach sessions per month; 63 High Risk Outreach sessions (4 times per year)	732 routine outreach sessions per month; 35 High Risk Outreach session (4 times per year)
Polio3 coverage	97%; year 2014	95%; year 2014
Measles first dose coverage	87%; year 2014	98%; year 2014
Pentavalent 3 coverage	96%; year 2014	94%; year 2014
TT2+ (pregnant women)	54%; year 2014	52%; year 2014

Q8. Please summarise the performance of the province EPI programme as reported in any recent evaluation, for example identifying resources available, management, successes, and challenges. If information from a recent effective vaccine management (EVM) assessment is available, please include.

Temperature monitoring for vaccine storage and capacity for vaccine management based on implementation of the national policy at the provincial level showed outstanding performance for the nine program criteria evaluated during the most recent assessment of the Effective Vaccine Store Management, although there was still room for improvement. The National Immunization Program (NIP) has introduced new temperature monitoring devices using Fridge Tag 2 for all vaccine storage sites in two provinces in 2015 and plans to scale up to eight other provinces in 2016, including the two provinces selected for the HPV vaccine demonstration project. The first temperature monitoring study completed in May 2015 confirmed that the vaccines are kept within the recommended temperature (2°C to 8°C) most of the time during storage and transport; as well as provided information of risk for each level (e.g., when and where vaccines had been exposed, especially to freezing). The result from the temperature monitoring study was used to draw conclusions on causes that led to unwanted temperature excursions and helped shape key recommendations for improvement.

The storage volume capacity at the provincial district and health centre level has been increased in the last two years with instalment of new cold chain equipment using funds from Gavi IVG for introduction of PCV, as well as funding made available from LDSC. In addition, with the Gavi HSS proposal 2015-2019, about 1,400 refrigerators will be procured for the district and health center levels. This will secure a sufficient volume of storage capacity for new vaccine introduction.

Buildings to accommodate storage of vaccines and injection devices at the provincial level have been improved in many provinces, with continued building of more new Provincial Health Department offices to provide extra space for vaccine storage. Transportation of vaccines and injection devices are integrated with the Essential Drugs distribution system. The Provincial Health Department receive vaccines quarterly from the Central Medical Store.

Maintenance of the buildings, cold chain equipment, and means of transportation at the sub-national level are among the weak areas that need to be improved. These require regular advocacy to increase budgets for maintenance work at the sub-national level. The vaccine arrival report was identified as one of the weakest areas at the provincial level.

NIP has assigned core staff to provide technical support to each province. This will provide the opportunity to follow up on the issues identified from the previous monitoring visits, including supply chain management.

Q9. Please describe any current or past linkages the province EPI programme has had with the primary and/or secondary schools or other outreach locations in the district, e.g., going to schools for health education, delivery of vaccinations, fixed routine outreaches (used by the routine immunisation programme), etc.

Cambodia has experience with vaccination in schools through the highly successful Measles-Rubella Supplemental Immunization Activity (SIA) conducted in 2013 to vaccinate 9 month olds to 15 year olds children. School-age children were primarily vaccinated through schools.

A total of 4,576,633 children in the targeted age groups were vaccinated with measles-rubella vaccine with overall coverage percentage of 105%. Almost 70% of this vaccination was in school.

Specific lessons learned from the 2013 MR SIA include:

It is important to address rumours on social media (e.g., there were instances of wrong information on MR vaccine communicated via Facebook) to prevent refusals among school children and in villages; for the MR SIA, there was a need to involve district governors and local leaders to address refusals.

There is a need to produce IEC materials in the local languages of some ethnic minorities. There are many Vietnamese and Laotian communities in Cambodia which do not speak the Khmer language and though the SIA message was widely disseminated across Cambodia, it did not necessarily reach the hard to reach and ethnic minorities.

The health worker guidelines should provide better detailed descriptions of vaccination strategies in schools. Although the guideline did mention vaccination should take place at schools, class by class, inside the classroom and briefly mentioned the roles of school headmasters and teachers, it would have been better to detail what is expected from teachers during the immunization session and to clearly indicate NO vaccinations should take place in the school yards. In practice during the 2013MR SIA, many vaccinations were done in the school yards, resulting in situations where children were missed for vaccination and also in poor crowd management.

The health worker guideline also did mention about the need to prepare a list of children in advance of the day of vaccination but did not clearly specify how to deal with absent children, i.e., whether they should be referred to a nearby health center or whether a vaccination team would revisit the school for mop-up activity. It would be better to provide specific and consistent instructions on what must be done for children absent from school.

Close supervision and monitoring at multiple levels was very useful in identifying areas for improvement and taking corrective actions.

In addition, two Gardasil Access Program (GAP) projects were conducted in 2009-2011 by Hôpital de l'Amitié Khméro-Soviétique and Association des Médecins Cambodgiens with one project delivering HPV vaccine using hospital clinics and the other project delivering HPV vaccine in 9 schools and some hospital clinics. From this GAP project experience, school and health colleagues report:

- There is a need to educate the teachers adequately so that they communicate well to students and parents;
- Parent meetings will be needed to introduce information on HPV vaccination and address any questions or concerns;
- Some girls were worried about the injections, so creating a calm environment is important as well as having AEFI kits and appropriate protocols in place to address fainting or other events that could occur at the schools at the time of vaccination (e.g., prepare pediatric teams at the provincial hospitals to respond to any incidents that may arise from the HPV vaccination campaigns).

Q10. Please describe the potential challenges to access and deliver HPV vaccinations to girls and the ways in which these challenges will be addressed. For example, special sensitisation activities that will be done to reduce the potential for rumours.

The challenges will be to communicate adequately with the various members of the community (girls, parents, health workers, teachers, others) so that they understand the benefits of HPV vaccine, so that concerns about safety are adequately addressed, so that there is positive interest in the vaccine, and so vaccine acceptance and demand are generated.

Important challenges for delivery will be to access the 3.7% of girls who are out-of-school nationwide. 2010 WHO-UNESCO data show that the proportion of out-of-school 9 year old Cambodian girls vary by certain characteristics:

- 2.0% of urban 9 year old girls are out-of-school as compared with 4.0% of rural 9 year old girls;
- 0.9% of the richest quintile of 9 year old girls are out-of-school as compared with 6.8% of 9 year old girls in the poorest quintile.

The National Immunization Programme, Cambodia has conducted assessments of equity in access to immunization in Cambodia in several stages, beginning with the 2010 EPI review which identified Categories of High Risk Communities. High risk populations included: the Urban poor: 10%, the Rural hard-to-reach: 18%, Ethnic minorities: 24%, and Mobile populations: 48%.

- Urban Poor: this refers typically to slum dwellers and squatters who are often the poorest of the poor in comparison to the rural poor;
- Rural Hard to Reach: this refers to people who live in rural areas that have obstacles to easy access. This can include not only physical distance, but also poor quality roads and seasonal flooding;
- Ethnic: this includes minority people who may have a different language and cultural or religious identity;
- Mobile: this refers to people who regularly move from one place to another, usually in search of work. Types of work include garment factory workers, seasonal agricultural workers, construction workers and fishing families.

The above categories describe the populations where infant immunization has not been optimal and will undoubtedly also include girls at high risk for not getting HPV vaccination. In addition to these categories, there may be some 9 year old girls who are trying to make money or who are street children and may be unaccompanied by family.

Finding and vaccinating these high risk girls will be critical.

Q11. Please describe any recent studies, evaluations, or summaries of lessons learned related to socio-economic and/or gender barriers to the immunisation programme. If disaggregated vaccine coverage data by sex or wealth quintile is available from the routine immunisation programme, please note them in this section.

The Cambodia Demographic and Health Survey (DHS) of 2014 provide an analysis of differences in immunization coverage by maternal education, wealth, and urban/rural area of residence:

- Full infant vaccination coverage varies by mother's education, increasing from 58% among children of mothers with no education, to 70% among children of mothers with primary education, to 83% among mothers with secondary education, and to 92% among mothers with higher education.
- Full infant immunization coverage is higher in urban areas (86%) than in rural areas (71%).
- Full coverage is highest among infants in the highest quintile of wealth (91%) compared with children in the lowest quintile of wealth (61%).

The National Immunization Program has also previously undertaken several studies and examinations of inequity in immunization after the 2010 EPI review in the country. Further details may be found in the following references:

Soeung SC, Grundy J, Duncan R, Thor R, Bilous JR. From reaching every district to reaching every community: analysis and response to the challenge of equity in immunization in Cambodia. *Health Policy and Planning* (2013) 28 (5): 526-535. doi: 10.1093/heapol/czs096 First published online: October 9, 2012

Soeung SC, Grundy J, Sokhom H, Blanc DC, Thor R. The social determinants of health and health service access: an in depth study in four poor communities in Phnom Penh, Cambodia. *Int J Equity* 2012, 11:46. <http://www.equityhealthj.com/content/11/1/46>

These analyses have led to the development of a unique approach implemented in the past 2 years in Cambodia – the High Risk Community Outreach. High Risk Community Outreach takes place 3-4 times per year and requires specific, targeted microplanning at the community level to identify the high-risk communities and how best to locate them so that outreach teams can engage and vaccinate those populations (see the High-Risk Community Outreach Implementation Guideline).

1.2 Objective 1: HPV vaccine delivery strategy

Q12a. Please identify a single year of age (or single grade in school) at the target vaccination cohort within the target population of 9-13 year old girls and provide information below (see HPV Demo Supplementary Guidelines section 3.2). Countries are encouraged to use the resources in Annex A

of the HPV Demo Supplementary Guidelines to understand data sources and methods for estimating the target population in their country.

Note: The total target population for the Gavi HPV vaccination demonstration programme cannot exceed 15,000 girls per year (all districts combined). Please see section 3.2 of the HPV Demo Supplementary Guidelines for exceptions for large countries.

Girls who are 9 years old will be eligible for HPV vaccination. The data source for the information in the table below are the provincial departments that provide the Education, Youth, and Sports, Education Statistics & Indicators.,

Target population Who are the girls eligible for HPV vaccine based on the criteria set by the programme?	Province 1: Kampong Thom		Province 2: Svay Rieng	
	Total eligible Year 1	Total eligible Year 2	Total eligible Year 1	Total eligible Year 2
1. 9 year old girls in primary school	N = 7005	N = 7005	N = 4957	N = 4957
2. 9 year old girls not enrolled in school	N = 241	N = 241	N = 507	N = 507
TOTAL	7246	7246	5464	5464

Q12b. Please describe the rationale for the choice of the target population.

Cambodia plans to target HPV vaccination to 9 year old girls. The reason for selecting 9 year old girls as the single year cohort target population is that the country would like to deliver HPV vaccine to the majority of the girls via delivery in primary schools and this age group has the highest school enrolment with 96.3% of 9 year old girls in school. The older girls in the 9-13 year old age span have lower school enrolment rates (96.2% of 10 year old girls, 94.7% of 11 year olds, 88.1% of 12 year olds, and 76.4% of 13 year olds are enrolled).

Eligibility will be age-based in all settings, rather than a mixture of grade-based and age-based for several reasons:

- All girls know their age.
- Grade-based eligibility requires age cut-offs to exclude girls in the selected grade who may be younger than 8 years old or older than 13 years old, so it is not a clean single-criterion-based selection approach but in actual practice would have to actually be a mixture of grade- and age-based criteria.
- Eligibility by grade where girls of different ages are in a grade would mean that girls of the selected grade but with various ages could get vaccinated but girls of those same ages who are in other grades or not enrolled in school would not be eligible. This would be confusing from the program and communications perspectives. Health workers, parents, and girls would not always be clear on eligibility criteria.
- Students may repeat grades for educational reasons. Cambodian educational statistics show that 3-4% of girls in primary school are repeaters. Thus, a grade-based approach would also require exclusion of eligibility of repeater girls in the selected grade who had been vaccinated in the prior year.
- In any case, grade-based selection is a proxy for age-based eligibility. Age-based criteria are readily understood and can be readily implemented.

Q13. Please describe the delivery strategies that will be used to reach the target population in each district of the HPV vaccination demonstration program. **Countries should explicitly define the target population and the delivery strategy that will be used for vaccination.** A variety of

delivery strategies are available, e.g., schools, health facilities, fixed outreaches, mobile teams, and other innovative approaches.

For the 96.3% of 9 year old girls enrolled in primary school, HPV vaccine delivery is planned to take place in the schools with Project Year 1 delivery of the 1st dose in December 2016 and delivery of the 2nd dose in June 2016.

For the out-of-school 9 year old girls, 3 delivery strategies in combination with targeted social mobilization efforts will be employed:

- 1) HPV vaccination will be available for administration at Fixed Sites (health centers) continuously throughout the year;
- 2) HPV vaccination will be added to the existing Routine Outreach activities throughout the year;
- 3) HPV vaccination will be added to the High-Risk Outreach activities which take place 3-4 times per year and will be available throughout the year.

The national EPI review in 2010 showed that approximately 20% of infants did not receive all the basic vaccines and the remaining unimmunized infants resided mostly in high risk communities, namely urban poor areas, remote rural villages, ethnic and migrant communities. Following these results, Cambodia adopted the Reaching Every Community (REC) strategy as 'High Risk Community Strategy' (HRC). The main activity of this High Risk Community strategy is to reach the missed children from immunization services by conducting four times per year (quarterly) outreach immunization services in the identified high risk villages/communities.

Since 2011, the NIP took several steps, including implementation of a pilot project in three provinces to develop the high risk communities' strategies. An independent evaluation of the strategy to reach high-risk groups was conducted in 2012 and found that the strategy was effective. Lessons learned from implementing immunization services in these three provinces were incorporated into revisions of the High Risk Communities' implementation guidelines. The HRC strategy has five steps for implementation:

1. List all villages/communities in the catchment areas of the Health Centre.
2. Develop micro plans to include at least 4 outreach immunization services per year to every high risk community.
3. Prepare budgets for outreach immunization services in high risk community
4. Implement outreach immunization service according to the micro plan
5. Monitor results in high risk communities using immunization card checking

A specific database of high-risk communities has been developed (presently 1832 communities) to allow outreach immunization services at least four times in a year. Given that high-risk communities are generally poor, in isolated areas, and with limited access to health services, the implementation of this strategy is helping to address the obstacles of remoteness and to improve the access to the immunization service and coverage.

Activities to reach high risk communities are undertaken by health staff from the health center level, supervised by EPI staff from the national and provincial health department levels. In 2014, three rounds of outreach immunization services (all antigens) were conducted and immunized many populations of high risk infants who were not able to receive vaccines earlier.

The High-Risk Outreach activities have successfully reached high risk infant populations and will be an important strategy for HPV vaccination. However, special additional consideration is also needed to reach high-risk 9 year old girls who may have some characteristics that are different from high-risk infants. For example, 9 year old girls not in school may be found on the streets, in the markets, or in the fields. Some may also attend pagoda classes. There are several non-governmental organizations (NGOs) that may have some experience with performing outreach to these populations of children for educational or other activities and could possibly share insights

into accessing the particularly vulnerable and at-risk 9 year old girls (e.g., Save the Children; World Vision; End Child Prostitution, Abuse and Trafficking in Cambodia; Vulnerable Children Assistance Organization, Street Children, etc.). During the microplanning stage at the local operational district level for High-Risk Outreach activities, health centers could liaise with NGOs, pagodas, and the local health committees to further characterize who and where the out-of school girls in their districts are in order to identify where to find them for HPV vaccination and how to conduct the best social mobilization efforts to sensitize the population regarding the availability (date/time/location) and importance of HPV vaccination.

Please complete the table below for each district in the HPV vaccination demonstration programme..

Target age or grade	Year 1		Year 2	
Who are the eligible girls?	N. of girls	Delivery strategy	N. of girls	Delivery strategy
1. 9 year old girls	11,924	School	11,924	School
2. 9 year old girls	235	Fixed site, health center	235	Fixed site, health center
3. 9 year old girls	270	Routine outreach	270	Routine outreach
4. 9 year old girls	281	High risk community outreach	281	High risk community outreach
TOTAL	12,710		12,710	

Countries are encouraged to use resource materials available in Annex A to learn what has been done elsewhere, and discuss and carefully select the delivery strategies that would work best in their local context.

Q14. Please describe the planned schedule for vaccinations for each dose by the delivery strategies listed in Q13. For example, one session for each dose at two fixed times a year, or continuous availability at vaccination locations, or week-long or month-long availability twice yearly, etc.

The planned schedule for HPV vaccinations by each delivery strategy is as follows:

- School delivery: one session for each dose at two fixed times a year
- Fixed Sites (health centers): available continuously throughout the year
- Routine Outreach: available for all Routine Outreach sessions throughout the year
- High-Risk Community Outreach: available for all High-Risk Outreach sessions (3-4) throughout the year

Q15. Please describe the mechanism or strategy for reaching all the target girls with two doses¹ who were missed on the main vaccination days, specifying plans for reaching hard-to-reach or marginalized girls.

School girls who are absent and not vaccinated in schools will be instructed to go to the nearby fixed site health center to get HPV vaccine or may also get vaccinated through the Routine Outreach or High-Risk Community Outreach strategies. Hard-to-reach girls (i.e., those living in remote areas) may be vaccinated through schools or through the High Risk Community outreach. A focus on marginalized girls will be highlighted in the microplanning (see response to Q13) where characterizing who and where these girls are in the specific communities will be important, in order to target social mobilization efforts to educate and mobilize the girls to get vaccinated through the Fixed Sites, Routine Outreach, and High-Risk Community Outreach strategies.

Q16. Please provide a description of the process currently used to obtain (parental or guardian) consent for other vaccines given to the same age group targeted for HPV vaccine delivery, e.g.,

¹ NB: Three doses are required only for those known to be immunocompromised.

meningitis, hepatitis, measles, or other vaccines. Please specify whether there are any specific legal requirements for parental/guardian consent for vaccinations given to the same age group targeted for HPV vaccine delivery.

When the 2013 measles-rubella campaign for 9 month olds to 14 year olds took place, there was widespread communication of the planned campaign (using Schools, Fixed Sites, Routine Outreach, and High-Risk Community Outreach strategies) through television, radio, and through village health support groups (VHSG) as well as through local authorities such as provincial governors, district governors, commune council chiefs, village chiefs and also through school teachers. There was implied parental consent for students attending school on the day of vaccination and for children being vaccinated through the other strategies.

There are no legal requirements for parental/guardian consent for vaccination given to the same age group as targeted for HPV vaccine delivery.

Q16b. Please describe the consenting procedure that will be used for HPV vaccine delivery. Specify how the parents or guardians will be informed about HPV vaccination and how they can express their willingness to allow their daughters/girls to be vaccinated or not.

Note: Consenting procedures should in all cases be consistent with Ministry of Health policy on consent for vaccination (see HPV Demo Supplementary Guidelines section 3.2, item 5).

The consenting procedure that will be used for HPV vaccine delivery will be the same as the one used for the 2013 measles-rubella campaign: widespread communication about HPV vaccination will take place, using a broad variety of modes, to ensure community awareness and understanding. Strong communication and broad availability of information on HPV vaccine together with where and when vaccination will take place will support use of implied parental consent for girls attending school on the day of vaccination or girls being vaccinated through other strategies.

Q17. Please summarise ability to manage all the technical elements which are common to any new vaccine introduction, e.g. cold chain equipment and logistics, waste management, vehicles and transportation, adverse events following immunization (AEFIs), surveillance, and monitoring, noting past experience with new vaccine introductions (such as rotavirus, pneumococcal vaccine, or others).

Countries are encouraged to use data and information from recent post-introduction evaluations (PIE) of routine vaccine delivery to inform and provide evidence of the ability to manage the technical elements of vaccine delivery for the HPV vaccination demonstration programme.

Cambodia has successful experiences with introducing Japanese Encephalitis in 3 provinces in 2009-10, then now in 6 provinces in 2015, substituting DTP with pentavalent vaccine in 2010, introducing measles 2nd dose in June 2012, and introducing PCV13 in January 2015. Cambodia conducted an EPI Review in 2010 and conducted a Post-Introduction Evaluation (PIE) of the measles 2nd dose introduction in June 2014. Measles 2nd dose PIE findings identified areas for strengthening training and for making key new vaccine introduction practices readily accessible as posters or brochures rather than bound guidelines. Need for more advanced planning and more engagement of broader array of stakeholders at least a year in advance of introduction. Having sufficient advocacy materials with messages targeted to different audiences and collaboration with the Ministry of Education to include health education on vaccination were identified as useful areas to address.

Cambodia is currently preparing to introduce IPV in the fall of 2015 and will expand the cold chain to meet the needs of IPV introduction. Waste management needs improvement to safely dispose of needles and other waste. Updated national AEFI guidelines are being completed at this time. VPD surveillance guidelines are also in the process of being updated. An EVM assessment was done in 2012 with interval progress in improvements based on recommendations from that EVM; another EVM is scheduled to take place in July 2015. Health workers were trained prior to each vaccine introduction and regular supervision is in place.

Rotavirus sentinel surveillance is conducted at the national pediatric hospital and there are 6 JE sentinel surveillance sites. Plans have been made to initiate an IBD surveillance site in the near future.

Q18a. Please describe the cold chain status for the selected provinces and the data source(s) for this information. Information such as the number of cold storage facilities, function and working order of the facilities, storage capacity (and any excess capacity), distribution mechanism for routine delivery of vaccines, status of vaccine carriers and icepacks (e.g., supply shortages or excesses), and plan for HPV vaccine storage and distribution during the HPV vaccination demonstration programme.

Component	Province 1: Kampong Thom	Province 2: Svay Ring
Number and type of cold storage facilities	1 Provinces, 3 ODs, 52 HCs, 3 HPs*	1 Province, 4 ODs, 42 HCs, 0HP
	77 Refrigerators**	65 Refrigerators**
Functioning and working order of the facilities	59	47
Storage capacity (any excess)	No excess	No excess
Distribution mechanism	<ul style="list-style-type: none"> ▪ Quarterly: from central vaccine stores to province ▪ Monthly from province to district ▪ Monthly from district to health center and HP. 	<ul style="list-style-type: none"> ▪ Quarterly: from central vaccine stores to province ▪ Monthly from province to district ▪ Monthly from district to health center.
Number and status of vaccine carriers	71 vaccine carriers Each HC has received one new vaccine carrier including 4 icepacks in 2014	97 vaccine carriers Each HC has received one new vaccine carrier including 4 icepacks in 2014
Number and status of icepacks (any shortages or excess)	Each HC has at least three sets of icepacks for vaccine carriers by the end of 2014. No shortages or excess.	Each HC has at least three sets of icepacks for vaccine carriers by the end of 2014. No shortages or excess.

Q18b. Additional district cold chain information if necessary:

1.3 Objective 1: HPV vaccine delivery training and community sensitisation & mobilisation plans

Q19a. Please describe plans for training of health workers and others who will be involved in the HPV vaccination demonstration programme.

Approximately 4-6 weeks prior to the delivery of the 1st dose of HPV vaccine, two different training of the trainers (ToT) will take place at the provincial level, with one to orient the Dept of Education and School Health leaders and the other to educate the Dept of Health leaders and trainers. Approximately 2-4 weeks prior to delivery of the 1st dose, training at the district level of health workers and teachers will take place. Orientation and advocacy meeting with different government departments and other stakeholders will also be taken place in provinces and ODs immediate after ToT.

Q19b. (Optional) If available, countries may provide additional detail in the table below on training content, role, and framework.

Who will be trained	Role in vaccine delivery (e.g., sensitisation, mobilisation, immunisation, supervision, monitoring, etc.)	Training content (e.g., basics on cervical cancer, HPV, HPV vaccine, IEC messages, safe injections, AEFI monitoring, etc.)	Who will provide the training?
Health workers	Immunisation, supervision, monitoring	Basics on cervical cancer, HPV, HPV vaccine, HPV vaccine schedule and eligibility of girls, IEC messages, safe injections, AEFI monitoring, role of teachers during school vaccination, where girls can be vaccinated if absent at school	National Immunization Program
Provincial and ODNIP staff	Supervision, monitoring	Basics on cervical cancer, HPV, HPV vaccine, HPV vaccine schedule and eligibility of girls, IEC messages, role of teachers during school vaccination, where girls can be vaccinated if absent at school	National Immunization Program
Teachers	Sensitization of community, prepare lists of 9 year old girls, collaborate with health workers, inform parents, answer questions, education of the girls on HPV vaccine	Basics on cervical cancer, HPV, HPV vaccine, HPV vaccine schedule and eligibility of girls, IEC messages, role of teachers during school vaccination, where girls can be vaccinated if absent at school	National Immunization Program and Ministry of Education, Youth, and Sports Dept of School Health
OD leaders	Orientation	Basics on cervical cancer, HPV, HPV vaccine, HPV vaccine schedule and eligibility of girls, IEC messages, role of teachers during school vaccination, where girls can be vaccinated if absent at school	National Immunization Program and Ministry of Education, Youth, and Sports Dept of School Health
Provincial leaders	Orientation	Basics on cervical cancer, HPV, HPV vaccine, HPV vaccine schedule and eligibility of girls, IEC messages, role of teachers during school vaccination, where girls can be vaccinated if absent at school	National Immunization Program and Ministry of Education, Youth, and Sports Dept of School Health

Q20a. Please describe the communication plans for sensitising and mobilising communities (e.g. girls, parents, teachers, health workers, district officials, community groups, etc.) for the HPV vaccination demonstration programme.

Communication and education are recognized as key for successful sensitization of health workers, the community, teachers, parents, and girls in order to achieve successful social mobilization. Reaching a new target population with a new vaccine targeting girls only will require reviewing lessons learned from the HPV vaccination project in Cambodia and from HPV vaccination implementation in other countries, as well as understanding any current sensitivities, concerns, or enthusiasm for the HPV vaccine currently. Within the TAG, a subgroup on communication will help provide inputs. A consultant with experience in HPV vaccine communication will help develop a communication and mobilization plan approximately 6 months prior to the 1st dose and will help guide its implementation.

Q20b. (Optional) If available, countries may provide additional detail in the table below on the types of information and/or materials that may be used/disseminated, to which audience, by which mechanism, and the frequency of each.

Types of information or materials (e.g., leaflet, poster, banner, handbook, radio announcement, etc.)	Audience receiving material (e.g., girls, parents, teachers, health workers, district officials, community groups, etc.)	Method of delivery (e.g., parent meetings, radio, info session at school, house visit, etc.)	Who delivers (e.g., teachers, health workers, district official, etc.)	Frequency & Timing (e.g., daily, weekly, twice before programme starts; day of vaccination, two weeks before programme begins, etc.)
poster	Girls, parents, health workers, community groups	At schools and in health centers,	Province health department and school health department	2 weeks before vaccination begins
leaflet	Parents, community groups, district officials	Information session at school or in the community	Teachers, health workers	2 weeks before vaccination begins
banner	Community groups	At schools and in health centers	Health workers, district officials	2 weeks before vaccination begins
radio	Girls, parents, health workers, community groups, etc.	Radio	Province health department and school health department	2 weeks before vaccination begins and twice daily during the school campaigns

Q21. Briefly describe any potential barriers or risks to community acceptance and the process or communication plan that might be used to address this. Considerations for rumour management and crisis communication should also be described. Consider briefly describing any positive leverage points that might be beneficial for programme implementation to promote acceptability.

In general, there seems to be good demand for HPV vaccine in Cambodia among some who know about the benefit of vaccine and have money. In some non-public clinics, HPV vaccine can be obtained at a charge of around \$50 per dose and up to 200 doses per month are being administered. Nevertheless, potential barriers to community acceptance will be to communicate adequately with the various members of the community (girls, parents, health workers, teachers, others) so that they understand the benefits of HPV vaccine and particularly, so that concerns about safety are robustly addressed. Rumour management and preparedness for crisis communication will be needed. As described in the response to Q9, Cambodia's 2013 MR SIA encountered some instances of wrong

information about MR vaccine communicated via social media that resulted in refusals among school children and involvement of district governors and local leaders to address the concerns was necessary. Based on that experience with MR vaccination campaign, for this new vaccine targeted for delivery to 9 year old girls, it will be important to have communication plans and crisis communication plans prepared. To promote acceptability, it may be helpful to identify local champions for HPV vaccination or information on real-life impact of cervical cancer on women.

1.4 Objective 1: HPV vaccine delivery evaluation plan

Q22a. Indicate the agency/person who will lead the evaluation of coverage and acceptability, feasibility, and costs required for the “Learn by Doing” objective.

Professor Sann Chan Soeung will lead the evaluation of coverage and acceptability, feasibility, and costs required for the “Learn by Doing” objective.

Q22b. (Optional) Technical partners (e.g. local WHO staff) are required to participate in planning and conducting the evaluation of HPV vaccine delivery. Please specify if such (an) expert(s) already exist on the country team (name, title, organization). Alternatively, or in addition, an international participant can be requested through technical partners if additional expertise is thought necessary.

Dr. Md. Shafiqul Hossain, WHO EPI Officer, will participate in the planning and conduct of the evaluation of HPV vaccine delivery. CDC will work with WHO to provide assistance in vaccine coverage survey.

1.5 Objective 2: Integration of adolescent health interventions

Q23a. Please summarise the anticipated activities for the integration of adolescent health interventions, such as planning milestones, stakeholder meetings, process for identifying a lead for this activity, and the process to involve the TAG in this work (see HPV Demo Supplementary Guidelines section 3.2, item 7).

The demonstration programme will allow Cambodia to explore synergies for promoting and strengthening health interventions for adolescents. It is proposed that an adolescent health intervention assessment is conducted within year 1 of the demonstration programme as recommended by GAVI. It is proposed that that a TAG sub team on the adolescent health assessment will be formed before the delivery of the HPV 1st dose. This sub team will comprise of Ministry of Health, Ministry of Education Youth and Sports, UNFPA, WHO and other stakeholders working on adolescent health in Cambodia. The TAG sub team will agree on a process, timeframe and responsibilities of members for implementation of the adolescent assessment. A consultant will be hired to conduct the assessment immediately after the delivery of the 1st dose of the HPV vaccine in year 1. The first deliverable of the consultant will be the initial mapping of stakeholders, interventions and data sources and revised and adapted data collection tools. These findings will be presented to the TAG sub team. Data collection will then commence through a desk review and key informant interviews from month 4 – 7 following the introduction of the HPV first dose. The findings will then be presented to the TAG sub team for validation and for initial prioritisation of interventions which could be jointly delivered with the second dose of the HPV vaccine. The prioritisation and findings would be presented to the TAG by month 9 following the first does of the HPV vaccine. This would allow the MOH and MOEYS to decide if they would like to request that specified and prioritised interventions could be jointly delivered with the HPV vaccination in year 2. The final report to GAVI would then be submitted which would include adolescent health intervention assessment findings, selection and decision on specific interventions’, details on the implication for joint delivery.

Q23b. (Optional) Countries can provide a brief summary below of the current adolescent health services or interventions and health education activities and implementing agencies in the district(s) selected to implement the HPV vaccination demonstration programme.

The National Reproductive Health Program developed a youth guideline and a youth reproductive health protocol in 2007 and after that, National Maternal and Child Health conducted a national training of the trainers (2 trainers per province) and then all trainers trained the health center staff. At this time, the protocol has reached 718 Health centers. Not all 718 health centers have special or dedicated rooms for youths to receive health services.

Kampong Thom province:

There are several agencies supporting Kampong Thom province for maternal and child health programmes, including GIZ/EPOS (RH and voucher), UNICEF (Maternal, Newborn) and UNFPA (support Reproductive maternal and newborn health through HSSP) but there are no specific activities for adolescent health.

Provincial health departments trained midwives of 29 health centers during 2007-2009 on Youth reproductive health and have dedicated rooms in the health centers for youth but the youth services have not been functioning up to now. The Department of Health is a member of the Steering Committee for Women and Children Affairs that focuses on gender and violence.

Svay Rieng province:

- Training on youth reproductive health was provided to midwives of all the health centers in the province in 2012.
- Training was provided to young people on youth reproductive health in communes sponsored by organizations supported by the Child Fund in 2013. Similar training was also provided in schools and sponsored by organizations supported by the Child Fund in 2014.
- An awareness training workshop of the ASEAN Youth was organized by the provincial education department on youth reproductive health at Svay Rieng University in 2013 and 2014.

1.6 Objective 3: Development or revision of cancer control or cervical cancer prevention and control strategy

Q24a. Please summarise the planned activities for the development or revisions of a national cervical cancer prevention and control strategy, such as planning milestones, stakeholder meetings, methodology for developing the strategy, process for identifying a lead for this activity, and the process to involve the TAG in this work (see HPV Demo Supplementary Guidelines section 3.2, item 8).

The Ministry of Health's Noncommunicable Disease Task Force is conducting a series of consultative meetings from June through August 2015 to provide an opportunity for stakeholders to review and comment on a draft national cervical cancer prevention and control strategy and a draft standard operating procedures (SOP) for screening and treatment of cervical cancer. Under the umbrella of the Noncommunicable Disease Task Force, a Technical Working Group for Cervical Cancer Prevention and Control will be established to develop a draft national cervical cancer prevention and control strategy and finalize standard operating procedures (SOP) for screening and treatment of cervical cancer with the technical support from WHO and UNFPA. The members of TWG for Cervical Cancer Prevention and Control include the Department of Preventive Medicine, the National Center for Maternal and Child Health, the National Immunization Program, Khmer-Soviet Friendship Hospital, Calmette Hospital, WHO, UNFPA, and relevant NGOs. The updated SOP and national cervical cancer prevention and control are based on the WHO "Comprehensive Cervical Cancer Control: a guide to essential practice". Both the national strategy and the SOP are expected to get approval from the Ministry of Health by the end of 2015.

Q24b. (Optional) Provide a brief summary of the current cervical cancer prevention and treatment services and implementing agencies in the district selected to implement the HPV vaccination demonstration programme. If available, countries can include information on target populations, delivery structure, and funding sources.

In 2013 the Ministry of Health developed a draft SOP and initiated 3 pilots for a preventive screen and treat program for cervical cancer. The pilot project in Prey Chor Operational District in Kampong Cham Province funded by the Health Service Support Program Phase 2 (HSSP2) is in operation. The HSSP2 is a pooled fund between health development partners. The purpose of this project was to test different screen-and-treat strategies, and to compare results with 2 other pilot screening projects being implemented by NGOs in Kampot, Prey Veng and Kamong Thom. The target population to be screened and treated is women aged 30-49 years. The Ministry of Health provided training on screening methodology using Visual Inspection with Acetic Acid (VIA) and cryotherapy to 30 midwives and 2 medical doctors from 15 health centers and Prey Chor Referral Hospital.

1.7 Technical advisory group

Q25. Please identify the membership and terms of reference for the multi-disciplinary technical advisory group established that will develop and guide implementation of the HPV vaccination demonstration programme and list the representatives (at least positions, and ideally names of individuals) and their agencies (see HPV Demo Supplementary Guidelines section 2.7).

- Countries are encouraged to use their ICC or a subset of the ICC as the multi-disciplinary TAG.
- The TAG must at least have representatives from the national EPI programme, cervical cancer prevention and control, education, the ICC (if separate from the ICC), representative(s) from adolescent and/or school health(if they are represented within the Ministry of Health), and representative(s) from civil society organisation(s) that reach the target population of 9-13 year old girls.

Proposed TAG for HPV Vaccine Demonstration Program

No	Agency/Organization	Representation
1	National Immunization Program	Manager, deputy, and focal person(3)
2	Department of Preventive Medicine	Manager and Cervical Cancer screening (1)
3	Ministry of Education	School health department (1)
4	Maternal and Child Health Center	Adolescent and child health(1)
5	National Center for Health Promotion	Health promotion (1)
6	University of Health Sciences	Academic (1)
7	World vision	Department worked for vulnerable children (1)
8	WHO	EPI program (1)
9	UNICEF	EPI(1)
10	UNFPA	Reproductive Health, Cervical Cancer, and Adolescent Health (1)
11	NGO/CSO (URC)	Adolescent Health (1)
	TOTAL	13

The Ministry of Health will communicate with proposed organizations and departments to be the member of TAG for HPV vaccination demonstration programme.

Q26. If known, please indicate who will act as the chair of the technical advisory group.

Enter the family name in capital letters.

	Name/Title	Agency/Organisation	Area of Representation
Chair of Technical Advisory Group	Prof Sann Chan Soeung	National Immunization Program	Immunization

1.8 Project manager/coordinator

Q27. List the contact details, position, and agency of the person who has been designated to provide overall coordination for the day-to-day activities of the two-year HPV vaccination demonstration programme, taking note that a technical officer/lead/manager from EPI might be most suitable as a part of their current role and responsibilities.

Enter family name in capital letters.

Name	Dr. Keo Samley	Title	Senior staff
Tel no	+855 12759947 +855 96 955 3448 +855 97 790 8077		
Fax no	[Type text]	Agency	National Immunization Program
Email	keosamley@gmail.com	Address	National Immunization Program, Ministry of Health, Cambodia

5. Timeline

The HPV vaccination demonstration programme will include immunisation of the cohort of girls in two consecutive years (Figure I). Countries are required to begin vaccinating in the demonstration district(s) within two years of the application.

Figure I. HPV vaccination demonstration programme timeline

Gavi Funding Approval	Planning Up to 8 months	Implementation Year 1 (begins first day of dose 1)			Implementation Year 2 (begins at first day of dose 1)		
		6 months	3 months	3 months	6 months	3 months	3 months
	Planning Training Supply Distribution Sensitisation Mobilisation	First year of vaccination PIE at the time of final dose Costing study starts after the first dose	Evaluation of first year Coverage survey within 6 weeks of final dose	Review lessons learned Adjust program for Year 2 Report of Year 1 to Gavi (Results from all evaluations, surveys and assessments) NITAG/ICC/vaccine policy body discussion on introduction and if relevant draft Gavi application for national introduction	Second year of vaccination		Report of Year 2 to Gavi
		Desk adolescent interventions	Review of health	Decide if joint delivery will be in Year 2 If decided, incorporate joint delivery in program for Year 2	If feasible, implement joint delivery of services	Evaluate joint delivery (Coverage Survey & the costing study)	
		Start drafting cervical cancer prevention & control strategy			Completion of draft cervical cancer prevention & control strategy		Draft Cervical Cancer strategy to Gavi

Q28. Please draft a chronogram using the Gavi chronogram template for the main activities for HPV vaccination preparations and implementation, assessment of adolescent health interventions, evaluation of the demonstration programme, and development/revision of a national cervical cancer prevention and control strategy.

Please download the Excel chronogram template from the Gavi website at: www.gavi.org, and attach to the application form as **Attachment 2**.

Countries should ensure enough time is scheduled for planning activities prior to delivery of HPV1. For programme tracking purposes, Year 1 starts with delivery of the first dose of vaccine.

6. Budget

Q29. Please provide a draft budget for year 1 and year 2, identifying activities to be funded with Gavi's programmatic grant as well as costs to be covered by the country and/or other partner's resources. The budget should include costs for planning and preparations, vaccine implementation, assessment of adolescent health interventions, evaluation of the demonstration programme, and development/revision of a national cervical cancer prevention and control strategy.

Please download the Excel budget template from the Gavi website at: www.gavi.org, and attach to the application form as **Attachment 3**.

Note: If there are multiple funding sources for a specific cost category, each source must be identified and their contribution distinguished in the budget.

7. Procurement of HPV vaccines and cash transfer

HPV vaccines will be provided and will be procured through UNICEF. Auto-disable syringes and disposal boxes will be provided.

Please note that, using the estimated total for the target population in the district and adding a 10% buffer stock contingency, the Gavi Secretariat will estimate supplies needed for HPV vaccine delivery in each year and communicate it to countries as part of the approval process.

Q30. Please indicate how funds for operational costs requested in your budget in section 6 should be transferred by the Gavi Alliance (if applicable).

Operational funds should be transferred to the government.

8. Fiduciary Management Arrangements Data

Please indicate below whether the **grant to partially support the activities of the HPV vaccination demonstration programme** is to be transferred to the government, or to WHO or UNICEF. Please note that WHO and/or UNICEF will require administrative fees of approximately 7% and 8% respectively which would need to be covered by the operational funds.

Grant is to be transferred to the government.

If the grant for the HPV vaccination demonstration programme should be transferred to the government, countries which have completed a financial management assessment (FMA) should confirm whether the financial management modalities – including bank details – agreed with Gavi are still applicable, or alternatively provide details of any modification they intend to submit relating to the existing financial management arrangements.

Countries without an FMA, but who would like the grant for the HPV vaccination demonstration programme to the Government, should provide as **Attachment 4** a description of their proposed funding mechanism to manage the grant for the HPV demonstration programme, covering the following processes:

1. Planning, budget and coordination
2. Budget execution arrangements including internal controls
3. Procurement arrangements
4. Accounting and financial reporting
5. External audit arrangements
6. Internal audit oversight

9. Signatures

1.9 Government

The Government of the Kingdom of Cambodia] acknowledges that this Programme is intended to assist the government to determine if and how it could implement HPV vaccine nationwide. If the Demonstration Programme finds HPV vaccination is feasible (i.e. greater than 50% coverage of targeted girls within each strategy) and acceptable, Gavi will encourage and entertain a national application during the first or second year of the Programme. Application forms and guidelines for national applications are available at www.gavi.org. The data from the Demonstration Programme and timing of a national application are intended to allow uninterrupted provision of vaccine in the demonstration district and nationwide scale-up.

The Government of the Kingdom of Cambodia would like to expand the existing partnership with the Gavi Alliance for the improvement the health of adolescent girls in the country, and hereby requests for Gavi support for an HPV vaccination demonstration programme.

The Government of the Kingdom of Cambodia commits itself to improving immunisation services on a sustainable basis. The Government requests that the Gavi Alliance and its partners contribute financial and technical assistance to support immunisation of targeted young adolescent girls with HPV vaccine as outlined in this application.

The Government of the Kingdom of Cambodia acknowledges that some activities anticipated in the demonstration programme could be considered research requiring approval by local ethics committees (e.g., collecting data from a random sample of parents of eligible girls for the HPV vaccine coverage survey). The Government of the Kingdom of Cambodia acknowledges responsibility for consulting and obtaining approval from appropriate local ethics committees (e.g., human subject protection committee or Institutional Review Boards) in country, as required. By signing this application, the Government of the Kingdom of Cambodia and the TAG members acknowledge that such approval may be necessary and that it will obtain such approval as appropriate.

The table in **Attachment 3** of this application shows the amount of support requested from the Gavi Alliance as well as the Government of the Kingdom of Cambodia's financial commitment for the HPV vaccination demonstration programme.

Please note that this **application will not be reviewed by Gavi's Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Education** or their delegated authority.

Q32. Please provide appropriate signatures below.

Minister of Health (or delegated authority)		Minister of Education, Youth and Sports (or delegated authority)	
Name		Name	
Date		Date	
Signature		Signature	

Q33. This application has been compiled by:

Full Name	Position	Telephone	Email
Prof Sann Chan Soeung	Manager, NIP	012933344	workmoh@gmail.com
Dr. Keo Samley	Senior staff, National Immunization Program	+885 96 955 3448 +885 97 790 8077	keosamley@gmail.com

1.10 National Coordinating Body – Inter-Agency Coordinating Committee (ICC) for Immunisation

Q34. We the members of the ICC, HSCC, or equivalent committee (Technical Working Group for Health) met on 11 July 2015 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

The Technical Working Group (TWG) for Health works as ICC/HSCC in Cambodia and chaired by Professor Eng Huot, Secretary of State. WHO Representative in Cambodia is the vice chair of TWGH and all related departments/institutions of MOH and donors/partners are the member of the TWGH. .

The endorsed minutes of this meeting are attached as **Attachment 1**.

Q35. In case the Gavi Secretariat has queries on this submission, please contact:

Name	Prof Sann Chan Soeung	Title	Manager, National Immunization Program, Adviser to MOH
Tel no			
Fax no		Address	National Immunization Program, Ministry of Health, Cambodia
Email	workmoh@gmail.com		
Mobile no	012933344		

10. Attachments

Attachment 1. Minutes of the Inter-Agency Coordinating Committee (TWGH) meeting endorsing the HPV vaccination demonstration programme application.

Attachment 2. Chronogram for the HPV vaccination demonstration programme.

Attachment 3. Budget and finances for the HPV vaccination demonstration programme.

Attachment 4. Proposed funding mechanism for HPV vaccination demonstration programme. This is required ONLY for countries without an existing FMA and countries currently receiving Gavi cash support through a UN agency.