Annual Progress Report 2009

Submitted by

The Government of

[*CAMBODIA*]

Reporting on year: **2009**

Requesting for support year: **2011**

31st May 2010

Deadline for submission: 15 May 2010

Please send an electronic copy of the Annual Progress Report and attachments to the following e-mail address: apr@gavialliance.org

any hard copy could be sent to :

GAVI Alliance Secrétariat,
Chemin de Mines 2.
CH 1202 Geneva,
Switzerland

Enquiries to: **apr@gavialliance.org** or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and general public.

Note: *Before starting filling out this form get as reference documents the electronic copy of the APR and any new application for GAVI support which were submitted the previous year.*

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

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

AMENDMENT TO THE APPLICATION
The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in its application. The GAVI Alliance will document any change approved by the GAVI Alliance, and the Country's application will be amended.

RETURN OF FUNDS
The Country agrees to reimburse to the GAVI Alliance all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION
The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any GAVI Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in its application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION
The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS
The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.
The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY
The Country and the signatories for the Country confirm that its application, and Annual Progress Report, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY
The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

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

ARBITRATION
Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.
For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.
The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application..

By filling this APR the country will inform GAVI about :
- *accomplishments using GAVI resources in the past year*
- *important problems that were encountered and how the country has tried to overcome them*
- *Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners*
- *Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released*
- *how GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.*

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

By signing this page, the Government hereby attest the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in page 2 of this Annual Progress Report (APR).

For the Government of [*CAMBODIA*]

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

Minister of Health (or delegated authority):	**Minister of Economy and Finance (or delegated authority):**
Title:	Title: Deputy Prime Minister, Minister of Economy & Finance
Signature:	Signature: KEAT CHHON
Date: Dr. MAM BUNHENG, Minister of Health, 21 MAY 2010	Date: 31 MAY 2010

This report has been compiled by:

Full name: Professor Sann Chan Soeung Position: Deputy Director General for Health Telephone: 855-12933 344 E-mail: workmoh@gmail.com	Full name: Dr. Chea Sokhim Position: Co-ordinator HSS, Office of Health Sector Support Project, MOH Telephone: 855 -12 894741 E-mail: sokhimc_dr@yahoo.com
Full name: Mrs. Khout Thavary Position: Deputy Director Department of Budget and Finance Telephone: 855 -12 835 003 E-mail : Thavary_kh@yahoo.com	Full name: Mr. John Grundy Position: GAVI HSS Consultant Telephone: 855 -12 680455 E-mail: jgrundy@unimelb.edu.au

ICC Signatures Page

If the country is reporting on ISS, INS, NVS support

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

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

Name/Title	Agency/Organisation	Signature	Date
Sun Nasy, Program Impl Adviser	RACHA	[signature]	30/04/2010
VETH SRENG Community Health Specialist	RHAC	[signature]	30/04/2010.
Sin Somuny	Executive D.	[signature]	30/04/2010
MICHELLE GARDNER, COUNTRY REPRESENTATIVE, PATH		[signature]	30/04/2010
Yuko SASAKI / Project formulation advisor	JICA	[signature]	03/05/2010
KATIE CRAWFORD HLTH + EDUC DIR	USAID	[signature]	03/05/2010
Isabelle Austin OIC Deputy Representative	UNICEF	[signature]	3/05/2010
PIETER VAN MAAREN/REP.	WHO	[signature]	4/5/2010

ICC may wish to send informal comments to: apr@gavialliance.org
All comments will be treated confidentially

Comments from partners:

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Comments from the Regional Working Group:

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HSCC Signatures Page

If the country is reporting on HSS

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), ... *[insert name]* endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

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

Name/Title	Agency/Organisation	Signature	Date
Yumiko SASAKI / Project formulation advisor	JICA	Y. Sasaki	03/05/2010
KATE CRAWFORD HLTH TEAM DIR	USAID	K Crawford	03/05/2010
PIETER VAN MAAREN / REP	WHO	[illegible]	04/05/2010

HSCC may wish to send informal comments to: apr@gavialliance.org
All comments will be treated confidentially

Comments from partners:

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Comments from the Regional Working Group:

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

This report on the GAVI Alliance CSO Support has been completed by:

Name: ……………………………………………………………………………………

Post: ……………………………………………………………………………………

Organisation:.………………………………………………………………………………...

Date: ……………………………………………………………………………………

Signature: ……………………………………………………………………………………

This report has been prepared in consultation with CSO representatives participating in national level coordination mechanisms (HSCC or equivalent and ICC) and those involved in the mapping exercise (for Type A funding), and those receiving support from the GAVI Alliance to help implement the GAVI HSS proposal or cMYP (for Type B funding).

We, the undersigned members of the National Health Sector Coordinating Committee, ……………………………………. (insert name of committee) endorse this report on the GAVI Alliance CSO Support.

Name/Title	Agency/Organisation	Signature	Date

Signature of endorsement does not imply any financial (or legal) commitment on the part of the partner agency or individual.

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List of supporting documents attached to this APR

1. *Expand the list as appropriate;*
2. *List the documents in sequential number;*
3. *Copy the document number in the relevant section of the APR*

Document N°	Title	APR Section
	Calculation of ***[Country's]*** ISS-NVS support for 2011 *(Annex 1)*	1.1; 2.4; 3.7
1 (3 sets)	Minutes of all the ICC meetings held in 2009	1.5
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4	Minutes of the HSCC meetings held in 2009 including those on discussion/endorsement of this report	5.1.8
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1. General Programme Management Component

1.1 *Updated baseline and annual targets (fill in Table 1 in Annex1-excell)*

The numbers for 2009 in Table 1 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2009.** The numbers for 2010-15 in Table 1 should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

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

*Provide justification for any changes **in births**:*

There is a change of population denominator in 2008 associated with the release of the latest national census results (see annex). This resulted in a reduction of the birth cohort in 2008. This was reported in last years APR. An updated DHS will be conducted in 2010 which will provide new figures on mortality rates. This information will be updated in next years APR.

*Provide justification for any changes **in surviving infants**:*

N/A

*Provide justification for any changes **in Targets by vaccine**:*

N/A

*Provide justification for any changes **in Wastage by vaccine**:*

N/A

1.2 *Immunisation achievements in 2009*

Please comment on the achievements of immunisation programme against targets (as stated in last year's APR), the key major activities conducted and the challenges faced in 2009 and how these were addressed:

1. Immunization coverage exceeded targets. In 2009, there were 339,196 children under the age of 1 vaccinated with DPT-Hep B 3 which is highest number of children vaccinated to date. A DHS survey will be conducted in 2010 to confirm these results
2. The number of districts with coverage greater than 80% for DTPHepB3 has increased to 68 (out of 77). A remaining 9 districts are below this rate, and will be the focus for coverage improvement planning activity in 2010
3. The % of vaccinations at facilities (compared to health outreach) has increased nationally from an estimated 20% in 2006 to 39% in 2009, indicating that population demand for immunization services is increasing substantially.
4. Despite coverage improvement, there is still concern that high risk populations (urban slum dwellers and remote area residents and ethnic communities in the Tonle Sap region) are still not accessing services. A high risk strategy is being designed and implemented in 2010 to manage this risk (based on recommendations of study conducted in 2009 – see annex).

5. Surveillance of measles has been strengthened. Of 4779 suspected cases, there were 4028 specimens collected, of which 95 cases were confirmed.
6. New vaccine introduction activity took place in 2009. In 3 selected provinces that were high risk for Japanese Encephalitis, routine immunization services were commenced for children aged 10 months in the last quarter of 2009. Vaccine was provided through a donation from PATH. Introduction activities included training, strengthening of surveillance, production of IEC materials and AEFI monitoring.
7. New introduction activities for nationwide pentavalent vaccine also took place in 2009, in preparation for vaccine introduction in the first quarter of 2010.
8. The national program reports successful conducting of maternal and neonatal tetanus elimination activities including supplementary Immunization programs at garment factories and in high risk operational districts. Cambodia expects to achieve validation of MNT elimination in 2012.
9. Effective collaborations have been maintained between MoH and development partners and local NGOs especially at the service delivery level where community and local authority participation is high.
10. The main challenge for the national program has been to maintain and improve coverage, while at the same time maintaining activities for new vaccine introduction (JE and Pentavalent) and H1N1 campaigns for high risk groups nationally. The program has attempted to manage this risk by delegation of responsibility to Provinces and districts for maintaining program performance. Health system developments (GAVI HSS and Health Sector Support program) have also provided additional system support for EPI through introducing internal contracting for MCH. This is improving the capacity of health services for health outreach for hard to reach areas and increasing demand for health care services at facilities.

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

N/A

1.3 *Data assessments*

1.3.1 Please comment on any discrepancies between immunisation coverage data from different sources (for example, if survey data indicate coverage levels that are different than those measured through the administrative data system, or if the WHO/UNICEF Estimate of National Immunisation Coverage and the official country estimate are different)[1].

The last DHS survey was conducted in 2005, which demonstrated a high correlation between survey results and administrative data. In 2010, the following is proposed:

1. National EPI review with support through WHO
2. DHS 2010 survey
3. Household data checking through HSS being implemented in 2nd quarter 2010.

1.3.2 Have any assessments of administrative data systems been conducted from 2008 to the present? [YES]. If YES:

Please describe the assessment(s) and when they took place.

1.3.3 Please describe any activities undertaken to improve administrative data systems from 2008 to the present.

[1] *Please note that the WHO UNICEF estimates for 2009 will only be available in July 2010 and can have retrospective changes on the time series*

As Above

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

Pending the results for household data verification and wider national level discussion, MoH is considering that HSS be could be applied more widely in other operational districts in the country.

A HSS household data check (cross referencing household data health centre data) is being conducted by the Department of Planning and Health Information in April 2010 in 10 HSS ODs, which will also provide information on quality of immunization data and other health indicators.

From each OD, a health centre is randomly selected. Using random selection, a list of clients who received services are selected from health centre registers. The services are classified into MCH and EPI categories. Evaluators then visit the homes of the clients who received the services and are interviewed to confirm the services have been received. Clients are classified as having received the service (or not), as having moved from the area, or as not existing.

1.4 ** Overall Expenditures and Financing for Immunisation*

The purpose of Table 2 is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Table 2: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$.

Expenditures by Category	**Expenditure Year 2009**	**Budgeted Year 2010**	**Budgeted Year 2011**
Traditional Vaccines[2]	$707,280	$435,707	$873,612
New Vaccines	$2,713,162	$2,255,500	$ 3.597,496
Injection supplies with AD syringes	$628,602	$436,372	$438,867
Injection supply with syringes other than Ads	$35,200	$35,200	$78,847
Cold Chain equipment	-	$387,750	-
Operational costs	$2,578, 776	$2,412,238	$2,453,425
Other (please specify)	$2,952	$863,082	-
Total EPI			
Total Government Health	**$6,665,972**	**$6,825,849**	**$7,442,247**

Exchange rate used	

Please describe trends in immunisation expenditures and financing for the reporting year, such as differences between planned versus actual expenditures, financing and gaps. Give details on the reasons for the reported trends and describe the financial sustainability prospects for the immunisation program over the next three years; whether the funding gaps are manageable, challenging, or alarming. If either of the latter two is applicable, please explain the strategies being pursued to address the gaps and indicate the sources/causes of the gaps.

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

The Government of Cambodia started to share costs for traditional vaccines for routine activities (BCG,OPV,DPT,MV,TT) with development partners in 2000. By 2008, the Government of Cambodia fully covered the costs for traditional vaccines by 2008 (including HepB Birth dose). Additionally, 2010 was the first year for Cambodia to co-finance with GAVI for procurement of DPT-HepB-Hib vaccines. Furthermore, beginning in 2010, traditional vaccines and co-financing vaccines will be procured using UNICEF Procurement Service (PS)rather than through the Vaccine Independence Initiative mechanism, which is a significant milestone for the country.
With the introduction of new vaccines, although there is a trend towards higher levels of financing of vaccines by Government, the proportion of the overall government level of financing of vaccines is not rising due to the higher costs of newer vaccines mostly funded by GAVI.

The surveillance system has demonstrated the burden of Japanese encephalitis disease in Cambodia (18% of all meningo-encephalitis cases). However, the recommended national campaign and routine immunization strategy has to be scaled back due to lack of sustainable finance. The NGO PATH provided a donation to support routine introduction for 1 year old children in 3 high risk provinces with funding continuing until the end of 2011.

The sustainability of immunization service operations (outreach services, IEC and fixed facility services) has been improved through implementation of the Health Sector Support Program (supported by MOH, World Bank and Bilateral donors) and GAVI HSS. Both these approaches support operational costs for immunization and maternal and child health care services through internal contracting. Additionally, all immunization activities are integrated into the annual operational planning system of the Ministry of Health at all levels of the health system, which assists immunization managers to coordinate resources more effectively and efficiently (through coordination of EPI with other health care services and sources of funding). Overall expenditure and Financing for Immunization '. (i) HSSP2 donors include AFD, AusAIDS, BTC, DFID, UNICEF, UNFPA, and the World Bank; (ii) HSSP2 finances immunization service operations nationally through internal contracting and through non contracting ODs and provinces.

In the medium term (next 3-4 years) the prospects of sustainable financing of immunization in Cambodia remains quite good.

1.5 *Interagency Coordinating Committee (ICC)*

How many times did the ICC meet in 2009?

The Immunization Coordination Sub Committee met once in 2009, and once in the first quarter of 2010, and once again in the second quarter of 2010.

Please attach the minutes **(Document N°1)** from all the ICC meetings held in 2009, including those of the meeting endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on items 1.1 through 1.4

Conduct “”spot checks” (household data checks) for immunization and HSS.

Recommendations from the September 2009 ICSC were as follows:

Follow up action reimbursements and plan for procurement
Follow up action on NIP Policy review and cold chain review in last quarter of 2009

The following recommendations were provided in the March ICC to implement a mechanism for procurement of co-financing vaccines and devices:

a. NIP plan the quantity of each item in the annual vaccine forecast (Sept 2009).

b. NIP need to include the quantities and the amount in the "Annual Operational Plan" of the National Immunization Plan (May 2009).
c. That MoH/NIP/UNICEF agree on a work plan for Procurement Service.

Refer to attached minutes of meetings from more details.

Are any Civil Society Organisations members of the ICC ?: **[Yes].** If yes, which ones?

List CSO member organisations:

PATH
MEDICAM (the health "umbrella" organization of health NGOs in Cambodia
RACHA
RACH

1.6 *Priority actions in 2010-2011*

What are the country's main objectives and priority actions for its EPI programme for 2010-2011? Are they linked with cMYP?

1. Implement programs to reach high risk populations in urban slums and remote areas (RED/CIP Strategy - follow up actions from health access research study in Phnom Penh)

    a. Orphanage vaccination services
    b. Mapping hard to reach communities and districts
    c. Improving outreach for remote areas

2. Implement programs to eliminate and control vaccine preventable diseases:

    a. Targeted measles SIA 2011
    b. Implement TT SIAs in order to proceed towards tetanus elimination goal.
    c. Conduct hepatitis B sero survey in 2011

3. Introduction of Pentavalent vaccine nationally in the first quarter of 2010.

4. Improving the quality of meningo-encephalitis surveillance

5. Strengthen data quality activities including: (1) DHS 2010 (2) International EPI review (3) HSS Household Checks

6. Improve the quality of disease surveillance including strengthening of AEFI systems

7. Improve public private partnership for immunization (conduct evaluation in 2010)

2. Immunisation Services Support (ISS)

1.1 *Report on the use of ISS funds in 2009*

Funds received during 2009: US$. N/A
Remaining funds (carry over) from 2008: US N/A
Balance carried over to 2010: US$ N/A

Please report on major activities conducted to strengthen immunisation using ISS funds in 2009.

Cambodia has been approved for ISS support in the amount of US$ 141,000 based on additional number of children immunised in 2008 (ISS 2) but is still awaiting transfer of funds.

1.2 *Management of ISS Funds*

Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2009 calendar year? **[IF YES] :** please complete **Part A** below.
[NO] : please complete **Part B** below.

Part A: briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of ISS funds.

N/A

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

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

This section describes the proposed plan for utilization of ISS funds for 2010, as no funds were received in 2009

The ISS funds will be deposited in a specific government account for GAVI ISS funds.

Budgets should be reflected in annual operational plans of health centres and districts.

Funds will be channelled to the sub national level through the Provincial and Operational District manager and EPI manager.

Funds will be acquitted by the Provincial and District accountant and national level accounts will be maintained by the National Immunization Program Senior Accountant.

The ISS funds are managed externally to the pooled fund mechanisms of the Ministry of Health.

1.3 *Detailed expenditure of ISS funds during the 2009 calendar year*

N/A

Please attach a detailed financial statement for the use of ISS funds during the 2009 calendar year **(Document N°...................).** *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. N/A

External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available for your ISS programme during your government's most recent fiscal year, this must also be attached **(Document N°......................)**. (ISS N/A)

1.4 *Request for ISS reward*

In June 2009, the GAVI Board decided to improve the system to monitor performance of immunisation programmes and the related calculation of performance based rewards. Starting from 2008 reporting year, a country is entitled to a reward:

a) if the number of children vaccinated with DTP3 is higher than the previous year's achievement (or the previous high), and

b) if the reported administrative coverage of DTP3 (reported in the JRF) is in line with the WHO/UNICEF coverage estimate for the same year.

If you may be eligible for ISS reward based on DTP3 achievements in 2009 immunisation programme, estimate the $ amount by filling Table 3 in Annex 1.[3]

[3] The Monitoring IRC will review the ISS section of the APR after the WHO/UNICEF coverage estimate is made available.

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

3.1 *Receipt of new & under-used vaccines for 2009 vaccination programme*

Did you receive the approved amount of vaccine doses that GAVI communicated to you in its decision letter (DL)? Fill Table 4.

Table 4: Vaccines received for 2009 vaccinations against approvals for 2009

	[A]		**[B]**	
Vaccine Type	**Total doses for 2009 in DL**	**Date of DL**	**Total doses received by end 2009 ***	**Total doses of postponed deliveries in 2010**
Pentavalent Liquid Single Dose	**1,336,300**	**21st December 2009**	**750,000**	**586,300**

- *Please also include any deliveries from the previous year received against this DL*

Decision letter 22 December 2009 saying Cambodia will receive 1,336,300 doses of pentavalent through GAVI, and 92,800 doses of pentavalent through Govt co financing

If numbers [A] and [B] are different,

What are the main problems encountered? *(Lower vaccine utilisation than anticipated? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date?...)*	• The vaccine introduction was delayed due to excess remaining stocks of DPT vaccine.
What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF SD)	• All stocks of remaining DPT Hep B vaccine will be utilized before introduction of pentavalent commences (it is currently being introduced)

3.2 *** Introduction of a New Vaccine in 2009*

3.2.1 If you have been approved by GAVI to introduce a new vaccine in 2009, please refer to the vaccine introduction plan in the proposal approved and report on achievements.

Vaccine introduced:	Pentavalent vaccine
Phased introduction [NO]	
Nationwide introduction [YES /]	Date of introduction April 2010
The time and scale of introduction was as planned in the proposal? If not, why?	See 3.1

3.2.2 Use of new vaccines introduction grant (or lumpsum)

Funds of Vaccines Introduction Grant received:	US$ 131,000	Receipt date: December 2008

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

1. Nationwide training of trainers and then training of 4 to 5 health staff in each of the 977 health centres of Cambodia

2. Development of new vaccine IEC materials
3. National launch activity
4. TV spot on pentavalent vaccine

Please describe any problems encountered in the implementation of the planned activities:

No major problems encountered.

However, implementation of H1N1 campaign activities diverted management attention from due to rapid need to roll out pandemic vaccine to high risk groups immediately.

Is there a balance of the introduction grant that will be carried forward? [YES]
If YES, how much? US$ 21,866

Please describe the activities that will be undertaken with the balance of funds:

The remaining grant funds will be utilized for follow up supervision programs post introduction.

3.2.3 Detailed expenditure of New Vaccines Introduction Grant funds during the 2009 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2009 calendar year **(Document N° 2).** *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

3.3 *Report on country co-financing in 2009 (if applicable)*

Table 5: Four questions on country co-financing in 2009

Q. 1: How have the proposed payment schedules and actual schedules differed in the reporting year?			
Schedule of Co-Financing Payments	Planned Payment Schedule in 2009	Actual Payments Date in 2009	Proposed Payment Date for 2010
	(month/year)	(day/month)	
1st Awarded Vaccine (specify)	N/A	N/A	June 2010
2nd Awarded Vaccine (specify)			
3rd Awarded Vaccine (specify)			

Q. 2: Actual co-financed amounts and doses?		
Co-Financed Payments	Total Amount in US$	Total Amount in Doses
1st Awarded Vaccine (specify)	$318,518.80	92800
2nd Awarded Vaccine (specify)		
3rd Awarded Vaccine (specify)		

Q. 3: Sources of funding for co-financing?
1. Government YES
2. Donor (specify)
3. Other (specify)

Q. 4: What factors have accelerated, slowed or hindered mobilisation of resources for vaccine co-financing? (NOT APPLICABLE – JUST COMMENCING CO FINANCING IN 2010)
1.
2.
3.
4.

If the country is in default please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Default Policy http://www.gavialliance.org/resources/9___Co_Financing_Default_Policy.pdf

3.4 *Effective Vaccine Store Management/Vaccine Management Assessment*

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? *[April 2009]*

If conducted in 2008/2009, please attach the report. (**Document N°**.3)
An EVSM/VMA report must be attached from those countries which have introduced a New and Underused Vaccine with GAVI support before 2008.
Was an action plan prepared following the EVSM/VMA? *[YES]*

If yes, please summarise main activities to address the EVSM/VMA recommendations and their implementation status.

The EVSM 2009 reported major improvements in the Cambodian Cold Chain system since the last EVSM in 2003. These improvements include the following:

- Completeness of vaccine arrival reports for international shipments
- Regular calculation of vaccine volume estimates and required store capacity
- Installation of 3 new cold rooms and one new freezer room
- Regular and reliable delivery of stock to provinces
- Very good stock forecasting and procurement
- Implementation of new computerized stock management program since 2006

Main recommendations in the 2009 EVSM were:

- Train customs staff in the handling of vaccines
- Train all staff of CMS on the new international shipping temperature indicators
- Train more CMS staff on the handling of vaccines according to WHO and UNICEF guidelines.
- Introduce the manual recording of all temperature recordings on a daily basis according to WHO guidelines
- Introduce a monthly temperature records review system
- Conduct annual temperature recording device validations
- Introduce the new Fridge-tag and Freeze-tag to all cold/freezer rooms
- Prepare and introduce a system and guidelines for the handling of discarded vaccines

Key recommendations have been incorporated into the 2010 work plan of NIP and follow-up will be going on.

When is the next EVSM/VMA* planned? *[2012]*

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

3.5 *Change of vaccine presentation*

N/A

If you would prefer during 2011 to receive a vaccine presentation which differs from what you are currently being supplied (for instance, the number of doses per vial; from one form (liquid/lyophilised) to the other; ...), please provide the vaccine specifications and refer to the minutes of the ICC meeting recommending the change of vaccine presentation. If supplied through UNICEF, planning for a switch in presentation should be initiated following the issuance of Decision Letter for next year, taking into account country activities needed in order to switch as well as supply availability.

Please specify below the new vaccine presentation:

Please attach the minutes of the ICC meeting **(Document N°................)** that has endorsed the requested change.

3.6 *Renewal of multi-year vaccines support for those countries whose current support is ending in 2010*

N/A

If 2010 is the last year of approved multiyear support for a certain vaccine and the country wishes to extend GAVI support, the country should request for an extension of the co-financing agreement with GAVI for vaccine support starting from 2011 and for the duration of a new Comprehensive Multi-Year Plan (cMYP).

The country hereby request for an extension of GAVI support for *..........................[vaccine type(s)]* vaccine for the years 2011-*.........[end year].* At the same time it commits itself to co-finance the procurement of *..........................[vaccine type(s)]* vaccine in accordance with the minimum GAVI co-financing levels as summarised in Annex 1.

The multi-year extension of *..........................[vaccine type(s)]* vaccine support is in line with the new cMYP for the years .... *[1st and last year]* which is attached to this APR **(Document N°..............).**

The country ICC has endorsed this request for extended support of *..........................[vaccine type(s)]* vaccine at the ICC meeting whose minutes are attached to this APR. **(Document N°...................)**

3.7 *Request for continued support for vaccines for 2011 vaccination programme*

In order to request NVS support for 2011 vaccination do the following:

1. Go to Annex 1 (excel file)
2. Select the sheet corresponding to the vaccines requested for GAVI support in 2011 (e.g. Table4.1 HepB & Hib; Table4.2 YF etc)

3. Fill in the specifications of those requested vaccines in the first table on the top of the sheet (e.g. Table 4.1.1 Specifications for HepB & Hib; Table 4.2.1 Specifications for YF etc)
4. View the support to be provided by GAVI and co-financed by the country which is automatically calculated in the two tables below (e.g. Tables 4.1.2. and 4.1.3. for HepB & Hib; Tables 4.2.2. and 4.2.3. for YF etc)
5. Confirm here below that your request for 2011 vaccines support is as per Annex 1:

[YES, I confirm**]**

If you don't confirm, please explain:

4. Injection Safety Support (INS)

In this section the country should report about the three-year GAVI support of injection safety material for routine immunisation. In this section the country should not report on the injection safety material that is received bundled with new vaccines funded by GAVI.

4.1 *Receipt of injection safety support in 2009 (for relevant countries)*

Are you receiving Injection Safety support in cash *[NO]* or supplies *[NO]*

If INS supplies are received, please report on receipt of injection safety support provided by the GAVI Alliance during 2009 (add rows as applicable).

Table 7: Received Injection Safety Material in 2009

Injection Safety Material	Quantity	Date received

Please report on any problems encountered:

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

Even if you have not received injection safety support in 2009 please report on progress of transition plan for safe injections and management of sharps waste.

If support has ended, please report what types of syringes are used and the funding sources:

Table 8: Funding sources of Injection Safety material in 2009

Vaccine	Types of syringe used in 2009 routine EPI	Funding sources of 2009
BCG	AD SYRINGES	GOVERNMENT
Measles	AD SYRINGES	GOVERNMENT
TT	AD SYRINGES	GOVERNMENT
DTP-containing vaccine	AD SYRINGES	GAVI

Please report how sharps waste is being disposed of:

Safety boxes at health facilities and incinerators disposal of waste (SICIM) at each district level

Does the country have an injection safety policy/plan? [YES]
If YES: Have you encountered any problem during the implementation of the transitional plan for safe injection and sharps waste? (Please report in box below)
IF NO: Are there plans to have one? (Please report in box below)

The usable life of some incinerators is short. Incineration capacity at many sites only appropriate for EPI services, but there is some demand from curative services.

Capital expenditure for incinerators is exclusively donor supported. There are also challenges with maintenance of equipment.

4.3 *Statement on use of GAVI Alliance injection safety support in 2009 (if received in the form of a cash contribution)*

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

Fund from GAVI received in 2009 (US$): ....
Amount spent in 2009 (US$):..................
Balance carried over to 2010 (US$):..................

Table 9: Expenditure for 2009 activities

2009 activities for Injection Safety financed with GAVI support	Expenditure in US$
Total	

If a balance has been left, list below the activities that will be financed in 2010:

Table 10: Planned activities and budget for 2010

Planned 2010 activities for Injection Safety financed with the balance of 2009 GAVI support	Budget in US$
Total	

5. Health System Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. This section **only needs to be completed by those countries that have been approved and received funding for their HSS application before or during the last calendar year**. For countries that received HSS funds within the last 3 months of the reported year this section can be used as an inception report to discuss progress achieved and in order to enable release of HSS funds for the following year on time.
2. All countries are expected to report on GAVI HSS on the basis of the January to December calendar year. In instances when countries received funds late in 2009, or experienced other types of delays that limited implementation in 2009, these countries are encouraged to provide interim reporting on HSS implementation during the 1 January to 30 April period. This additional reporting should be provided in Table 13.
3. HSS reports should be received by 15th May 2010.
4. It is very important to fill in this reporting template thoroughly and accurately and to ensure that, **prior to its submission to the GAVI Alliance, this report has been verified by the relevant country coordination mechanisms** (HSCC or equivalent) in terms of its accuracy and validity of facts, figures and sources used. Inaccurate, incomplete or unsubstantiated reporting may lead the Independent Review Committee (IRC) either to send the APR back to the country (and this may cause delays in the release of further HSS funds), or to recommend against the release of further HSS funds or only 50% of next tranche.
5. Please use additional space than that provided in this reporting template, as necessary.
6. Please attach all required supporting documents (see list of supporting documents on page 8 of this APR form).

Background to the 2010 HSS monitoring section

It has been noted by the previous monitoring Independent review committee, 2009 mid-term HSS evaluation and tracking study[4] that the monitoring of HSS investments is one of the weakest parts of the design.

All countries should note that the IRC will have difficulty in approving further trenches of funding for HSS without the following information:

- Completeness of this section and reporting on agreed indicators, as outlined in the approved M&E framework outlined in the proposal and approval letter;
- Demonstrating (with tangible evidence) strong links between activities, output, outcome and impact indicators;
- Evidence of approval and discussion by the in country coordination mechanism;
- Outline technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year
- Annual health sector reviews or Swap reports, where applicable and relevant
- Audit report of account to which the GAVI HSS funds are transferred to
- Financial statement of funds spent during the reporting year (2009)

5.1 *Information relating to this report*

5.1.1 Government fiscal year (cycle) runs from JANUARY 1 2009 to DECEMBER 31 2009).
5.1.2 This GAVI HSS report covers 2009 calendar year from January to December
5.1.3 Duration of current National Health Plan is from JANUARY 2008 to DECEMBER 2015.
5.1.4 Duration of the current immunisation cMYP is from DECEMBER 2008 TO JANUARY 2015

[4] All available at http://www.gavialliance.org/performance/evaluation/index.php

5.1.5 Person(s) responsible for putting together this HSS report who can be contacted by the GAVI secretariat or by the IRC for possible clarifications:

Dr. Chea Sokhim GAVI HSS Coordinator Health Sector Support Office Ministry of Health
Email:
Phone: 855 12 894 741

[It is important for the IRC to understand key stages and actors involved in the process of putting the report together. For example: '*This report was prepared by the Planning Directorate of the Ministry of Health. It was then submitted to UNICEF and the WHO country offices for necessary verification of sources and review. Once their feedback had been acted upon the report was finally sent to the Health Sector Coordination Committee (or ICC, or equivalent) for final review and approval. Approval was obtained at the meeting of the HSCC on 10th March 2008. Minutes of the said meeting have been included as annex XX to this report.*']

Name	Organisation	Role played in report submission	Contact email and telephone number
Government focal point to contact for any programmatic clarifications:			
Professor San Chan Soeung	*Deputy Director General for Health Ministry of Health*	*Oversight of APR process and HSS*	workmoh@gmail.com *855 12933344*
Focal point for any accounting of financial management clarifications:			
Khout Thavary *Mr Myo Minn Financial Management Advisor Ministry of Health*	*Deputy Manager* *Department of Budget and Finance Ministry of Health*	*Preparation of financial statements, audits and coordination of financial reporting* *Advice on preparation of financial statements and audits*	*855 12 835003* *855 1256854*
Other partners and contacts who took part in putting this report together:			
Dr Chea Sokhim	*Coordinator HSS Office of Health Sector Support Project MOH*	*Coordination of information from provinces, districts and central departments*	*855 12894741* sokhimc_dr@yahoo.com
John Grundy	*HSS Consultant Ministry of Health*	*Technical advice on monitoring and evaluation and support for APR drafting*	jgrundy@unimelb.edu.au *855 12 680 455*

5.1.6 Please describe briefly the main sources of information used in this HSS report and how was information verified (validated) at country level prior to its submission to the GAVI Alliance. Were any issues of substance raised in terms of accuracy or validity of information

(especially financial information and indicators values) and, if so, how were these dealt with or resolved?

[This issue should be addressed in each section of the report, as different sections may use different sources. In this section however one might expect to find what the MAIN sources of information were and a mention to any IMPORTANT issues raised in terms of validity, reliability, etcetera of information presented. For example: *The main sources of information used have been the external Annual Health Sector Review undertaken on (such date) and the data from the Ministry of Health Planning Office. WHO questioned some of the service coverage figures used in section XX and these were tallied with WHO´s own data from the YY study. The relevant parts of these documents used for this report have been appended to this report as annexes X, Y and Z.*]

In terms of health indicators the main source of data is through the health information system of the Ministry of Health. This was collected from the Department of Planning and Health Information. The data is routinely provided to the central level from health centers, via districts and provinces. The second source of information was provided directly to the project officer at the Health Sector Support Project Office through telephone communications, written reports and field visits. This information is reported outcomes (results of indicators) which form the basis for financing of health contracts for the package of services (EPI, IMCI and MCH at the primary level of care).

There are two methods for validation of data.

The first method is to cross check the data received at the Department of Health Planning and Information with data received on contract performance at the Office of the Health Sector Support Project (HSSP). (HSSP2 supports priorities identified in Health Strategic Plan 2008-2015 (HSP2) through annual operational plans, including maternal and child health, non communicable diseases, health system strengthening and selected national programs of communicable diseases) GAVI HSS is a discrete fund component of HSSP.

It has been confirmed that there is a 100% match of data received on contracts performance at HSSP with the health information data received at DPHI.

The second method is through conducting household surveys to validate if the services have been received. The method is detailed in the ANNEX on methodology and is planned for implementation by the Dept. Planning and Health Information in the second quarter of 2010. Attempts will also be made to coordinate household survey and evaluations for GAVI-HSS with that for SOAs.

5.1.7 In putting together this report did you experience any difficulties that are worth sharing with the GAVI HSS Secretariat or with the IRC in order to improve future reporting? Please provide any suggestions for improving the HSS section of the APR report? Are there any ways for HSS reporting to be more harmonised with existing country reporting systems in your country?

1. In terms of M & E reporting, the GAVI HSS investment is guided by the M & E framework and report of the joint annual program review reporting processes. The Joint Annual Review Report of the MOH for 2009 will not be available in its final translated version until after the GAVI APR submission date.

5.1.8 Health Sector Coordinating Committee (HSCC)

How many times did the HSCC meet in 2009? Once. The HSSC also met in April 2010
Please attach the minutes **(Document N°4)** from all the HSCC meetings held in 2009, including those of the meeting which discussed/endorsed this report
Latest Health Sector Review report is also attached **(Document N° 5) (Joint annual program review)**

5.2 *Receipt and expenditure of HSS funds in the 2009 calendar year*

Please complete the table 11 below for each year of your government's approved multi-year HSS programme.

Table 11: Receipt and expenditure of HSS funds

	2007	2008	2009	2010	2011	2012	2013	2014	2015
Original annual budgets (per the originally approved HSS proposal)	1,850,000	987,043	987,043	1,010,070	1,032,260	1,052,865	1,071,540	1,088,545	1,104,205
Revised annual budgets (if revised by previous Annual Progress Reviews)	1,850,000	337,500	1,524,793	1,532,900	1,456,255	1383442	1314270	948557	886893
Total funds received from GAVI during the calendar year	1,850,000	337,500	1,509,500	1,464,000					
Total expenditure during the calendar year	146,987	1,380,062	1,316,971						
Balance carried forward to next calendar year	1,703,013	660,451	905166						
Amount of funding requested for future calendar year(s)				1,532,900	1456255	1383442	1314270	948557	886893

Please note that figures for funds carried forward from 2008, income received in 2009, expenditure in 2009, and balance to be carried forward to 2010 should match figures presented in the financial statement for HSS that should be attached to this APR.

Please provide comments on any programmatic or financial issues that have arisen from delayed disbursements of GAVI HSS *(For example, has the country had to delay key areas of its health programme due to fund delays or have other budget lines needed to be used whilst waiting for GAVI HSS disbursement)*:

In the first quarter 2010, the tranche that was approved by the Board has been late arriving in Cambodia. This has not impacted on the program as yet, but if the funds do not arrive by the end of the second quarter, some negative impacts could result.

Report on HSS activities in 2009 reporting year

Note on Table 12 below: *This section should report according to the original activities featuring in the HSS application. It is very important to be precise about the extent of progress, so please allocate a percentage to each activity line, from*

0% to 100% completion. Use the right hand side of the table to provide an explanation about progress achieved as well as to bring to the attention of the reviewers any issues relating to changes that have taken place or that are being proposed in relation to the original activities. It is very important that the country provides details based on the M& E framework in the original application and approval letter.

Please do mention whenever relevant the **SOURCES** of information used to report on each activity.

Table 12: HSS activities in the 2009 reporting year

Major Activities	Planned Activity for 2009	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
Objective 1: SERVICE DELIVERY		
Activity1.1: HEALTH CENTRE SERVICE DELIVERY CONTRACT	Establish and Implement Health Centre MPA Annual Operational Plans & Performance Agreements (using supply and demand side approaches) (MCH) and remote area service payments	**Planned Budget**: $555,574, **Expenditure**: $542,507 Achievements of this main area of HSS were as follows: Since 2006, there has been a 17% increase in DPT Hep B 3 coverage in 10 HSS ODs from 70% to 87%, and a 16% increase nationally from 78% to 94% Since 2006, there has been a 16% increase in measles coverage in 10 HSS ODs from 67% in 2006 to 83%, and a 15% increase nationally from 77% to 92%. Since 2006, from a baseline of 1 of 10 with DPT3 coverage > 80%, 9 out of 10 HSS districts have now reached > than 80% DPT 3 coverage. *Nationally,* from a baseline of 18 ODs, 68 ODs out of 77 have reached > than 80% coverage. Since 2006, there has been a 30% increase in delivery at facility coverage in 10 HSS ODs from 14% in 2006 to 44% in 2009, and a 26% increase nationally from 18% in 2006, to 44% in 2009. (source health information system). Evaluations have indicated that performance based incentives for delivery at facility and immunization are having an impact on service coverage. (source: see Annexes of HLSP and UNFPA evaluations) The annual review in march 2010 has established that there are some weaknesses of the system which include the following: (1) Shortage of human resources in some locations (2) Despite training, still major limitations with planning capacity at health centre level (3) lack of operational costs and community participation funding in some remote locations. (source Annual Review of HSS MOH march 2010)

		Changes proposed for 2010: Angkor Chum and Prey Kabas have been converted to SOA s by Sub-decree 69 dated 27 April 2009. These two ODs will be receiving SDG for fully implementation of SOA in 2010. Therefore, GAVI-HSS that used to be provided to these two ODs up to 2009 will be switching to OD Thmar Kaul of Battambang province and OD Bakan of Pursat province. The ICSC has recommended that the 2 ODs that have just left the GAVI HSS system should be monitored up to 2015 to see how this transition can be made from primary care internal contract to District contracting under HSSP2.
Activity 1.2: DISTRICT & PROVINCE MANAGEMENT CONTRACTS	Establish and Implement Annual Operational Plans & Performance Based Management Agreements for ODS and Provinces (MCH)	No differences in activity or expenditure reported. A national workshop in March 2010 has recommended more focus on the strengthening the quality of supervision.
Activity 1.3: COVERAGE IMPROVEMENT PLANNING	Integration of Immunization Coverage Improvement Planning into MPA Planning Systems (MCH) (gradual scale down of CIP))	**Planned budget**: $134,666 **Expenditure:** $44,898 The main area of non expenditure was coverage improvement planning (CIP) for immunization in the last quarter of 2010. Alternative funding sources for CIP were identified in the annual operational plans of Operational Districts
Activity 1.4: DEMAND SIDE STRATEGY	Implement, Evaluate and Fixed Site Strategy (MCH) (including demand side activities)	**Planned Budget**: $43,442 **Expenditure:** $38,410 Achievements; The strategy to implement immunization services at facility (increasing demand for immunization services at facilities) is having positive effects. The baseline was an estimate of 20% for fixed site immunization in 2006 (based on coverage surveys). There has been an increase of 28% to 48% in the 10 HSS OD in 2008 and nationally the rate has increased to 37%. (source: Health Information System)

Objective 2: MANAGEMENT SYSTEMS		
Activity 2.1: FINANCE SYSTEMS	Technical Support and Monitoring the implementation of financial management tool and revised planning manual of OD and HC and planning implementation: 1- Post Training follow up at OD/HC (For PMD = Dissemination workshop for outreach guideline) (joint funding Dept. Finance and Dept. Planning	**Planned Budget**: $126,592. **Expenditures** was $70,996, A financial management manual (FMM) was developed in October 2007. Based on lesson learned from the previous .auditor's report and feedback from implementation units, the GAVI Financial management manual (FMM) will be revised in January 2010. Regular follow up training and review financial status was conducted with the joint supervision mission. One follow up Financial Management workshop or "FMM training course" was conducted in December 2009. (source: DBF HSS report at HSS Annual review)
Activity 2.2: PLANNING SYSTEMS	Regional dissemination workshop on revised planning manual Conduct OD assessment (Consolidate and analyze the result of OD assessment . Conduct Regional Consultative of Guideline for Developing Operational District (4WS) Strengthen OD capacity in Qtrly review & Plan preparation: On-site supervision and monitoring Strengthen OD capacity in Annual review & Plan preparation: Annual review (OD, RH and HC) & preparation according to Planning Manual Technical Support from OD planning team to RH and HCs in AOP development Conduct appraisal on AOP of Health Facilities and provide feedback Joint supervision on data validation Document Publication: Printing revised planning manual / financial system manual / MPA Guideline	Achievements in the area of planning were as follows: (1) Field supervision to the PHD/ODs was conducted 7 times in the year for monitoring RHs and HCs following conducting of planning training (2) 12 Field visits were conducted for spot-check on data collection and entering data at HCs in OD support by GAVI-HSS funds with participation from planning and health information units staff. (3) 75 health staff from HCs were trained in Planning Process with two phases of training. (4) 52 referral staff was trained on planning process with one training The revised planning manual and regional dissemination workshop was not conducted in 2009, and this activity has been moved to 2010 (source: GAVI HSS Annual review March 2010 MOH)
Activity 2.3: SUPERVISION	Strengthening of integrated supportive supervision programs from central to PHD, and OD to HC level	An integrated supervision team visited the 10 HSS ODs 4 times in 2010. The team consists of DPHI, NIP, CDC, Preventive Medicine and Dept Budget and

		Finance.
Activity 2:4: RESEARCH	Conduct Health Systems Operational Research Programs	As described elsewhere, two evaluations have been conducted in 2009, with one funded through AusAID UNFPA) and the other funded through GAVI (HLSP) (both evaluation reports are annexes to this APR). The research funds in 2009 were expended on a mid term review. A research program is proposed for 2010 and a HSS household check is currently being conducted.
Objective 3: QUALITY IMPROVEMENT		
Activity 3.1: MLM	Training workshops middle level management (150 HC staff and OD staff in each 5 days training Training workshops middle level management to Referral Hospital (On Planning)	This activity is integrated into planning and financial management training in ACTIVITY 2.1 and 2.2
Activity 3.2: IMCI	IMCI Clinical Training/IMCI Refresher Training Course Strengthen the facilitating supervision of OD level Strengthen monitoring and spot-checking form national level Capacity building for local trainers to conduct cascade training to HC staff and to VHSG on 12 keys family and community practices of IMCI IMCI Annual Review Meeting 2009 Immunization Training (10 OD TOT training Cold Chain/Vaccine Management/IIP and training of HC staff)	**Budget** $223, 447 **Expenditure**: $133,244 At least 2 Health Centre Staff from each of the 10 GAVI-HSS Operational Districts (ODS) have now received training on IMCI . This resulted in an increase in consultation of < 5 Year Old Children compared to the previous year. Main achievements: All 10 ODs have now received training in IMCI. The national HSS review reports that IMCI activities are integrated into the Annual Operating Planning (AOP) system, and training and supervision follow up has been conducted from PHD and OD (see national review report) The main area of under spending is in immunization training,
Activity 3.2: CHILD	Strengthen systems for child survival scorecard monitoring (include in 3.3)	Included in description in ACTIVITY 3.2

SURVIVAL	Conduct capacity Building & supportive supervision programs for IMCI and immunization	
Activity 3.4 : RMNCH Training and Quality Improvement (co financing AusAID UNFPA)	Promoting increased access to reproductive health services through (a) capacity building for staff on RNMCH (b) monitoring and supervision support for RMNCH by the provinces and ODs (c)funds for service for birth spacing, and post natal care (d) Reproductive health equity fund in Angkor Chum and Kg Tralach (2 of 10 HSS ODs	The program has been implemented as planned in 2009. This program is budgeted through UNFPA/AusAID Health Sector Support program, but is managed through the same contracts with the same GAV HSS ODs. Main achievements nationally have included improvements in new acceptors for family planning: The number of contacts for new acceptor of client s has increased by 7004 from 16701 in 2008 to 23705 in 2009. Number of post natal contact increases 22.499 visits from 41484 contacts in 2008 to 63973 contacts in 2009. Improvements in delivery by trained staff and ANC coverage have already been described.
Activity 3.5 : PRIVATE SECTOR	Implement, Evaluate and Scale Up Public / Private Collaboration (immunization with potential integration with MCH)	This activity was not implemented in 2009, and funds have been reprogrammed for implementation of the health contracts in the 10 HSS ODs
PROJECT MANAGEMENT	Office support, evaluation workshops, transportation, technical support Other logistics Performance Agreements for Monitoring Team (Planning, Finance, NIP central). Monitoring and Supervision Specialists central level Per-diem, allowances, transportation cost for PHD staffs (From Province to Phnom Penh) Annually Audit (External Audit) Miscellaneous 5% Implement research or evaluation studies to guide HSS program implementation (Mid-Year Review) M&E support costs and Evaluation Study (including 2 workshops)(Annual Review & Consultant Operation Cost)	**Budget**:: $168,552 **Expenditure**: $140,085 ***Annual Auditing*** Annual audit for the period of October 2007 to December 2008 has been conducted by "PricewaterhousCoopers" during the period of 16 June 2009 to 28 July 2009. The final auditor's report for (a) Financial Statement and (b) Internal Control report have been issued on 10 August 2009. The original auditor's report has been submitted to GAVI during August 2009. No significant finding in annual audit report except some weaknesses were identified in the internal control system in some provinces. An annual audit for the period of January 2009 to December 2009 will be expected to be conducted in May 2010. Financial report for 2009 has been completed and is ready for auditing by external audit. We have arranged to audit for 2009 with previous 2008 auditor "PricewaterhouseCoopers". Procurement of an external audit firm is in process and is expected to take place during May 2010. (Source: DBF Annual Report at GAVH HSS Annual Review MOH March 2010) ***Supervision***

	TA 3% (Planning, financing,PBMA)	Supervision has taken place on a quarterly basis to all contract districts ***Evaluation Studies*** Two evaluation studies took place in 2009. One external evaluation was conducted by a consultant through UNFPA, and the second evaluation was conducted by GAVI through HLSP. Both of these evaluations are annexed to this APR. A research design has been developed in 2009 for implementation in 2010. This will be an evaluation at community level of community and health worker perceptions of the quality of health services in HSS districts. This study is based on evaluation studies which confirm that the issue of quality of health care should be given more attention in HSS. (source S Biacabe HSS review 2008 and HLSP HSS country Study Cambodia 2009) As stated elsewhere, a HSS DQA (internal) is being conducted in April 2010. Three HSS reviews took place in 2009. District and provincial managers central level departments met centrally 3 times in 2010 for the purposes of annual review, mid year review and planning for 2010 (including identifying strengths and weaknesses, setting agreed targets for contracts, and inclusion of activities and budget in annual operational plans of the MOH. ***Technical Assistance*** A full time project officer is employed through the HSSP program to provide administrative, technical and coordination support to the HSS manager and to contracted districts. An international adviser (independent consultant) has been employed for a period of 20 days in 2009 to provide additional technical support in areas such as monitoring and evaluation and GAVI communications. This is being increased to 60 days in 2010. Finally, a research study will be contracted out to assess health centre utilization and access in 2010.

<u>Support functions</u>

*This section on **support functions** (management, M&E and Technical Support) is also very important to the GAVI Alliance. Is the management of HSS funds effective, and is action being taken on any salient issues? Have steps been taken to improve M&E of HSS funds, and to what extent is the M&E integrated with country systems (such as, for example, annual sector reviews)? Are there any issues to raise in relation to technical support needs or gaps that might improve the effectiveness of HSS funding?*

5.2.1 Management

Outline how management of GAVI HSS funds has been supported in the reporting year and any changes to management processes in the coming year:

The budget for HSS at the delivery level is calculated by the expected number of contacts for EPI, and selected MCH services at the primary level of care. Budgets are planned based on the expected number of contacts per year. The expected contacts are described in the performance contract (as well as conditions for performance such as management functions, reporting and 24 hour facility opening).

The funds are managed using the MOH procedures for Health Sector Support program 2 (as a discrete fund).

There is an annual release of funds to the provincial level, monthly releases to districts (based on report of health centre activity) and monthly release from the district based on the previous months performance. These procedures are outlined in the HSS financial management procedures manual.

All budgets are reflected in annual operational plans, so decision making on use of funds is through annual planning approval process of the Ministry of Health at each level of the health system.

There are no changes to the financial management system in 2010.

5.2.2 Monitoring and Evaluation (M&E)

Outline any inputs that were required for supporting M&E activities in the reporting year and also any support that may be required in the coming reporting year to strengthen national capacity to monitor GAVI HSS investments:

1. Two evaluation workshops were conducted in 2009. A two day workshop was conducted from 28-29 of June in Sihanouk Ville with 131 participants from Provincial Health Department, Operational District and Central Department as well as NGOs Partners. The key staff from EPI, MCH, OD chief, Chief of Technical Bureau from the provincial Health Department (PHD), Accountant from PHD and OD and M&E officers. The main objectives of the WS was to present the Annual Progress Report (APR) 2008, to see the mid-year progress of GAVI HSS 2009 and plan for 2010. During the WS, there was also the opportunity for presentation of the assessment findings of GAVI HSS 2008 by an external consultant.
2. A two day workshop was conducted from 27th-28th October 2009 in Phnom Penh with 130 participants from Provincial Health Department, Operational District and Central Department as well as key active NGOs Partners. The key staff from EPI, MCH, OD chief, Chief of Technical Bureau form PHD, Accountant from PHD and OD and M&E officers. The main objectives of the WS were to present 9 months Progress Report

2009, to share lesson learnt and orientate progress of GAVI HSS 2009 and plan for 2010. This includes recommendations on activities for inclusion in the annual operational plan of the district and provinces. The same process will be followed in 2010. An Annual Review of HSS will be conducted in march 2010 (GAVI, AusAID UNFPA), a mid year review will be conducted and a national meeting will be conducted late in 2010 for inclusion of HSS activities and strategies in annual operational plans (and designing of health contracts for 2011).

3. Two evaluations of HSS were conducted in 2009. The first was by an external consultant through UNFPA. The second was an external consultant team from HLSP that conducted an in depth case study on HSS in Cambodia. Both of these reports are annexed to this APR.
4. An M & E officer is employed full time through the HSSP (Health Sector Support Program). The M & E officer liaises with the central departments such as DPHI and Dept Budget and Finance and contracted districts on matters related to planning, formulation of contracts and validating contracts data (by cross checking it with DPHI data)
5. DPHI assisted the M & E officer to collect information on numerators and denominators for the 10 HSS ODs from the national data base. An international consultant contracted and managed through HSSP 2 was employed for 20 days in 2009 to assist with M & E and has been contracted for 60 days in 2010 for the same TOR
6. Information from the National Health Congress in February 2010 was used to re design some of the monitoring indicators for HSS.
7. The terms of reference for a health system research study in the 10 HSS ODs has been designed in 2009 for implementation in 2010. This will be tendered to a national research institute.
8. More consultation and assistance will be required from another development partners (World Bank, WHO, UNICEF, NGOs) in order to ensure that there are close linkages between the primary care contracts systems of MOH/GAVI/UNFPA/AusAID and the wider contract systems of Special Operating Agency (which incorporates hospital and primary care services into a larger contract – 2009 was year 1 of implementation). Two GAVI HSS districts have now moved into the larger contract system of SOA, and two new districts have entered into the GAVI HSS system. These two ODs entered into the SOA system as they now met the system criteria (adequate staff, facility standards, management standards etc).

5.2.3 Technical Support

Outline what technical support needs may be required to support either programmatic implementation or M&E. This should emphasise the use of partners as well as sustainable options for use of national institutes:

1. Technical support will be provided by the Department of Planning and Health Information in order to conduct data quality audits (facility and community level). DPHI will also conduct a training of Provinces and Districts in order to decentralize data quality audit processes to a lower level.
2. Terms of reference for a health system evaluation in the 10 HSS ODs have been developed for implementation in 2010. This study will be tendered through HSSP 2 for implementation by national research institutes and organizations.
3. A national immunization coverage survey, technically supported by WHO and UNICEF is planned for Cambodia in the second half of 2010, as is a Demographic Health Survey 2010 (previous survey conducted in 2005).
4. Technical support is required by partners to facilitate closer linkages between GAVH HSS and HSSP 2 SOA system. Although these linkages are already evident (ie. GAVI HSS ODs moving into SOA models etc) More support is required from partners to consider long term strategy. Technical support is also required from partners to strengthen the annual operating planning system, Provincial Technical Working Group meetings and integrated health outreach.

<u>Note on Table 13:</u> This table should provide up to date information on work taking place during the calendar year during which this report has been submitted (i.e. 2010).

The column on planned expenditure in the coming year should be as per the estimates provided in the APR report of last year (Table 4.6 of last year´s report) or –in the case of first time HSS reporters- as shown in the original HSS application. Any significant differences (15% or higher) between previous and present "planned expenditure" should be explained in the last column on the right, documenting when the changes have been endorsed by the HSCC. Any discrepancies between the originally approved application activities / objectives and the planned current implementation plan should also be explained here

Table 13: Planned HSS Activities for 2010

Major Activities	Planned Activity for 2010	Original budget for 2010 (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	Revised budget for 2010 (proposed)	2010 actual expenditure as at 30 April 2010	Explanation of differences in activities and budgets from originally approved application or previously approved adjustments
Objective 1: DELIVERY					
Activity 1.1: HEALTH CENTRE SERVICE DELIVERY CONTRACTS	Establish and Implement Health Centre MPA Annual Operational Plans & Performance Agreements (using supply and demand side approaches) (MCH)	770,051	577114	114,041.50	The performance based contracts have been reduced in value to changes made in the fee schedule for services provided. In particular, the child consultation fee has been integrated into a 1 off IMCI payment that has reduced the value of the contracts. Remote area allowance and community participation is also included in this category.
Activity 1.2: DISTRICT MANAGEMENT CONTRACTS	Establish and Implement Annual Operational Plans & Performance Based Management Agreements for ODS and Provinces (MCH)	136,220	112,600	400.00	The budgets for this category have been reduced in order to promote sustainability as alternative sources for management incentives will need to be identified after GAVI HSS.
Activity 1.3: COVERAGE IMPROVEMENT PLANNING	Integration of Immunization Coverage Improvement Planning into MPA Planning Systems (MCH) (gradual scale down of CIP))	100000	139,786	40,801.56	These funds have been increased to focus on the poorest coverage areas nationally as well as on 1 of the HSS ODs where EPI coverage is still low.

Activity 2.4	Conduct Health Systems Operational Research Programs	30,000	13,000		As reported elsewhere, two evaluations were conducted in 2009 (UNFPA/AusAID and HLSP-GAVI). $13,000 has been planned for 2010 to conduct a community and health centre based study on utilization of health centers in the HSS ODs.
Activity 1.4 FIXED SITE STRATEGY	Implement, Evaluate and Fixed Site Strategy (MCH) (including demand side activities)	25000	48,098	13,547.37	Fixed site investment has increased. At this stage, as reported in the M & E framework, the fixed site strategy has been very successful in the 10 HSS ODs in increasing demand. Additional funds will provided for management support from central, PHD and OD levels to support wider implementation of the strategy. This will be for the purpose for supporting policy change for the MPA guidelines to include the fixed site guidelines
Objective 2: SYSTEMS					
Activity 2.1:	Develop MPA Financial Management Systems & health financing guidelines	20,000	35,000	12,382.24	As reported in the Annual GAVI HSS review in 2010 (see Annex), the Dept of Budget and Finance is reporting that the financial management guidelines are not being followed at all times and more capacity building and monitoring support is required for OD Accountants.
Activity 2.2:	Strengthening of AOP planning systems and implementation of MPA Planning guidelines	45,000	120939	7,318.05	The budget has increased due to the carry forward of several main activities from 2009 – this includes conducting of regional AOP workshops and dissemination of MPA guidelines
Activity 2.3	Strengthening of integrated supportive supervision programs from central to PHD, and OD to HC level	69,776	54121	5,760.00	Monitoring of GAVI HSS implementation progress will be integrated with the service delivery field monitoring and Quarterly Service Delivery monitoring meetings. Meeting will be held among all concerned partners (MOH, JPIG Technical Lead Agencies - WB, AFD, BTC, and WHO) to

					discuss processes for the integration. It is expected that integration of monitoring GAVI HSS and service delivery monitoring will be initiated from quarter 3, 2010. Options will also be explored to strengthen verification system, including thru random spot checks, in coordination with verification system for SOAs.
Objective 3: CAPACITY BUILDING					
Activity 3.1: MLM	Conduct capacity building programs for Middle Level Management	46,000	16,737	0.00	These activities are now included in the planning and financial management categories (activities 2.1 – 2.4) Most of these activities are focused at the district level and below.
Activity 3.2: IMCI	Conduct capacity Building & supportive supervision programs for IMCI and immunization	104,000	148461	31,009.92	
Activity 3.3: Child Survival	Strengthen systems for child survival scorecard monitoring (include in 3.3)	10,000	12000	0.00	
Activity 3.4 : RMNCH Training and Quality Improvement (co financing AusAID/UNFPA)	RMNCH activities financed through AusAID and UNFPA	0	0		
Activity 3.5 PRIVATE SECTOR	Implement, Evaluate and Scale Up Public / Private Collaboration (immunization with potential integration with MCH)	10000	10000		
PROJECT MANAGEMENT	Office support, evaluation workshops, transportation, technical support and other	97,721	245,044	25,453.74	This category has now higher level of investments for the following reasons: (1) There is now a lot more focus on M & E. Three annual workshops are proposed per year to review and plan the program (2) Funds have been set

	logistics				aside to conduct a HSS DQA in the first quarter of 2010. (3) International TA has increased from 20 to 60 days (4) An additional evaluation study is proposed for late 2010 although the design for this has not been finalized as yet. (5) A miscellaneous calculation of 5% of the budget is set aside
TOTAL COSTS		1,463,768	$1,532,900	250,714.38	

* Additional comment on fixed site strategy: Policy dialogue will be conducted to get political support on making fixed site immunization to be official policy of the MOH. After the decision has made, planning for rolling out fixed site immunization (and potentially for other health services as well) will be conducted in consultation with PHDs/ODs and health partners. The initial step will be to start with SOA ODs and the evaluation will be done as part of the household survey.

Table 14: Planned HSS Activities for next year (ie. 2011 FY) *This information will help GAVI's financial planning commitments*

Major Activities	Planned Activity for 2011	Original budget for 2011 (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	Revised budget for 2011 (proposed)	2010 actual expenditure as at 30 April 2010	Explanation of differences in activities and budgets from originally approved application or previously approved adjustments
Objective 1: DELIVERY					
Activity 1.1: HEALTH CENTRE SERVICE DELIVERY CONTRACTS	Establish and Implement Health Centre MPA Annual Operational Plans & Performance Agreements (using supply and demand side approaches) (MCH)	577114	534464	114,041.50	There are no changes to report in this section other than those already described in Table 13. IMCI has been reduced by $33, 995
Activity 1.2: DISTRICT MANAGEMENT CONTRACTS	Establish and Implement Annual Operational Plans & Performance Based Management Agreements for ODS and Provinces (MCH)	112,600	112,600	400.00	
Activity 1.3: COVERAGE IMPROVEMENT PLANNING	Integration of Immunization Coverage Improvement Planning into MPA Planning	139,786	139,786	40,801.56	

	Systems (MCH) (gradual scale down of CIP))				
Activity 1.4 FIXED SITE STRATEGY	Implement, Evaluate and Fixed Site Strategy (MCH) (including demand side activities)	48,098	48,098	13,547.37	
Objective2: SYSTEMS					
Activity 2.1:	Develop MPA Financial Management Systems & health financing guidelines	35,000	35,000	12,382.24	
Activity 2.2:	Strengthening of AOP planning systems and implementation of MPA Planning guidelines	120939	120939	7,318.05	
Activity 2.3	Strengthening of integrated supportive supervision programs from central to PHD, and OD to HC level	54121	54121	5,760.00	
Activity 2.4	Conduct Health Systems Operational Research Programs	13,000	13,000		
Objective 3: CAPACITY BUILDING					
Activity 3.1: MLM	Conduct capacity building programs for Middle Level Management	16,737	16,737	0.00	
Activity 3.2: IMCI	Conduct capacity Building & supportive supervision programs for IMCI and	148461	114,466	31,009.92	

	immunization				
Activity 3.3: Child Survival	Strengthen systems for child survival scorecard monitoring (include in 3.3)	12000	12000	0.00	
Activity 3.4 : RMNCH Training and Quality Improvement (co financing AusAID/UNFPA)	RMNCH activities financed through AusAID and UNFPA	0	0		
Activity 3.5 PRIVATE SECTOR	Implement, Evaluate and Scale Up Public / Private Collaboration (immunization with potential integration with MCH)	10000	10000		
PROJECT MANAGEMENT	Office support, evaluation workshops, transportation, technical support and other logistics	245,044	245,044	25,453.74	
TOTAL COSTS		$1,532,900	$1,456,255	250,714.38	

5.3 *Programme implementation for 2009 reporting year*

5.3.1 Please provide a narrative on major accomplishments (especially impacts on health service programs, notably the immunisation program), problems encountered and solutions found or proposed, and any other salient information that the country would like GAVI to know about. Any reprogramming should be highlighted here as well. This should be based on the original proposal that was approved and explain any significant differences – it should also clarify the linkages between activities, output, outcomes and impact indicators.

*This section should act as an executive summary of performance, problems and issues linked to the use of the HSS funds. This is the section where the reporters point the attention of reviewers to **key facts**, what these mean and, if necessary, what can be done to improve future performance of HSS funds.*

1. Between commencement of the program in the last quarter of 2007 and the end of 2009, there have been significant increases in EPI coverage, and access to MCH care in the 10 HSS ODs (see M & E section for detail). There have also been significant increases nationally.
2. In 2009, there was no major reprogramming of funds.
3. In 2008, the methodology of “capitation” based funding (in the original proposal) was changed to a performance based “fee for service” by the Ministry of Health (HSSP 2) and included in the primary care contracts. The primary rationale for the change was to enable easier management of the contracts. The second rationale was that it was subsequently considered to be impractical to take a capitation based approach with such a small funding base of HSS GAVI.
4. In late 2008 and throughout 2009, AusAID/UNFPA is co financing the primary care contracts. That is, there is one primary care contract covering a package of MCH services at the primary level of care for immunization, ante natal care, post natal care and birth spacing. GAVI HSS and AusAID UNFPA are financing a single contract for each health centre and Operational District. This is an “add on” to the GAVI HSS investment and did not result in any reprogramming of the GAVI HSS funds.
5. In 2010, 2 of the original HSS ODs have now moved into the wider capitation based contracting model of “Special Operating Agency” funded by the pooled mechanism of HSSP 2. 2 new ODs have now moved into the GAVI HSS category of contracts in 2010.
6. Two HSS evaluations were reported on in 2009. The first was through UNFPA and the second through HLSP. These are annexed to this APR. In summary, both evaluations noted the improved health outcomes for EPI and MCH, increased health workforce motivation and improved opening hours of health facilities. Both evaluations expressed needs for closer alignment of M & E frameworks with national systems, more emphasis on quality in the proposal implementation, and increased efforts for strategizing linkages with the wider SOA model.
7. Due to reforms in incentives systems by the Government, cancellation of all donor supported management incentives came into operation in January 1 2010. A new system is being designed and recommended by the Government. This interruption to incentive systems may impact on the implementation of GAVI HSS.
8. The current preference for the MOH at this stage is for management of GAVI HSS funds as a discrete fund for HSSP2 (rather than pooled fund), integration of GAVI HSS into annual operational plans, and closer alignment with national M & E systems (see M & E section of this report). Although discussions have commenced in Cambodia on “HSS Joint Platform”, there is no clear directions as yet on what direction this HSS platform would take.

5.3.2 Are any Civil Society Organisations involved in the implementation of the HSS proposal? If so, describe their participation? For those pilot countries that have received CSO funding there is a separate questionnaire focusing exclusively on the CSO support after this HSS section.

CSOs do not receive funding directly from GAVI HSS.

However, CSOs are actively involved in implementation of HSS in the following ways:

1. The main coordinating mechanisms for CSO are Pro Technical Working Groups for Health at the provincial level. It is in the 2 monthly forum in the provinces that CSOs coordinate their activities with Provincial and OD departments.
2. Nationally, NGOs (RACH, RACHA, PATH, and MEDICAM) are invited to mid year and annual reviews of HSS with PHD and OD Directors in the 10 ODs.
3. Both GAVI HSS funds and activities and CSO programs and activities are reflected in the annual operational plans of health centres, districts and provinces. These plans are subject to annual and quarterly reviews and an appraisal process.

5.4 *Management of HSS funds*

Has a GAVI Financial Management Assessment (FMA) been conducted prior to or during the 2009 calendar year ? NO **[IF YES] :** please complete **Part A** below.
[IF NO] : please complete **Part B** below.

Part A: further describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of HSS funds.

An external financial audit (Price Water House Coopers) was conducted in 2009 as per GAVI requirements. A further audit is being conducted in 2010. All funds are managed according to MOH policy and procedures.

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

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

Type of Account

The Government account is used for GAVI, managed through the Department of Budget and Finance.

How Funds are channelled to sub national levels

The GAVI HSS fund is a discrete fund managed through the multi donor Health Sector Support program 2 2009 – 2013.

Budgets are approved through the routine health planning systems. That is, all GAVI HSS plans and budgets are included within annual operational plans of Districts, provinces and central Departments, and are subject to the same systems of annual review and appraisal.

A mid term and annual HSS workshop is conducted in which the HSS contracts are negotiated and reviewed. The signed contracts (by the Secretary of State and Provincial and District Health Directors) form

the basis for the annual release of the funds to the provinces. It is at these workshops that the activities and costs are integrated into the annual operational plans of the Provinces and Districts (facilitated by Dept. Planning and Health Information).

Based on the contract, for the 10 HSS ODs, funds are released annually to the Province and deposited in a commercial account.

The provinces release the funds to the Districts on a monthly basis based on the previous month's performance by the health centres for the MCH and EPI package. Monthly funds are deposited in safety boxes at District level.

The health centres report to the District for a monthly meeting, receive their funds for the previous months performance report, and submit their health information report which forms the basis for the next funding request.

5.5 *Detailed expenditure of HSS funds during the 2009 calendar year*

Please attach a detailed financial statement for the use of HSS funds during the 2009 calendar year **(Document N°6).** *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

If any expenditure for the January – April 2010 period are reported above in Table 16, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document N° N/A)**.

External audit reports for HSS, ISS and CSO-b programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available for your HSS programme during your government's most recent fiscal year, this should also be attached **(Document N°7)**.

5.6 *General overview of targets achieved*

The indicators and objectives reported here should be exactly the same as the ones outlined in the original approved application and decision letter. There should be clear links to give an overview of the indicators used to measure outputs, outcomes and impact:

Table 15: Indicators listed in original application approved

Name of Objective or Indicator *(Insert as many rows as necessary)*	**Numerator**	**Denominator**	**Data Source**	**Baseline Value and date**	**Baseline Source**	**2009 Target**
Objective 1: SERVICE DELIVERY						Note: National Targets from JAPR
1. National DPT – HEPB 3 coverage (%)	Under 1 children immunized with DPT – Hep B3	Children under the age of 1	DPHI	78.3% - 2005	DHS 2005	93%
2. Number / % of districts achieving ≥80% DTP3 coverage	No of districts achieving ≥80% DTP3 coverage	Total no. of districts	NIP	18/76 - 2006	NIP	76 (2015 target)
3. Under five mortality rate (per 1000)	Total deaths under the age of 5 per	Total under 5 population	Not available for 2009	2005	DHS 2005	-
4. Measles Coverage	Under 1 children immunized with measles	Children under the age of 1	DPHI	2005	DHS 2005	93%
5. % pregnant women who have at least 2 ANC visit from a trained health professional	Total expected births with at least 2 ANC visits	Expected Births	DPHI	60% - 2005	NSRH 2005 [5]	80%
6. Proportion of deliveries attended by trained health staff	Total deliveries by trained health staff (doctor, midwife – nurse)	Expected births	DPHI	44% - 2005	DHS 2005	65%

[5] This target will be reviewed an annual basis given that a 5% rise from 2005 would be required each year to reach the target.

Objective 2: MANAGEMENT SYSTEMS Objective 3: QUALITY IMPROVEMENT	Numerator	Denominator	Data Source	Baseline Value and date	Baseline Source	2009 Target
7. % of OD that have reached performance targets specified in the OD Contracts	No of OD that have reached contractual targets at the end of each year.	No of OD that have signed OD Contract (10 in 2007)	DPHI	0% - 2006	DPHI	10
8. % of facilities implementing full MPA * [6]	No of facilities (health centres) implementing MPA	No of facilities (health centres) in Cambodia	DPHI	48% (470 out of 972) 2006	DPHI	84%
9. Number of new case of general consultation per inhabitant per year for children under the age of 5 *	Consultations	Total number of inhabitants	DPHI	1 - 2006	DPHI	>1
10. No. of Health Sector Plan 2 Policy Package Approved *	Number of guidelines and policies developed and adopted by MOH for scale up	-	DPHI	0 - 2006	DPHI	This indicator no longer used
11. % immunization provided at the fixed site	Total number of immunizations provided at facilities (health centres or hospitals)	Total number of immunizations provided	Surveys	20-25% 2003 - 2004	(1) KAP Study on Immunization NIP/PATH 2003 (2) Health Coverage Survey PATH/NIP 2005	40% (2015 Target)
12. % of approved budget reaching health facilities *	Total budget dispersed	Total budget planned	OD Accountant	Not available	Not available	This indicator not measurable – will require a health system assessment

In the space below, please provide justification and reasons for those indicators that in this APR are different from the original approved application:

Provide justification for any changes in the **definition of the indicators:**

[6] * These indicators are part of the draft M & E Framework

Indicators 10 and 12 in the original application have now been removed as they are not measured as part of the national M & E framework. This also fits with recent evaluators comments to align more closely with National M & E systems.

3 new indicators have been added in order to align more closely with the national M & E framework and to reflect the inputs into the HSS contracts of the AusAID UNFPA investment. These are as follows:

% Women reproductive age current user modern method of birth spacing
% of total deliveries taking place in facilities
% Health centers that implement IMCI

There was a denominator change in 2008 following publication of new population figures by the Ministry of Planning based on the publication of the latest census report (attached as annex to this APR). Between 2007 and 2008 there was a reduced population denominator following publication of the census report. Births reduced from 385,437 to 353,439**.**

Provide justification for any changes in **data source**: There have been no changes in data source. All data is from Dept. Planning and Health Information sources.

Table 16: Trend of values achieved

Name of Indicator *(insert indicators as listed in above table, with one row dedicated to each indicator)*	**2007**	**2008**	**2009**	**Explanation of any reasons for non achievement of targets**
National DPT – HEPB 3 coverage (%) NATIONAL	82	91	94	
National DPT – HEPB 3 coverage (%) 10 HSS ODS	70	80	87	In the 10 HSS ODs, despite raising coverage by 17% between 2007 and 2009, the 10 HSS ODs still trail national coverage (although gap is reduced by 6%). When this program commenced, ODs were selected on the basis of lower coverage and no NGO presence. This being the case, it may require more time to reach this level of performance, especially in those districts with larger remote areas. It should also be noted that in the original HSS application the 2015 was 90%, but this has been shifted upwards following improved performance in recent years.
Number / % of districts achieving ≥80% DTP3 coverage NATIONAL	33	62	68	Denominator – 77 ODs
Number / % of districts achieving ≥80% DTP3 coverage 10 HSS ODs	1	7	9	
Under five mortality rate (per 1000)	83/100	-	-	Next DHS survey is in 2010
Measles Coverage NATIONAL	79	91	92	
Measles Coverage 10 HSS ODs	67	78	83	As for DPT3
% pregnant women who have at least 2 ANC visit from a trained health professional NATIONAL	41	81	83	
% pregnant women who have at least 2 ANC visit from a trained health professional 10 HSS ODs	55	72	81	Exceeded targets

Proportion of deliveries attended by trained health staff NATIONAL Proportion of deliveries attended by trained health staff 10 HSS ODs	47 40	58 47	63 58	Under Joint annual review targets of 65%. Once again, these targets have been revised upwards from the original HSS application, with performance in the 10 HSS ODs slightly higher than national results.
7.. % of facilities implementing full MPA	-	-	-	A study will be conducted in 2010 to assess progress of this indicator. National data not available.
8. Number of new case of general consultation per inhabitant per year for children under the age of 5		.4	-	Data not yet available
% of total deliveries taking place in facilities NATIONAL % of total deliveries taking place in facilities 10 HSS ODs	25 21	39 34	44 44	No targets described in JAPR, but the 10 HSS ODs have now caught up to the national figures
Total User Modern Birth Spacing method 10 HSS OD % Women reproductive age current user modern method of birth spacing NATIONAL	No data 24%	16701 26%	23705 28%	Denominator not clears for OD level.
Number of children under the age of 5 years (new case) per child per year NATIONAL	1	1.1	1	Target was > 1
% Health centers trained IMCI NATIONAL % Health centers trained IMCI 10 HSS ODs	48% No data	69% No data	78% 100%	This indicator measures staff trained. The plan is to monitor IMCI implementation in 2010.
% of OD that have reached performance targets specified in the OD Contracts 10 HSS ODs	3	7	9	
% immunization provided at the fixed site NATIONAL % immunization at fixed site 10 HSS ODs	20 20	32 37	37 48	The national target for 2015 in the original application was 40%. The 10 HSS ODs have now overtaken national figures for fixed site immunization services

Explain any weaknesses in links between indicators for inputs, outputs and outcomes:

In the 10 HSS ODs, there are other national health investments in the same 10 HSS ODs. These include the health sector support project which provides support in areas such as infrastructure, infectious disease control programs, and health equity funds.

The links between inputs, outputs and outcomes would be more effectively assessed through conducting health system research that can complement the findings from monitoring and evaluation.

7.1 *Other sources of funding in pooled mechanism for HSS*

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

Table 17: Sources of HSS funds in a pooled mechanism

The sector wide program at the Ministry of Health is referred to as Health Sector Support program 2 (HSSP 2) financed by the Government of Cambodia and 7 international partners. This fund has a pooled funding mechanisms and a discrete funding mechanism. GAVI HSS is one of the discrete components.

Donor	Amount in US$	Duration of support	Contributing to which objective of GAVI HSS proposal
AusAID/UNFPA AusAID and UNFPA invest in a "discrete fund" and a "pooled Fund" through the Health Sector Support program (jointly funded by development partners and the Government). For the discrete fund, AusAID/UNFPA funds the birth spacing and post natal care components of the health contracts in the 10 HSS ODs, with GAVI financing the EPI and ANC components of the contracts.	In 2009, AusAID/UNFPA invested in 10 HSS operational districts (the same districts as GAVI)	2008, 2009, 2010, 2011	The AusAID/UNFPA financial and technical support contributes to the overall goal of the HSS program which is as follows: "The Goal of HSS 2, is, by 2015, to contribute to reduction of maternal, new born and child morbidity and mortality to MDG Targets through improved decentralized health systems and human resource management, and enhanced access by the population for a continuum of RMCNH Care (including immunization).The expected outcomes of the program is an increase in DPT 3 immunization coverage nationally from a baseline of 78% in 2005 to 90% in 2015, and increases in deliveries of trained staff from 44% in 2005 to 90% in 2015."
HSSP 2	$140 million for 5 years	2009 - 2013	The Health Sector Support Program operates across 21 of the 24 Provinces in Cambodia. This program involves infrastructure development, capacity building programs and extension of health contracting and health equity fund schemes. None of the 10 HSS funds is a contracting District classified as "special operating

			agency." However, two districts have reproductive health equity funds supported through HSSP 2, and some of the 10 ODs have had infrastructure investment support. All these inputs are included and coordinated through the annual operational planning system of the Ministry of Health, and contribute directly to the above mentioned HSS goal.
Government of Cambodia	$15 payment per delivery at facility by trained staff	2008 - 2015	The Government of Cambodia makes a fee for service one off payment of $15 per delivery at facility by trained staff to the trained staff (midwife) assisting the delivery. This contributes to the overall goal of HSS to increase the rate of delivery by trained staff.

8. Strengthened Involvement of Civil Society Organisations (CSOs)

8.1 *TYPE A: Support to strengthen coordination and representation of CSOs*

This section is to be completed by countries that have received GAVI TYPE A CSO support[7]

Please fill text directly into the boxes below, which can be expanded to accommodate the text.

Please list any abbreviations and acronyms that are used in this report below:

8.1.1 Mapping exercise

Please describe progress with any mapping exercise that has been undertaken to outline the key civil society stakeholders involved with health systems strengthening or immunisation. Please describe the mapping exercise, the expected results and the timeline (please indicate if this has changed). Please attach the report from the mapping exercise to this progress report, if the mapping exercise has been completed (**Document N°**................).

Please describe any hurdles or difficulties encountered with the proposed methodology for identifying the most appropriate in-country CSOs involved or contributing to immunisation, child health and/or health systems strengthening. Please describe how these problems were overcome, and include any other information relating to this exercise that you think it would be useful for the GAVI Alliance secretariat or Independent Review Committee to know about.

[7] Type A GAVI Alliance CSO support is available to all GAVI eligible countries.

8.1.2 Nomination process

Please describe progress with processes for nominating CSO representatives to the HSCC (or equivalent) and ICC, and any selection criteria that have been developed. Please indicate the initial number of CSOs represented in the HSCC (or equivalent) and ICC, the current number and the final target. Please state how often CSO representatives attend meetings (% meetings attended).

Please provide Terms of Reference for the CSOs (if developed), or describe their expected roles below. State if there are guidelines/policies governing this. Outline the election process and how the CSO community will be/have been involved in the process, and any problems that have arisen.

Please state whether participation by CSOs in national level coordination mechanisms (HSCC or equivalent and ICC) has resulted in a change in the way that CSOs interact with the Ministry of Health. Is there now a specific team in the Ministry of Health responsible for linking with CSOs? Please also indicate whether there has been any impact on how CSOs interact with each other.

8.1.3 Receipt and expenditure of CSO Type A funds

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type A funds for the 2009 year.

Funds received during 2009: US$................
Remaining funds (carried over) from 2008: US$............
Balance to be carried over to 2010: US$................

8.2 *TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP*

This section is to be completed by countries that have received GAVI TYPE B CSO support[8]

Please fill in text directly into the boxes below, which can be expanded to accommodate the text.

Please list any abbreviations and acronyms that are used in this report below:

8.2.1 Programme implementation

Briefly describe progress with the implementation of the planned activities. Please specify how they have supported the implementation of the GAVI HSS proposal or cMYP (refer to your proposal). State the key successes that have been achieved in this period of GAVI Alliance support to CSOs.

Please indicate any major problems (including delays in implementation), and how these have been overcome. Please also identify the lead organisation responsible for managing the grant implementation (and if this has changed from the proposal), the role of the HSCC (or equivalent).

[8] Type B GAVI Alliance CSO Support is available to 10 pilot GAVI eligible countries only: Afghanistan, Burundi, Bolivia, DR Congo, Ethiopia, Georgia, Ghana, Indonesia, Mozambique and Pakistan.

Please state whether the GAVI Alliance Type B support to CSOs has resulted in a change in the way that CSOs interact with the Ministry of Health, and or / how CSOs interact with each other.

Please outline whether the support has led to a change in the level and type of involvement by CSOs in immunisation and health systems strengthening (give the current number of CSOs involved, and the initial number).

Please outline any impact of the delayed disbursement of funds may have had on implementation and the need for any other support.

Please give the names of the CSOs that have been supported so far with GAVI Alliance Type B CSO support and the type of organisation. Please state if were previously involved in immunisation and / or health systems strengthening activities, and their relationship with the Ministry of Health.

For each CSO, please indicate the major activities that have been undertaken, and the outcomes that have been achieved as a result. Please refer to the expected outcomes listed in the proposal.

Table 18: Outcomes of CSOs activities

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2009	Outcomes achieved

Please list the CSOs that have not yet been funded, but are due to receive support in 2010/2011, with the expected activities and related outcomes. Please indicate the year you expect support to start. Please state if are currently involved in immunisation and / or health systems strengthening.

Please also indicate the new activities to be undertaken by those CSOs already supported.

Table 19: Planned activities and expected outcomes for 2010/2011

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2010 / 2011	Expected outcomes

8.2.2 Receipt and expenditure of CSO Type B funds

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type B funds for the 2009 year.

Funds received during 2009: US$................
Remaining funds (carried over) from 2008: US$............
Balance to be carried over to 2010: US$................

8.2.3 Management of GAVI CSO Type B funds

Has a GAVI Financial Management Assessment (FMA) been conducted prior to or during the 2009 calendar year ? **[IF YES] :** please complete **Part A** below.
[IF NO] : please complete **Part B** below.

Part A: further describe progress against requirements and conditions for the management of CSO Type B funds which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of CSO Type B funds.

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

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

8.2.4 Detailed expenditure of CSO Type B funds during the 2009 calendar year

Please attach a detailed financial statement for the use of CSO Type B funds during the 2009 calendar year **(Document N°...................).** *(Terms of reference for this financial statement are attached in Annex 4).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

External audit reports for CSO Type B, ISS, HSS programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available for your CSO Type B programme during your government's most recent fiscal year, this should also be attached **(Document N°......................)**.

8.2.5 Monitoring and Evaluation

Please give details of the indicators that are being used to monitor performance; outline progress in the last year (baseline value and current status), and the targets (with dates for achievement).

These indicators will be in the CSO application and reflect the cMYP and / or GAVI HSS proposal.

Table 20: Progress of CSOs project implementation

Activity / outcome	Indicator	Data source	Baseline value and date	Current status	Date recorded	Target	Date for target

Finally, please give details of the mechanisms that are being used to monitor these indicators, including the role of beneficiaries in monitoring the progress of activities, and how often this occurs. Indicate any problems experienced in measuring the indicators, and any changes proposed.

9. Checklist

Table 21: Checklist of a completed APR form

Fill the blank cells according to the areas of support reported in the APR. Within each blank cell, please type: Y=Submitted or N=Not submitted.

	MANDATORY REQUIREMENTS (if one is missing the APR is NOT FOR IRC REVIEW)	ISS	NVS	HSS	CSO
1	Signature of Minister of Health (or delegated authority) of APR		X	X	
2	Signature of Minister of Finance (or delegated authority) of APR		X	X	
3	Signatures of members of ICC/HSCC in APR Form		X	X	
4	Provision of Minutes of ICC/HSCC meeting endorsing APR		X		
5	Provision of complete excel sheet for each vaccine request		X		
6	Provision of Financial Statements of GAVI support in cash		X		
7	Consistency in targets for each vaccines (tables and excel)		X		
8	Justification of new targets if different from previous approval (section 1.1)				
9	Correct co-financing level per dose of vaccine		X		
10	Report on targets achieved (tables 15,16, 20)			X	
11	Provision of cMYP for re-applying				

	OTHER REQUIREMENTS	ISS	NVS	HSS	CSO
12	Anticipated balance in stock as at 1 January 2010 in Annex 1		X		
13	Consistency between targets, coverage data and survey data		X		
14	Latest external audit reports (Fiscal year 2009)			X	
15	Provide information on procedure for management of cash			X	
16	Health Sector Review Report (Joint Annual Program Review)			X	
17	Provision of new Banking details				
18	Attach VMA if the country introduced a New and Underused Vaccine before 2008 with GAVI support		X		
19	Attach the CSO Mapping report (Type A)				

10. Comments

Comments from ICC/HSCC Chairs:

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

~ End ~

GAVI ANNUAL PROGRESS REPORT ANNEX 2
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR IMMUNISATION SERVICES SUPPORT (ISS) AND NEW VACCINE INTRODUCTION GRANTS

I. All countries that have received ISS /new vaccine introduction grants during the 2009 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2009, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2009 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 2 of this annex.

a. Funds carried forward from the 2008 calendar year (opening balance as of 1 January 2009)
b. Income received from GAVI during 2009
c. Other income received during 2009 (interest, fees, etc)
d. Total expenditure during the calendar year
e. Closing balance as of 31 December 2009
f. A detailed analysis of expenditures during 2009, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2009 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2009 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR ISS AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local Currency (CFA)	**Value in USD[7]**
Balance brought forward from 2008 (*balance as of 31 December 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	65,338,626	136,375
Total expenditure during 2009	30,592,132	63,852
Balance as at 31 December 2009 (*balance carried forward to* 2010)	60,139,324	125,523

Detailed analysis of expenditure by economic classification[8] – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per-diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditure						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2009	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

[7] An average rate of CFA 479.11 = USD 1 applied.
[8] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own system for economic classification.

GAVI ANNUAL PROGRESS REPORT ANNEX 3
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR HEALTH SYSTEMS STRENGTHENING (HSS)

I. All countries that have received HSS grants during the 2009 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2009, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2009 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

   a. Funds carried forward from the 2008 calendar year (opening balance as of 1 January 2009)
   b. Income received from GAVI during 2009
   c. Other income received during 2009 (interest, fees, etc)
   d. Total expenditure during the calendar year
   e. Closing balance as of 31 December 2009
   f. A detailed analysis of expenditures during 2009, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2009 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2009 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR HSS FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local Currency (CFA)	**Value in USD[9]**
Balance brought forward from 2008 (*balance as of 31 December 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	65,338,626	136,375
Total expenditure during 2009	30,592,132	63,852
Balance as at 31 December 2009 (*balance carried forward to* 2010)	60,139,324	125,523

Detailed analysis of expenditure by economic classification[10] – GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
HSS PROPOSAL OBJECTIVE 1: EXPAND ACCESS TO PRIORITY DISTRICTS						
ACTIVITY 1.1: TRAINING OF HEALTH WORKERS						
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per-diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
TOTAL FOR ACTIVITY 1.1	**24,000,000**	**50,093**	**18,800,000**	**39,239**	**5,200,000**	**10,854**

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[9] An average rate of CFA 479.11 = USD 1 applied.

[10] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own HSS proposal objectives/activities and system for economic classification.

ACTIVITY 1.2: REHABILITATION OF HEALTH CENTRES						
Non-salary expenditure						
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditure						
Equipment	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Capital works	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR ACTIVITY 1.2	**18,000,000**	**37,570**	**11,792,132**	**24,613**	**6,207,868**	**12,957**
TOTALS FOR OBJECTIVE 1	**42,000,000**	**87,663**	**30,592,132**	**63,852**	**11,407,868**	**23,811**

GAVI ANNUAL PROGRESS REPORT ANNEX 4
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR CIVIL SOCIETY ORGANISATION (CSO) TYPE B

I. All countries that have received CSO 'Type B' grants during the 2009 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2009, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2009 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2008 calendar year (opening balance as of 1 January 2009)
b. Income received from GAVI during 2009
c. Other income received during 2009 (interest, fees, etc)
d. Total expenditure during the calendar year
e. Closing balance as of 31 December 2009
f. A detailed analysis of expenditures during 2009, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2009 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2009 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR CSO 'Type B' FINANCIAL STATEMENTS:
An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO 'Type B'		
	Local Currency (CFA)	Value in USD[11]
Balance brought forward from 2008 (*balance as of 31 December 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	65,338,626	136,375
Total expenditure during 2009	30,592,132	63,852
Balance as at 31 December 2009 (*balance carried forward to* 2010)	60,139,324	125,523

Detailed analysis of expenditure by economic classification[12] – GAVI CSO 'Type B'						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
CSO 1: CARITAS						
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per-diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
TOTAL FOR CSO 1: CARITAS	**24,000,000**	**50,093**	**18,800,000**	**39,239**	**5,200,000**	**10,854**
CSO 2: SAVE THE CHILDREN						
Salary expenditure						
Per-diem payments	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131

[11] An average rate of CFA 479.11 = USD 1 applied.

[12] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own CSO 'Type B' proposal and system for economic classification.

Non-salary expenditure						
Training	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Other expenditure						
Capital works	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR CSO 2: SAVE THE CHILDREN	**18,000,000**	**37,570**	**11,792,132**	**24,613**	**6,207,868**	**12,957**
TOTALS FOR ALL CSOs	**42,000,000**	**87,663**	**30,592,132**	**63,852**	**11,407,868**	**23,811**