



GAVI Alliance

Annual Progress Report **2011**

Submitted by
The Government of
Cambodia

Reporting on year: **2011**

Requesting for support year: **2013**

Date of submission: **5/22/2012**

Deadline for submission: 5/22/2012

Please submit the APR **2011** using the online platform <https://AppsPortal.gavialliance.org/PDExtranet>

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

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

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

**GAVI ALLIANCE
GRANT TERMS AND CONDITIONS**

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

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

AMENDMENT TO THE APPLICATION

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

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

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

ANTICORRUPTION

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

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

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

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

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

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US\$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US \$100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

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

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

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

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

1. Application Specification

Reporting on year: **2011**

Requesting for support year: **2013**

1.1. NVS & INS support

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

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2011	Request for Approval of
ISS	Yes	ISS reward for 2011 achievement: Yes
HSS	Yes	next tranche of HSS Grant Yes
CSO Type A	No	Not applicable N/A
CSO Type B	No	CSO Type B extension per GAVI Board Decision in July 2011: N/A

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year **2010** is available [here](#).

2. Signatures

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

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

For the Government of **Cambodia**

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

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

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

Full name	Position	Telephone	Email
Dr. Chea Sokhim	M&E Officer	855-12 894 741	sokhimc_dr@yahoo.com

2.2. ICC signatures page

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

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

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

2.2.1. ICC report endorsement

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

Name/Title	Agency/Organization	Signature	Date
H.E.Prof.Eng Huot, Secretary of State for Health	Ministry of Health		
H.E.Dr. Te Kuy Seang, Secretary of State for Health	Ministry of Health		

H.E. Prof. Heng Tay Kry, Secretary of State for Health	Ministry of Health		
H.E. Dr. Tep Lun, Director General for Health	Ministry of Health		
H.E. Koeut Meach, Director General for Administration and Finance	Ministry of Health		
Dr. Chi Mean Hea, Deputy Director General for Health	Ministry of Health		
Prof. Tung Rathavy, Director of National of Maternal and Child Health Care Centre	NMCHC/MoH		
Dr. Hem Sareth, Director of Provincial Health Department	PHD/Takeo		
Dr. Ung Ratana, Deputy Director of Provincial Health Department	PHD/Ratanakiri		
Dr. Ly Nareth, Health Operations Officer	WB		
Mrs. Sam Sochea, Program Officer	UNFPA		
Mr. Kong Sao, HIS and Planning Officer	PHD/Ratanaliri		
Mr. Ly Van Thy, Deputy Country Director	US-CDC		
Ms. Ung Vanny, Health Education Officer	UNICEF		
Dr. Tho Sochantha, Deputy Director of National Control Malaria	CNM/MoH		

Dr. Sok Touch, Director of Communicable Disease Control	CDC/MoH		
Dr. Lan Van Seng, Deputy Director of National Centre Control AIDS	NCHADS		
Dr. Ir Por, Senior Staff	NIPH/MoH		
Mr. Phy Maly, Senior Staff	HSD		
Dr. Pieter Van Maaren, Country Representative	WHO		
Mr. Tim Johuistr, Senior Health Specialist	WB		
Dr. Yumiko Sasak, Project Advisor	JICA		
Dr. Piseth Meng, Health Program Manager	AusAID		
Mr. Myogsun Cho, Health Program Specialist	KOICA		
Dr. Chea Sokhim, M&E Officer	GAVI/HSS/HSSP2/MoH		
Dr. Chheng Morn, Deputy Program Manager of National Immunization Program	NIP/MoH		
Mr. Soun Veasna, Program Officer	JICA		
Prof. Sann Chan Soeung, Deputy Director of General for Health	MoH		

Dr. Richard Duncan, Technical Officer	WHO		
Mrs. Chea Chandy, Gender Specialist	ADB		
Ms. Anna Castelh, Partnership Specialist	JPIG		
Prof. Chan Nith, Deputy Director of CNU	CNU		
Dr. Sung Vinntok, Deputy Director of International Cooperation Department	DIC/MoH		
Dr. Ray rany, Chief of Tobacco Health	NCHP		
Mr. Chengli Bunthy, GFAM PM	MEDICAM		
Mr. Chea Chhiv Srong, Director of Central Medical Store	CMS/MoH		
Dr. Ket Vansith, Deputy Director of NBTC	NBTC/MoH		
Mr. Kojima Shinichi, Coordinator	JICA		
Mr. Tong Pun Hach, Officer	AAF		
Mr. Som Saveth, Chief of Audit Office	IAD/MoH		
Mr. Net Neath, Research Staff	CGRI		

Mr. John Hustedt, Stop Team	WHO		
Dr. Mey Sambo, Director of Personnel Department	PD/MoH		

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

All comments will be treated confidentially

Comments from Partners:

The APR-2011 was endorsed by the ICSC on the 9th April 2011. This APR report is also endorsed during the meeting of TWGH on 12 April 2012. This is the highest Technical Forum that participating from concerned government and partner counterparts.

Comments from the Regional Working Group:

N/A

2.3. HSCC signatures page

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

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

Name/Title	Agency/Organization	Signature	Date
H.E. Dr. Mam Bun Heng, Minister of Health	Ministry of Health		
H.E. Ph. Chou Yin Sim, Secretary of State for Health	Ministry of Health		
H.E. Prof. Heng Tay Kry, Secretary of State for Health	Ministry of Health		
H.E. Dr. Tep Lun, Director General for Health	Ministry of Health		
H.E. Prof. Koeut Meach, Director General for Administration and Finance	Ministry of Health		

Dr. Char Meng Chuor, Director of National Malaria Control	Ministry of Health		
Mrs. Khim Sovannara, Representative from Budget and Finance	Ministry of Economy and Finance		
Mr. Sok Sam Ang, Director of Budget and Finance	Ministry of Health		
Prof. Sann Chan Soeung, Deputy Director General for Health	Ministry of Health		
Mrs. Hang Sony, Administration and Budget Staff of NIP	Ministry of Health		
Dr. Chea Sokhim, M&E Officer and HSS Coordinator (GAVI-HSS-HSSP2)	Ministry of Health		

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

All comments will be treated confidentially

Comments from Partners:

For Cambodia, the Health Sector Steering Committee-HSSC is the highest Level to endorse the APR report and NVS.

Comments from the Regional Working Group:

N/A

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

Cambodia is not reporting on CSO (Type A & B) fund utilisation in 2012

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4. Baseline & annual targets

Number	Achievements as per JRF		Targets (preferred presentation)							
	2011		2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Total births	379,058	343,998	388,003	388,003	397,160	397,160	406,533	406,533	416,127	416,127
Total infants' deaths	N/A	0		0		0		0		0
Total surviving infants	379058	343,998	388,003	388,003		397,160		406,533		416,127
Total pregnant women	379,058	403,731	388,003	388,003	397,160	397,160	406,533	406,533	416,127	416,127
Number of infants vaccinated (to be vaccinated) with BCG	356,315	348,151	388,003	388,003	397,160	397,160	406,533	406,533	416,127	416,127
BCG coverage	94 %	101 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Number of infants vaccinated (to be vaccinated) with OPV3	352,524	323,686	368,603	368,603	377,302	377,302	386,206	386,206	395,206	395,206
OPV3 coverage	93 %	94 %	95 %	95 %	95 %	95 %	95 %	95 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with DTP1	352,524	331,432	368,603	368,603	377,302	377,302	386,206	386,206	395,321	395,321
Number of infants vaccinated (to be vaccinated) with DTP3	352,524	324,628	368,603	368,603	377,302	377,302	386,206	386,206	395,321	395,321
DTP3 coverage	95 %	94 %	95 %	95 %	95 %	95 %	95 %	95 %	95 %	95 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	4	0	0	0	5	0	5	0	5
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.04	1.00	1.00	1.00	1.05	1.00	1.05	1.00	1.05
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib	379,058	343,998	368,603	368,603	377,302	377,302	386,206	386,206	395,206	395,206
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib	360,105	343,998	368,603	368,603	377,302	377,302	386,206	386,206	395,206	395,206
DTP-HepB-Hib coverage	95 %	100 %	95 %	95 %	95 %	95 %	95 %	95 %	95 %	95 %
Wastage[1] rate in base-year and planned thereafter (%)	5	4	5	5	5	5	5	5	5	5
Wastage[1] factor in base-year and planned thereafter (%)	1.05	1.04	1.05	1.05	1.05	1.05	1.05	1.05	1.05	1.05
Maximum wastage rate value for DTP-HepB-Hib, 1 dose/vial, Liquid	5 %	5 %	5 %	5 %	5 %	5 %	5 %	5 %	5 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	333,571	318,610	368,603	368,603	377,302	377,302	386,206	386,206	395,321	395,321
Number of infants vaccinated (to be vaccinated) with 2nd dose of Measles		0	368,603	368,603	377,302	377,302	386,206	386,206	395,321	395,321
Measles coverage	88 %	0 %	95 %	95 %	95 %	95 %	95 %	95 %	95 %	95 %
Wastage[1] rate in base-year and planned thereafter (%)	0	50	50	50	0	0	0	0	0	0

Number	Achievements as per JRF		Targets (preferred presentation)							
	2011		2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Wastage ^[1] factor in base-year and planned thereafter (%)	1	2	2	2	1	1	1	1	1	1
Maximum wastage rate value for Measles, 10 dose (s) per vial, LYOPHILISED	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %
Pregnant women vaccinated with TT+	345,545	257,133	360,054	360,054	364,395	364,395	369,073	369,073	372,853	372,853
TT+ coverage	91 %	64 %	93 %	93 %	92 %	92 %	91 %	91 %	90 %	90 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0	0	0	0	0	0	0
Vit A supplement to infants after 6 months	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	0 %	2 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %

*

** Number of infants vaccinated out of total surviving infants

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

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

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

5. General Programme Management Component

5.1. Updated baseline and annual targets

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

The numbers for 2011 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2011**. The numbers for 2012 - 2015 in [Table 4 Baseline and Annual Targets](#) should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

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

- Justification for any changes in **births**

Number of births reported for the 2011 JRF has been reduced from that originally projected. The MOH is currently in the process of standardizing all health denominators across all programs and at health service levels (national, provincial, district and health centre) that more accurately reflects the true figure. This is resulting in a reduction in the number of children under one year from previous estimates but this is considered by the MOH, and health partners (WHO and UNICEF) to be more accurate, especially given a decrease in fertility rates in recent years.

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

N/A

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

N/A

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

Wastage rate for DTP-HepB-Hib vaccine was less than target (4% vs 5%). This reflects good stock management and cold chain procedures and efficient implementation of immunization sessions.

5.2. Immunisation achievements in 2011

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2011 and how these were addressed:

The DTP-HepB-Hib (Penta) coverage target of 93% in the 2010 APR was achieved with the official estimated coverage for Penta 3 reported in the 2011 JRF of 94%. Importantly, high coverage rates are increasingly uniform across all districts with 43 of 77 districts reporting Penta3 coverage > 90% and 63 of 77 districts reporting Penta3 coverage > 80%. No districts reported Penta3 coverage < 50%.

Targets for BCG, OPV and measles vaccine were either achieved or exceeded.

Wastage targets for DTP-HepB-Hib were bettered (target 5%, achieved 4%).

Key immunization achievements for 2011 were:

- Implementation of two measles/OPV supplementary immunization activities, that specifically targeted high risk communities for OPV (round 1) and measles and OPV (round 2). Nearly 2 million infants and children were vaccinated with measles vaccine and 700,000 children in high risk villages received supplemental doses of OPV vaccine.
- The measles SIA was used to comprehensively map out high risk village status throughout Cambodia through a random check of 20 + children (0 -23 mths) immunization cards to assess community immunization status. The NIP now has an extensive database of over 1600 high risk villages that it is working with provinces and districts in 2012 to specifically target to ensure greater equity in immunization service delivery.
- The NIP conducted a Hepatitis B birth dose assessment that will guide refinement of policy and practices to ensuring that as many infants as possible receive a timely dose of Hepatitis B vaccine within 24 hours of birth. In addition, the NIP with the Cambodian University of Health Science undertook a HepB serosurvey in 3 provinces (urban and two rural) with technical support from WHO and CDC USA. This clearly demonstrated the impact of the introduction of HepB vaccine in Cambodia, with the results of this work expected to be published in the medical literature soon.
- The NIP conducted three rounds of TT SIA in the 4 remaining districts considered high risk and the country is on track to achieve MNTE status in 2012.
- In response to increasing numbers of rubella cases and to developed further evidence to support the introduction of rubella vaccine, two sentinel CRS surveillance sites were established in partnership with the Cambodia Pediatric Society that is documenting the burden of rubella in the country. WHO also supported NIP and Government Pediatric staff for a study tour to Mongolia to learn from their experience with rubella/CRS surveillance and MR vaccine introduction.

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

N/A

5.3. Monitoring the Implementation of GAVI Gender Policy

In the past three years, were the sex-disaggregated data on immunisation services access available in your country? Choose one of the three: **yes, available**

If yes, please report all the data available from 2009 to 2011

Data Source	Timeframe of the data	Coverage estimate
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DHS 2010	2010	DTP3 - 85.1 for female and 84.6 for male
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How have you been using the above data to address gender-related barrier to immunisation access?

Given independent verification of equal access to immunization services for both males and female, gender barriers are not considered a problem in Cambodia.

If no sex-disaggregated data is available at the moment, do you plan in the future to collect sex-disaggregated data on routine immunisation reporting? **No**

What action have you taken to achieve this goal?

N/A

5.4. Data assessments

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

The DHS 2010 confirms the dramatic improvement reported immunization coverage in Cambodia since 2005, and estimates that the rate of fully immunized children is 79%. Discrepancies do occur for some antigens especially at the sub national level, and this reflect issue surrounding estimates based on 2008 population census and changes that have occurred with fertility rates and movement of people since then.

* Please note that the WHO UNICEF estimates for 2011 will only be available in July 2012 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2010 to the present? **Yes**

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

In 10 health system strengthening (HSS) districts (GAVI supported) a strategy for health system data quality selfassessment (including EPI) was implemented in 2011. The final report of this assessment is attached.

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2009 to the present.

The NIP is moving towards a strategy focusing on high risk communities, with the basis of community immunization assessment being the checking of infants and childrens immunization cards at the 18 months measles dose. During the Nov 2011 measles SIA, over 53,000 children in high risk villages had their immunization cards assessed and the NIP has developed an extensive database to identify high risk communities for targeting in 2012.

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

see 5.4.3

5.5. Overall Expenditures and Financing for Immunisation

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

Exchange rate used	1 US\$ = 1	Enter the rate only; Please do not enter local currency name
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Table 5.5a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US\$

Expenditure by category	Expenditure Year 2011	Source of funding						
		Country	GAVI	UNICEF	WHO	PATH	HSSP2 (SWAp)	To be filled in by country
Traditional Vaccines*	1,071,500	819,577	0	24,500	227,423	0	0	0
New and underused Vaccines**	3,871,907	248,640	3,613,120	0	0	10,147	0	0
Injection supplies (both AD syringes and syringes other than ADs)	805,397	726,365	61,046	16,768	1,218	0	0	0

Cold Chain equipment	0	0	0	0	0	0	0	0
Personnel	19,143	19,143	0	0	0	0	0	0
Other routine recurrent costs	816,494	305,596	0	28,633	255,058	0	227,207	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	2,620,086	17,000	0	290,454	962,632	0	1,350,000	0
To be filled in by country		0	0	0	0	0	0	0
Total Expenditures for Immunisation	9,204,527							
Total Government Health		2,136,321	3,674,166	360,355	1,446,331	10,147	1,577,207	0

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

Please state if an Annual Action Plan for the year 2011, based on the cMYP, was developed and costed.

5.5.1. If there are differences between available funding and expenditures for the reporting year, please clarify what are the reasons for it.

N/A

5.5.2. If less funding was received and spent than originally budgeted, please clarify the reasons and specify which areas were underfunded.

N/A

5.5.3. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2012 and 2013

N/A

Table 5.5b: Overall Budgeted Expenditures for Immunisation from all sources (Government and donors) in US\$.

Expenditure by category	Budgeted Year 2012	Budgeted Year 2013
Traditional Vaccines*	769,307	1,007,317
New and underused Vaccines**	4,176,407	3,679,126
Injection supplies (both AD syringes and syringes other than ADs)	318,276	382,324
Injection supply with syringes other than ADs	78,847	80,053
Cold Chain equipment	256,727	245,186
Personnel	1,197,485	1,191,298
Other routine recurrent costs	1,446,628	1,456,920
Supplemental Immunisation Activities	0	2,045,919
Total Expenditures for Immunisation	8,243,677	10,088,143

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

If there are major differences between the cMYP projections and the budgeted figures above, please clarify the main reasons for it.

5.5.4. Are you expecting to receive all funds that were budgeted for 2012 ? If not, please explain the reasons for the shortfall and which expenditure categories will be affected.

Yes

5.5.5. Are you expecting any financing gaps for 2013 ? If yes, please explain the reasons for the gaps and strategies being pursued to address those gaps.

No

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2011 calendar year? **No, not implemented at all**

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

Action plan from Aide Mémoire	Implemented?
FMA to be conducted in April to May 2012	No

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

FMA to be conducted in April to May 2012.

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

N/A

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2011? **2**

Please attach the minutes (**Document N°**) from all the ICC meetings held in 2011, including those of the meeting endorsing this report.

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

N/A

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

If Yes, which ones?

List CSO member organisations:
List of participant from NGO is attached in both ICSC and TWGH meeting minutes..

5.8. Priority actions in 2012 to 2013

What are the country's main objectives and priority actions for its EPI programme for **2012** to **2013**?

Key objective are:

- Achieve Measles elimination in 2012
- Achieve neonatal tetanus elimination in 2012
- Maintain polio free status through high OPV3 coverage in all districts and sensitive AFP surveillance systems.
- Reduce the prevalence of HepB virus burden in line with regional targets through the further expansion of the birth dose in line with wider increases in facility births.
- Successfully implement the "High Risk Strategy" throughout Cambodia for reaching every community and realize an real increase in coverage for fully immunized children and women in the most marginalized communities.
- Monitoring progress in coverage improvements at the community level through the checking and recording of infant and womens immunization cards
- Incorporate activities required to reach all national goals within new microplan at the health centre level to reach every community.
- Introduce a 2nd routine dose of measles vaccine for all infants at 18 months of age and achieve coverage levels consistent with that required for measles elimination
- Implement the findings and recommendations of the 2011 EVM to further strengthen the cold chain system for vaccine distribution in Cambodia

Are they linked with cMYP? **Yes**

5.9. Progress of transition plan for injection safety

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

Please report what types of syringes are used and the funding sources of Injection Safety material in 2011

Vaccine	Types of syringe used in 2011 routine EPI	Funding sources of 2011
BCG	AD Syringe	Government
Measles	AD Syringe	Government
TT	AD Sryinge	Government/UNICEF (TT SIA)
DTP-containing vaccine	AD Syringe	Government/GAVI

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

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

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

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

Please explain in 2011 how sharps waste is being disposed of, problems encountered, etc.

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

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2011

	Amount US\$	Amount local currency
Funds received during 2011 (A)	350,500	350,500
Remaining funds (carry over) from 2010 (B)	141,000	141,000
Total funds available in 2011 (C=A+B)	491,500	491,500
Total Expenditures in 2011 (D)	81,059	81,059
Balance carried over to 2012 (E=C-D)	410,441	410,441

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

ISS funds are managed through the Department of Budget and Finance within the MOH. All ISS funds are reflected in the annual operational planning system of the MOH. ISS funds are monitored through the Department of Budget and Finance processes. ISS funding budgets and implementation are presented to the ISCS (ICC) for information of partners.

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

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

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2011

1. Immunization Training for new health staff at the district and health centre level

2. Coverage Improvement Plan (catch up immunization activity at the end of 2011) planning and monitoring

3. Supervision for fixed site and private sector immunization activities by national immunization staff

4. Maintenance of cold chain equipment and repairs

5. Annual EPI review workshop.

Results: Immunization training for new staff at HC; Coverage Improvement Plan (CIP) and Monitoring (9 provinces, 33 OD, 1.563 HRV); Supervision for fixed site and private activities; Cold chain maintenance and repairs; Annual EPI review workshop. There is \$US 81,059 \$US of total of 491,500 for ISS was spend for CIP in 8 provinces out of GAVI support. The CIP activities are composed of supervision, micro-planning, and support to VHV/VHSG in the community. There were number of 197,624. Missing vaccinated children and reproductive age women and pregnancy women cached up from this intervention. <?xml:namespace prefix = o />

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

6.2. Detailed expenditure of ISS funds during the 2011 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2011 calendar year (Document Number) (Terms of reference for this financial statement are attached in Annexe 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

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

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

6.3. 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 original target set in the approved ISS proposal), 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, which will be published at

http://apps.who.int/immunization_monitoring/en/globalsummary/timeseries/tscoveredtp3.htm

If you may be eligible for ISS reward based on DTP3 achievements in 2011 immunisation programme, estimate the \$ amount by filling **Table 6.3** below

The estimated ISS reward based on 2011 DTP3 achievement is shown in Table 6.3

Table 6.3: Calculation of expected ISS reward

				Base Year**	2011
				A	B***
1	Number of infants vaccinated with DTP3* (from JRF) specify			339196	324628
2	Number of additional infants that are reported to be vaccinated with DTP3				-14568
3	Calculating	\$20	per additional child vaccinated with DTP3		0
4	Rounded-up estimate of expected reward				0

* Number of DTP3: total number of infants vaccinated with DTP3 alone plus the number of those vaccinated with combined DTP-HepB3, DTP-HepB-Hib3.

** Base-year is the previous year with the highest DTP3 achievement or the original target set in the approved ISS proposal, whichever is higher. Please specify the year and the number of infants vaccinated with DTP3 and reported in JRF.

*** Please note that value B1 is 0 (zero) until **Number of infants vaccinated (to be vaccinated) with DTP3** in section 4. Baseline & annual targets is filled-in

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

7.1. Receipt of new & under-used vaccines for 2011 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2011 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below **Table 7.1**

Table 7.1: Vaccines received for 2011 vaccinations against approvals for 2011

	[A]	[B]	
Vaccine type	Total doses for 2011 in Decision Letter	Total doses received by 31 December 2011	Total doses of postponed deliveries in 2012
DTP-HepB-Hib		1,206,800	0
Measles		0	0

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

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

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

N/A

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

N/A

7.1.2. For the vaccines in the **Table 7.1**, has your country faced stock-out situation in 2011? **No**

If **Yes**, how long did the stock-out last?

N/A

Please describe the reason and impact of stock-out, including if the stock-out was at the central level only or at lower levels.

N/A

7.2. Introduction of a New Vaccine in 2011

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2011, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

Vaccine introduced	N/A	
Phased introduction	No	
Nationwide introduction	Yes	
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **January 2013**

If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 20)

N/A

7.2.3. Adverse Event Following Immunization (AEFI)

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

Is there a national AEFI expert review committee? **Yes**

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

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

7.3. New Vaccine Introduction Grant lump sums 2011

7.3.1. Financial Management Reporting

	Amount US\$	Amount local currency
Funds received during 2011 (A)	116,500	116,500
Remaining funds (carry over) from 2010 (B)	0	0
Total funds available in 2011 (C=A+B)	116,500	116,500
Total Expenditures in 2011 (D)	0	0
Balance carried over to 2012 (E=C-D)	116,500	116,500

Detailed expenditure of New Vaccines Introduction Grant funds during the 2011 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2011 calendar year (Document No 14) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

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

Funds received November 2011 for Measles 2nd dose introduction in 2012. No activities funded in 2011, expenditure to be reported in the APR 2012.

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

N/A

Please describe the activities that will be undertaken with any remaining balance of funds for 2012 onwards

N/A

7.4. Report on country co-financing in 2011

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2011?	
Co-Financed Payments	Total Amount in US\$	Total Amount in Doses
1st Awarded Vaccine DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	227,416	77,700
1st Awarded Vaccine Measles, 10 dose(s) per vial, LYOPHILISED	0	0
	Q.2: Which were the sources of funding for co-financing in reporting year 2011?	
Government	Government of Cambodia	
Donor		
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US\$ and supplies?	
1st Awarded Vaccine DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	323,662	

	Q.4: When do you intend to transfer funds for co-financing in 2013 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2013	Source of funding
1st Awarded Vaccine DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	September	Government
1st Awarded Vaccine Measles, 10 dose(s) per vial, LYOPHILISED		
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	N/A	

If the country is in default, please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Default Policy:

<http://www.gavialliance.org/about/governance/programme-policies/co-financing/>

N/A

Is GAVI's new vaccine support reported on the national health sector budget? **Yes**

7.5. Vaccine Management (EVSM/VMA/EVM)

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

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

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

Please attach:

- (a) EVM assessment **(Document No 15)**
- (b) Improvement plan after EVM **(Document No 16)**
- (c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 17)**

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

Kindly provide a summary of actions taken in the following table:

Deficiency noted in EVM assessment	Action recommended in the Improvement plan	Implementation status and reasons for delay, if any
Reported just finalized at time of APR	recommendations to commence mid year 2012	no delays expected

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

If yes, provide details

N/A

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

7.6. Monitoring GAVI Support for Preventive Campaigns in 2011

Cambodia does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

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

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2012

Renewal of multi-year vaccines support for Cambodia is not available in 2012

7.9. Request for continued support for vaccines for 2013 vaccination programme

In order to request NVS support for 2013 vaccination do the following

Confirm here below that your request for 2013 vaccines support is as per [7.11 Calculation of requirements](#)
Yes

If you don't confirm, please explain

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation	2011	2012	2013	2014	2015
DTP-HepB, 10 dose(s) per vial, LIQUID	10					
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	1		2.182	2.017	1.986	1.933
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	10		2.182	2.017	1.986	1.933
DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED	2		2.182	2.017	1.986	1.933
HPV bivalent, 2 dose(s) per vial, LIQUID	2		5.000	5.000	5.000	5.000
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1		5.000	5.000	5.000	5.000
Measles, 10 dose(s) per vial, LYOPHILISED	10		0.242	0.242	0.242	0.242
Meningococcal, 10 dose(s) per vial, LIQUID	10		0.520	0.520	0.520	0.520
MR, 10 dose(s) per vial, LYOPHILISED	10		0.494	0.494	0.494	0.494
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2		3.500	3.500	3.500	3.500
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1		3.500	3.500	3.500	3.500
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10		0.900	0.900	0.900	0.900
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5		0.900	0.900	0.900	0.900
Rotavirus, 2-dose schedule	1		2.550	2.550	2.550	2.550
Rotavirus, 3-dose schedule	1		5.000	3.500	3.500	3.500
AD-SYRINGE	0		0.047	0.047	0.047	0.047
RECONSTIT-SYRINGE-PENTAVAL	0		0.047	0.047	0.047	0.047
RECONSTIT-SYRINGE-YF	0		0.004	0.004	0.004	0.004
SAFETY-BOX	0		0.006	0.006	0.006	0.006

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation	2016
DTP-HepB, 10 dose(s) per vial, LIQUID	10	
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	1	1.927
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	10	1.927
DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED	2	1.927
HPV bivalent, 2 dose(s) per vial, LIQUID	2	5.000
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5.000
Measles, 10 dose(s) per vial, LYOPHILISED	10	0.242
Meningogoccal, 10 dose(s) per vial, LIQUID	10	0.520
MR, 10 dose(s) per vial, LYOPHILISED	10	0.494
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	3.500
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	3.500
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10	0.900
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5	0.900
Rotavirus, 2-dose schedule	1	2.550
Rotavirus, 3-dose schedule	1	3.500
AD-SYRINGE	0	0.047
RECONSTIT-SYRINGE-PENTAVAL	0	0.047
RECONSTIT-SYRINGE-YF	0	0.004
SAFETY-BOX	0	0.006

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes	No Threshold	500,000\$	
			<=	>
DTP-HepB	HEPBHIB	2.00 %		
DTP-HepB-Hib	HEPBHIB		23.80 %	6.00 %
Measles	MEASLES	14.00 %		
Meningogoccal	MENINACONJUGATE	10.20 %		
Pneumococcal (PCV10)	PNEUMO	3.00 %		
Pneumococcal (PCV13)	PNEUMO	6.00 %		
Rotavirus	ROTA	5.00 %		
Yellow Fever	YF	7.80 %		

7.11. Calculation of requirements

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

ID		Source		2011	2012	2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	343,998	388,003	397,160	406,533	416,127	1,951,821
	Number of children to be vaccinated with the first dose	Table 4	#	343,998	368,603	377,302	386,206	395,206	1,871,315
	Number of children to be vaccinated with the third dose	Table 4	#	343,998	368,603	377,302	386,206	395,206	1,871,315
	Immunisation coverage with the third dose	Table 4	%	100.00 %	95.00 %	95.00 %	95.00 %	94.97 %	
	Number of doses per child	Parameter	#	3	3	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.04	1.05	1.05	1.05	1.05	
	Vaccine stock on 1 January 2012		#	250,000					
	Number of doses per vial	Parameter	#		1	1	1	1	
	AD syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	Yes	
g	Vaccine price per dose	Table 7.10.1	\$		2.18	2.02	1.99	1.93	
cc	Country co-financing per dose	Co-financing table	\$		0.20	0.20	0.20	0.20	
ca	AD syringe price per unit	Table 7.10.1	\$		0.0465	0.0465	0.0465	0.0465	
cr	Reconstitution syringe price per unit	Table 7.10.1	\$		0	0	0	0	
cs	Safety box price per unit	Table 7.10.1	\$		0.0058	0.0058	0.0058	0.0058	
fv	Freight cost as % of vaccines value	Table 7.10.2	%		6.00 %	6.00 %	6.00 %	6.00 %	
fd	Freight cost as % of devices value	Parameter	%		10.00 %	10.00 %	10.00 %	10.00 %	

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

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

	2011	2012	2013	2014	2015
Minimum co-financing	0.20	0.20	0.20	0.20	0.20
Recommended co-financing as per APR 2010			0.20	0.20	0.20
Your co-financing	0.20	0.20	0.20	0.20	0.20

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

		2012	2013	2014	2015
Number of vaccine doses	#	852,400	1,083,600	1,107,400	1,129,800
Number of AD syringes	#	1,251,900	1,264,100	1,293,900	1,324,000
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	13,900	14,050	14,375	14,700
Total value to be co-financed by GAVI	\$	2,036,000	2,381,500	2,397,500	2,383,000

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

		2012	2013	2014	2015
Number of vaccine doses	#	80,700	111,900	116,300	122,300
Number of AD syringes	#	0	0	0	0
Number of re-constitution syringes	#	0	0	0	0

Number of safety boxes	#	0	0	0	0
Total value to be co-financed by the Country	\$	187,000	239,500	245,000	250,500

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

		Formula	2011	2012		
			Total	Total	Government	GAVI
A	Country co-finance	V	0.00 %	8.65 %		
B	Number of children to be vaccinated with the first dose	Table 5.2.1	343,998	368,603	31,874	336,729
C	Number of doses per child	Vaccine parameter (schedule)	3	3		
D	Number of doses needed	B X C	1,031,994	1,105,809	95,621	1,010,188
E	Estimated vaccine wastage factor	Table 4	1.04	1.05		
F	Number of doses needed including wastage	D X E	1,073,274	1,161,100	100,402	1,060,698
G	Vaccines buffer stock	(F – F of previous year) * 0.25		21,957	1,899	20,058
H	Stock on 1 January 2012	Table 7.11.1	250,000			
I	Total vaccine doses needed	F + G – H		933,057	80,683	852,374
J	Number of doses per vial	Vaccine Parameter		1		
K	Number of AD syringes (+ 10% wastage) needed	(D + G – H) * 1.11		1,251,821	0	1,251,821
L	Reconstitution syringes (+ 10% wastage) needed	I / J * 1.11		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	(K + L) / 100 * 1.11		13,896	0	13,896
N	Cost of vaccines needed	I x vaccine price per dose (g)		2,035,931	176,050	1,859,881
O	Cost of AD syringes needed	K x AD syringe price per unit (ca)		58,210	0	58,210
P	Cost of reconstitution syringes needed	L x reconstitution price per unit (cr)		0	0	0
Q	Cost of safety boxes needed	M x safety box price per unit (cs)		81	0	81
R	Freight cost for vaccines needed	N x freight cost as of % of vaccines value (fv)		122,156	10,563	111,593
S	Freight cost for devices needed	(O+P+Q) x freight cost as % of devices value (fd)		5,830	0	5,830
T	Total fund needed	(N+O+P+Q+R+S)		2,222,208	186,612	2,035,596
U	Total country co-financing	I x country co-financing per dose (cc)		186,612		
V	Country co-financing % of GAVI supported proportion	U / (N + R)		8.65 %		

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

		Formula	2013			2014		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	V	9.35 %			9.50 %		
B	Number of children to be vaccinated with the first dose	Table 5.2.1	377,302	35,295	342,007	386,206	36,692	349,514
C	Number of doses per child	Vaccine parameter (schedule)	3			3		
D	Number of doses needed	$B \times C$	1,131,906	105,884	1,026,022	1,158,618	110,075	1,048,543
E	Estimated vaccine wastage factor	Table 4	1.05			1.05		
F	Number of doses needed including wastage	$D \times E$	1,188,502	111,178	1,077,324	1,216,549	115,579	1,100,970
G	Vaccines buffer stock	$(F - F \text{ of previous year}) \times 0.25$	6,851	641	6,210	7,012	667	6,345
H	Stock on 1 January 2012	Table 7.11.1						
I	Total vaccine doses needed	$F + G - H$	1,195,353	111,819	1,083,534	1,223,561	116,245	1,107,316
J	Number of doses per vial	Vaccine Parameter	1			1		
K	Number of AD syringes (+ 10% wastage) needed	$(D + G - H) \times 1.11$	1,264,021	0	1,264,021	1,293,850	0	1,293,850
L	Reconstitution syringes (+ 10% wastage) needed	$I / J \times 1.11$	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	$(K + L) / 100 \times 1.11$	14,031	0	14,031	14,362	0	14,362
N	Cost of vaccines needed	$I \times \text{vaccine price per dose (g)}$	2,411,028	225,539	2,185,489	2,429,993	230,862	2,199,131
O	Cost of AD syringes needed	$K \times \text{AD syringe price per unit (ca)}$	2,411,028	0	58,777	2,429,993	0	60,165
P	Cost of reconstitution syringes needed	$L \times \text{reconstitution price per unit (cr)}$	0	0	0	0	0	0
Q	Cost of safety boxes needed	$M \times \text{safety box price per unit (cs)}$	82	0	82	84	0	84
R	Freight cost for vaccines needed	$N \times \text{freight cost as of \% of vaccines value (fv)}$	144,662	13,533	131,129	145,800	13,852	131,948
S	Freight cost for devices needed	$(O+P+Q) \times \text{freight cost as \% of devices value (fd)}$	5,886	0	5,886	6,025	0	6,025
T	Total fund needed	$(N+O+P+Q+R+S)$	2,620,435	239,071	2,381,364	2,642,067	244,713	2,397,354
U	Total country co-financing	$I \times \text{country co-financing per dose (cc)}$	239,071			244,713		
V	Country co-financing % of GAVI supported proportion	$U / (N + R)$	9.35 %			9.50 %		

Table 7.11.4: Calculation of requirements for **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID** (part 3)

		Formula	2015		
			Total	Government	GAVI
A	Country co-finance	V	9.76 %		
B	Number of children to be vaccinated with the first dose	Table 5.2.1	395,206	38,576	356,630
C	Number of doses per child	Vaccine parameter (schedule)	3		
D	Number of doses needed	$B \times C$	1,185,618	115,728	1,069,890
E	Estimated vaccine wastage factor	Table 4	1.05		
F	Number of doses needed including wastage	$D \times E$	1,244,899	121,515	1,123,384
G	Vaccines buffer stock	$(F - F \text{ of previous year}) \times 0.25$	7,088	692	6,396
H	Stock on 1 January 2012	Table 7.11.1			
I	Total vaccine doses needed	$F + G - H$	1,251,987	122,207	1,129,780
J	Number of doses per vial	Vaccine Parameter	1		
K	Number of AD syringes (+ 10% wastage) needed	$(D + G - H) \times 1.11$	1,323,904	0	1,323,904
L	Reconstitution syringes (+ 10% wastage) needed	$I / J \times 1.11$	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	$(K + L) / 100 \times 1.11$	14,696	0	14,696
N	Cost of vaccines needed	$I \times \text{vaccine price per dose (g)}$	2,420,091	236,225	2,183,866
O	Cost of AD syringes needed	$K \times \text{AD syringe price per unit (ca)}$	61,562	0	61,562
P	Cost of reconstitution syringes needed	$L \times \text{reconstitution price per unit (cr)}$	0	0	0
Q	Cost of safety boxes needed	$M \times \text{safety box price per unit (cs)}$	86	0	86
R	Freight cost for vaccines needed	$N \times \text{freight cost as of \% of vaccines value (fv)}$	145,206	14,174	131,032
S	Freight cost for devices needed	$(O+P+Q) \times \text{freight cost as \% of devices value (fd)}$	6,165	0	6,165
T	Total fund needed	$(N+O+P+Q+R+S)$	2,633,110	250,398	2,382,712
U	Total country co-financing	$I \times \text{country co-financing per dose (cc)}$	250,398		
V	Country co-financing % of GAVI supported proportion	$U / (N + R)$	9.76 %		

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

ID		Source		2011	2012	2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	343,998	388,003	397,160	406,533	416,127	1,951,821
	Number of children to be vaccinated with the first dose	Table 4	#	318,610	368,603	377,302	386,206	395,321	1,846,042
	Number of children to be vaccinated with the second dose	Table 4	#	0	368,603	377,302	386,206	395,321	1,527,432
	Immunisation coverage with the second dose	Table 4	%	0.00 %	95.00 %	95.00 %	95.00 %	95.00 %	
	Number of doses per child	Parameter	#	1	1	1	1	1	
	Estimated vaccine wastage factor	Table 4	#	2.00	2.00	1.00	1.00	1.00	
	Vaccine stock on 1 January 2012		#	0					
	Number of doses per vial	Parameter	#		10	10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	Yes	
g	Vaccine price per dose	Table 7.10.1	\$		0.24	0.24	0.24	0.24	
cc	Country co-financing per dose	Co-financing table	\$		0.00	0.00	0.00	0.00	
ca	AD syringe price per unit	Table 7.10.1	\$		0.0465	0.0465	0.0465	0.0465	
cr	Reconstitution syringe price per unit	Table 7.10.1	\$		0	0	0	0	
cs	Safety box price per unit	Table 7.10.1	\$		0.0058	0.0058	0.0058	0.0058	
fv	Freight cost as % of vaccines value	Table 7.10.2	%		14.00 %	14.00 %	14.00 %	14.00 %	
fd	Freight cost as % of devices value	Parameter	%		10.00 %	10.00 %	10.00 %	10.00 %	

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

Co-financing group	Low
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	2011	2012	2013	2014	2015
Minimum co-financing	0.00	0.00	0.00	0.00	0.00
Recommended co-financing as per Proposal 2011			0.00	0.00	0.00
Your co-financing			0.00	0.00	0.00

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

		2012	2013	2014	2015
Number of vaccine doses	#	921,600	377,400	388,500	397,600
Number of AD syringes	#	613,800	418,900	431,200	441,400
Number of re-constitution syringes	#	102,300	41,900	43,200	44,200
Number of safety boxes	#	7,950	5,125	5,275	5,400
Total value to be co-financed by GAVI	\$	286,500	126,000	129,500	132,500

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

		2012	2013	2014	2015
Number of vaccine doses	#	0	0	0	0
Number of AD syringes	#	0	0	0	0
Number of re-constitution syringes	#	0	0	0	0

Number of safety boxes	#	0	0	0	0
Total value to be co-financed by the Country	\$	0	0	0	0

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

		Formula	2011	2012		
			Total	Total	Government	GAVI
A	Country co-finance	V	0.00 %	0.00 %		
B	Number of children to be vaccinated with the first dose	Table 5.2.1	0	368,603	0	368,603
C	Number of doses per child	Vaccine parameter (schedule)	1	1		
D	Number of doses needed	B X C	0	368,603	0	368,603
E	Estimated vaccine wastage factor	Table 4	2.00	2.00		
F	Number of doses needed including wastage	D X E	0	737,206	0	737,206
G	Vaccines buffer stock	(F – F of previous year) * 0.25		184,302	0	184,302
H	Stock on 1 January 2012	Table 7.11.1	0			
I	Total vaccine doses needed	F + G – H		921,508	0	921,508
J	Number of doses per vial	Vaccine Parameter		10		
K	Number of AD syringes (+ 10% wastage) needed	(D + G – H) * 1.11		613,725	0	613,725
L	Reconstitution syringes (+ 10% wastage) needed	I / J * 1.11		102,288	0	102,288
M	Total of safety boxes (+ 10% of extra need) needed	(K + L) / 100 * 1.11		7,948	0	7,948
N	Cost of vaccines needed	I x vaccine price per dose (g)		223,005	0	223,005
O	Cost of AD syringes needed	K x AD syringe price per unit (ca)		28,539	0	28,539
P	Cost of reconstitution syringes needed	L x reconstitution price per unit (cr)		379	0	379
Q	Cost of safety boxes needed	M x safety box price per unit (cs)		47	0	47
R	Freight cost for vaccines needed	N x freight cost as of % of vaccines value (fv)		31,221	0	31,221
S	Freight cost for devices needed	(O+P+Q) x freight cost as % of devices value (fd)		2,897	0	2,897
T	Total fund needed	(N+O+P+Q+R+S)		286,088	0	286,088
U	Total country co-financing	I x country co-financing per dose (cc)		0		
V	Country co-financing % of GAVI supported proportion	U / (N + R)		0.00 %		

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

		Formula	2013			2014		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	V	0.00 %			0.00 %		
B	Number of children to be vaccinated with the first dose	Table 5.2.1	377,302	0	377,302	386,206	0	386,206
C	Number of doses per child	Vaccine parameter (schedule)	1			1		
D	Number of doses needed	$B \times C$	377,302	0	377,302	386,206	0	386,206
E	Estimated vaccine wastage factor	Table 4	1.00			1.00		
F	Number of doses needed including wastage	$D \times E$	377,302	0	377,302	386,206	0	386,206
G	Vaccines buffer stock	$(F - F \text{ of previous year}) \times 0.25$	0	0	0	2,226	0	2,226
H	Stock on 1 January 2012	Table 7.11.1						
I	Total vaccine doses needed	$F + G - H$	377,302	0	377,302	388,432	0	388,432
J	Number of doses per vial	Vaccine Parameter	10			10		
K	Number of AD syringes (+ 10% wastage) needed	$(D + G - H) \times 1.11$	418,806	0	418,806	431,160	0	431,160
L	Reconstitution syringes (+ 10% wastage) needed	$I / J \times 1.11$	41,881	0	41,881	43,116	0	43,116
M	Total of safety boxes (+ 10% of extra need) needed	$(K + L) / 100 \times 1.11$	5,114	0	5,114	5,265	0	5,265
N	Cost of vaccines needed	$I \times \text{vaccine price per dose (g)}$	91,308	0	91,308	94,001	0	94,001
O	Cost of AD syringes needed	$K \times \text{AD syringe price per unit (ca)}$	91,308	0	19,475	94,001	0	20,049
P	Cost of reconstitution syringes needed	$L \times \text{reconstitution price per unit (cr)}$	155	0	155	160	0	160
Q	Cost of safety boxes needed	$M \times \text{safety box price per unit (cs)}$	30	0	30	31	0	31
R	Freight cost for vaccines needed	$N \times \text{freight cost as of \% of vaccines value (fv)}$	12,784	0	12,784	13,161	0	13,161
S	Freight cost for devices needed	$(O+P+Q) \times \text{freight cost as \% of devices value (fd)}$	1,966	0	1,966	2,024	0	2,024
T	Total fund needed	$(N+O+P+Q+R+S)$	125,718	0	125,718	129,426	0	129,426
U	Total country co-financing	$I \times \text{country co-financing per dose (cc)}$	0			0		
V	Country co-financing % of GAVI supported proportion	$U / (N + R)$	0.00 %			0.00 %		

Table 7.11.4: Calculation of requirements for Measles, 10 dose(s) per vial, LYOPHILISED (part 3)

		Formula	2015		
			Total	Government	GAVI
A	Country co-finance	V	0.00 %		
B	Number of children to be vaccinated with the first dose	Table 5.2.1	395,321	0	395,321
C	Number of doses per child	Vaccine parameter (schedule)	1		
D	Number of doses needed	$B \times C$	395,321	0	395,321
E	Estimated vaccine wastage factor	Table 4	1.00		
F	Number of doses needed including wastage	$D \times E$	395,321	0	395,321
G	Vaccines buffer stock	$(F - F \text{ of previous year}) \times 0.25$	2,279	0	2,279
H	Stock on 1 January 2012	Table 7.11.1			
I	Total vaccine doses needed	$F + G - H$	397,600	0	397,600
J	Number of doses per vial	Vaccine Parameter	10		
K	Number of AD syringes (+ 10% wastage) needed	$(D + G - H) \times 1.11$	441,337	0	441,337
L	Reconstitution syringes (+ 10% wastage) needed	$I / J \times 1.11$	44,134	0	44,134
M	Total of safety boxes (+ 10% of extra need) needed	$(K + L) / 100 \times 1.11$	5,389	0	5,389
N	Cost of vaccines needed	$I \times \text{vaccine price per dose (g)}$	96,220	0	96,220
O	Cost of AD syringes needed	$K \times \text{AD syringe price per unit (ca)}$	20,523	0	20,523
P	Cost of reconstitution syringes needed	$L \times \text{reconstitution price per unit (cr)}$	164	0	164
Q	Cost of safety boxes needed	$M \times \text{safety box price per unit (cs)}$	32	0	32
R	Freight cost for vaccines needed	$N \times \text{freight cost as of \% of vaccines value (fv)}$	13,471	0	13,471
S	Freight cost for devices needed	$(O+P+Q) \times \text{freight cost as \% of devices value (fd)}$	2,072	0	2,072
T	Total fund needed	$(N+O+P+Q+R+S)$	132,482	0	132,482
U	Total country co-financing	$I \times \text{country co-financing per dose (cc)}$	0		
V	Country co-financing % of GAVI supported proportion	$U / (N + R)$	0.00 %		

8. Injection Safety Support (INS)

Cambodia is not reporting on Injection Safety Support (INS) in 2012

9. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2011**. All countries are expected to report on:

- a. Progress achieved in 2011
- b. HSS implementation during January – April 2012 (interim reporting)
- c. Plans for 2013
- d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2011, or experienced other delays that limited implementation in 2011, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2011 fiscal year starts in January 2011 and ends in December 2011, HSS reports should be received by the GAVI Alliance before **15th May 2012**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2012, the HSS reports are expected by GAVI Alliance by September 2012.

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

4. If you are proposing changes to approved activities and budget (reprogramming) please explain these changes in this report (Table/Section 9.5, 9.6 and 9.7) and provide explanations for each change so that the IRC can approve the revised budget and activities. **Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval. The changes must have been discussed and documented in the HSCC minutes (or equivalent).**

5. If you are requesting a new tranche of funding, please make this clear in [Section 9.1.2](#).

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

7. Please attach all required [supporting documents](#). These include:

- a. Minutes of all the HSCC meetings held in 2011
- b. Minutes of the HSCC meeting in 2012 that endorses the submission of this report
- c. Latest Health Sector Review Report
- d. Financial statement for the use of HSS funds in the 2011 calendar year
- e. External audit report for HSS funds during the most recent fiscal year (if available)

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

- a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;
- b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;
- c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

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

9.1. Report on the use of HSS funds in 2011 and request of a new tranche

9.1.1. Report on the use of HSS funds in 2011

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

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

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

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

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

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

Table 9.1.3a (US)\$

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

Table 9.1.3b (Local currency)

	2007	2008	2009	2010	2011	2012
Original annual budgets (as per the originally approved HSS proposal)	7538750000	4077474633	4106098880	4074622380	4188911080	4211460000
Revised annual budgets (if revised by previous Annual Progress Reviews)	7538750000	1394212500	6343138880	6183718600	6080799376	5810556000
Total funds received from GAVI during the calendar year (A)	7538750000	1394212500	6279520000	5905776000	4983224000	4484000000

Remaining funds (carry over) from previous year (B)		7035146703	2958924800	4378640756	5595568084	
Total Funds available during the calendar year (C=A+B)	7538750000	8429359203	9238444800	10284416756	10578792084	4484000000
Total expenditure during the calendar year (D)	598972025	5491061523	4728684480	4721942224	4749491316	
Balance carried forward to next calendar year (E=C-D)	6939777975	2938297680	4509760320	5562474532	5829300768	4484000000
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0	0	5810556000

Report of Exchange Rate Fluctuation

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

[Table 9.1.3.c](#)

Exchange Rate	2007	2008	2009	2010	2011	2012
Opening on 1 January	4054	3992	4077	4165	4051	4039
Closing on 31 December	3999	4077	4165	4051	4039	4100

Detailed expenditure of HSS funds during the 2011 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2011 calendar year (*Terms of reference for this financial statement are attached in the online APR Annexes*). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number:)**

If any expenditures for the January April 2012 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number:)**

Financial management of HSS funds

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

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

The Government Ministry of Health HSSP2 account is used for GAVI, and it is managed through the Department of Budget and Finance. The GAVI fund is a discrete fund managed through the multi donor Health Sector Support Program[2009-2013]. The budgets are approved through the routine Annual Operational Plan of Ministry of Health Health Planning System. That is, all GAVI HSS plans and budgets are included within the annual operational plan of health centres, operational districts, provincial health departments and central departments, and are therefore 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, which are signed by the Secretary of State for Health and Provincial Health Department Directors, Operational District Directors and Health Centre Managers, form the basis for the annual release of the funds to the provinces. It is at these two workshops that activities and costs are integrated into the annual operational plans of the Provinces/Districts which is facilitated by Department of Planning and Health Information. Based on the Contract for the 10 ODs-HSS, the funds are released annually to the provinces and deposited in a commercial account in the Province. Then, the provinces release the funds to the Districts on a monthly basis based on the previous month's work performance by the health centre for the MCH and EPI services package. At the District level, monthly funds are deposited in the safety boxes. The Health Centres report to the district at the monthly meeting and receive their funds based on the previous months performance report after verification from technical and accountant staff.

NOTE: Average Exchange Rate at the end of year: 4,075 (2007); 4,131 (2008); 4,160 (2009); 4,034 (2010); 4,058 (2011); 4,000 (2012) was used to calculate in Table 9.1.3b.

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

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

9.2. Progress on HSS activities in the 2011 fiscal year

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

Please provide the following information for each planned activity:

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

Table 9.2: HSS activities in the 2011 reporting year

Major Activities (insert as many rows as necessary)	Planned Activity for 2011	Percentage of Activity completed (annual) (where applicable)	Source of information/data (if relevant)
1.1. Health service delivery	Establish and implement health centre MPA annual operational plans and performance agreements based on the supply and demand side approaches for services package of MCH and EPI.	100	PHD/OD Data, NIP Data, M&E Log-frame Data and MoH-HIS, are cross referenced.
1.2. Health district management	Establish and implement annual operational plans and performance based management agreement for PHD/ODs on MCH and EPI services delivery package.	100	PHD/OD Data, NIP Data, M&E Log-frame Data and MoH-HIS, are cross referenced.
1.3. Coverage improvement planning-CIP	Integration of immunization coverage improvement planning into the HC-MPA planning systems of MCH & EPI services package	90	Observation and informal meeting with HCs chief and ODs directors.

1.4.Fixed site strategy	Implement and evaluate fixed site strategy for services package of MCH and EPI.	100	PHD/OD Data,NIP Data,M&E Log-frame Data and MoH-HIS,are cross referenced.
2.1 System Development [Financial Management]	Develop MPA financial management system and health financing guidelines	100	Documents: MPA FMS Books,Audit Report of Price Water-house Coopers ,Technical/Financial Quarterly Reports.
2.2 System development [Planing]	Strengthening of AOP planning systems and implementation of MPA planning guidelines	100	Documents:DPHI quarterly report and Health Congress Report 2011.
2.3 System developmentSupport Supervision]	Strengthening of integrated supervision from central programs and departments to PHD/OD/HC levels	75	Documents: National Program and central departments quarterly reports.
2.4 System development [Research/Assessment]	Conduct health system operational research	100	Document: Report of 24 Hours Assessment
3.1Middle level mangement-MLM	Conduct capacity building programs for Middle Level Management	100	Document: DBF Report
3.2 IMCI Service	Conduct capacity Building & supportive supervision programs for IMCI and immunization	100	Document:CDC Reports
3.3 Child survival	Strengthen systems for child survival scorecard monitoring		N/A
3.4 Private sector participation	Implement, Evaluate and Scale Up Public / Private Collaboration (immunization with potential integration with MCH)	100	Document: Report of NIP Workshop
3.5 Project management [obj.3]	Office support, evaluation workshops, transportation, technical support and other logistics	100	Checklist of work plan and observation

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

Major Activities (insert as many rows as necessary)	Explain progress achieved and relevant constraints
1.1. Health service delivery [obj. 1]	All health centre MPA [149] in the 10-OD-HSS have achieved their target as specified in the contract with each HSS-OD for the 8 indicators of MCH and EPI (in the services delivery package).
1.2. Health district management[obj.1]	Achievement: 10 Annual Operational Plans were developed and signed between HSS-HSSP2 Program Director and PHD/OD-HSS.
1.3.Coverage improvement plan[obj.1]	The National Immunization Program and PHD/ODs have worked together on how to support the high risk areas[Health centre or villages] through introducing the micro planning at HC level and finding external support and including this in the Annual Operational Plan. Challenges: Lack of human resources to fulfill the task at all level,and a large workload from the national program concerned and at the peripheral level. Lack of motivation from VHV and VHSG.Fund for outreach is often delayed, with a problem of mobile population,and lack of clarity of the population denominator .
1.4. Fixed site strategy[obj.1]	Achievement: There is significantly improvement of fixed site immunization from 20% at baseline in 2007 to 45% in 2011 in the 10-OD-HSS[refer to 10-OD-HSS M&E Log-frame].

2.1 System development-Finance[obj.2]	Achievement:Funds disbursement and financial reporting is on time with good cooperation and assistance from the department of budget and finance/MoH. Most OD accountants understand more on financial and cash management and have good communication with the PHD accountant. In 2011,with GAVI-HSS budget support, there were 24 PHD accountants and 77 OD accountants who participated in the workshop on budget and finance management.
2.2 System development-Planing[obj.2]	Achievement: A.Planning Unit All level of health facilities under the ministry of health has continued to promote implementation of planning process. This is for the purpose of improving the quality of Annual Operational planning and linkage with the resources available for the year according to the AOP guidelines.Most provincial health department had conducted training for Data-base of HIS for Planning unit officer in with a total of 157 participants(8 for Planning officer at PHD,52 Planning officer from OD,11 planning officers from referral hospitals and another 86 from health centres. B.HIS Unit Quality of health information has been improving due to the monitoring and validating data from health centre (HC1) and hospital (Ho2). As result, the quality of data has improved noticeably from 67% in 2008, to 73% in 2010 and to 86% in 2011. The HIS Unit of DPHI/MoH this year collaborated with the National Centre for Maternal and Child Health Centre had conducted 5 courses on HIS management and data use for 125 HIS officers and PHD HIS-Officer. The HIS Unit also conducted training in HIS Management and Data use for officers from the private sector and NGO partner in total of 54 persons. A Data Quality Audit was also conducted in 2011 in the 10 HSS ODs and the report is included as an annex to this APR.
2.3 System developmentSupport Supervision]	Achievement: This year only 2 integrated supervision vists were conducted from the central level to thePHD/ODs, because of the frequency of individual technical supervision programs and departments. Constraints: Each program/Department has their individual schedule which makes it difficult to find suitable common time for integrated supervision.
2.4 System development[Research]	Achievement: The study had been conducted by Local firm [SBK].Qualitative study report in 10 OD-HSS (qualitative study) which details health provider and community perceptions of health service provision. The report was finalised and shared with all concerned partner and PHD/OD via workshop.
3.1Middle level mangement-MLM[obj.3]	Achievement: 101 staff have been trained in financial management manual (follow up training on revision of financial management manual) and 30 missions for supervision follow up in 10 provinces including ODs were conducted.
3.2 IMCI[obj.3]	Achievement:The health centre staff in 10-OD-HSS[149 HCs] is equipped with skills and knowledge on the management of the sick children including assessment, treatment and counselling and follow-up after treatment. Better care may increase the utilization of the health services and hence contribute to the mental and physical development of the children. The IMCI health facilities and its provincial/district management teams complied with MoU that was signed between ODs and GAVI-HSS-HSSP2. Spot-checks by the central CDC teams and provincial/district supervision teams helped strengthen the implementation of the IMCI at the health centres focusing on the quality of the clinical management of sick children and counseling skills (ANC, BS, and IMCI). In 2011, 298 health staff from the 10-GAVI ODs were trained in clinical training [20 persons],Refresher Clinical Training [40 persons],Facilitators Training [12 persons],Follow-up After Training [15 persons],Programme Managers Training- PMG[12 persons] and 200 participants in IMCI Annual Review Workshop.
3.3 Child survival[obj.3]	N/A

3.4 Private sector participation[obj.3]	Achievement: A workshop on Public and Private Collaboration on Immunization was conducted in Siem Reap with participation of 89 participants from 4 main provinces which have large and medium sized private clinic. 16 clinics participated in the Workshop. Constraints: It takes time to develop partnerships with the private sector in order to support increased immunization safety and increased immunization coverage.
3.5 project management[obj.3]	Achievement: The Program Monitoring Team and work plan for HSS- ODs project was implemented as per schedule. Constraints: Some challenges remain due to the need to work with many national programs and levels in the health system and different administrations.

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

Note: Activity 3.3 under objective 3, child survival was not put in the work plan for 2011. The child survival scorecard is being managed through the national budget.

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

Management incentives for Provincial and District level, and supplements for remote area health staff are paid according to the "Priority Operational Cost" (POC) guidelines of the Ministry of Health.

Although the fee for service model of the HSS program for the package of EPI-MCH services at the primary level of care has contributed to improved numbers of service contacts and improve service coverage in lower performing the districts of the country since 2007, it remains the case that there is no formal health human resource policy that supports such a model. The only possible exception is the fee for service model for delivery at health facilities, whereby the Government of Cambodia makes a one off fee for service payment of \$15 to the midwife attending this delivery.

The "contracting in" approach adopted by GAVI HSS is supported by Health Sector Plan 2, which recommends contracting as a strategy for strengthening decentralized health care management.

The emphasis on systems building and skills building, particularly in the areas of IMCI and immunization, supports broader human resource strategies to develop the primary care skills of the health care workforce in rural and remote areas.

9.3. General overview of targets achieved

Please complete **Table 9.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2010 from your original HSS proposal.

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2011 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2007	2008	2009	2010	2011		
1. DPT – HepB,Hib 3 Coverage at Nationally.	78.30%	DHS 2005	90	94	82	91	95	92	94	JRF,HIS-MoH	DPT-HepB,Hib raised about 16% from 78.30% in the based line to 94% in 2011. The rate has gone up 2% comparing to last year.

2. DPT – HepB,Hib 3 Coverage at 10 OD-HSS.	74%	MoH-MoP 2006	90		70	80	87	90	83	NIP/HIS-MoH/PHD -OD	Not yet achieved due to the fact that number of vaccinated children in the two campaigns were not included in the 10-OD-HSS. Mobile population, High risk area difficult to reach and shortage of staff and lack of microplanning.
3. OD achieving 80% or > of DPT,HepB,Hib (Nat.)	18	DPHI/NIP 2006	76		33	62	68	66	64	NIP/HIS-MoH/PHD -OD	Number has dropped about 2 ODs from last year (2010) of districts achieving ≥80% DTP3 coverage .
4. OD achieving 80% or > of DPT,HepB,Hib (OD-HSS)	0	DPHI/NIP 2006	10		1	7	9	9	10	NIP/HIS-MoH/PHD -OD	There has been improved from 1 to 10 [From 2007-2011] of districts achieving ≥80% DTP-HepB,Hib3 coverage .
5. Hepatitis Birth Dose-24 Hours. at Nationally.	25	MoH-NIP 2006		82	53	46	55	57	55	JRF,HIS-MoH	There has been about 2% dropped from 2010, the target has been not yet reached the target.
6. Hepatitis Birth Dose-24 Hours. at the 10-OD-HSS.	25	MoH-NIP 2006			45	47	61	65	96	NIP/HIS-MoH/PHD -OD	There has been about 71% improvement from the baseline, the target has been reached in 10-OD-HSS.
7. Measles Coverage at the Nationally.	70	MoH-MoP 2006	90	92	79	91	92	93	93	JRF,HIS-MoH	Measles raised 23% from 70% in the based line to 93% in 2011. The rate remain the same as last year 2010.
8. Measles Coverage at the 10-OD-HSS.	70	NSRH 2005	90		67	78	83	89	80	NIP/HIS-MoH/PHD -OD	Not yet achieved due to the fact that number of vaccinated children in the two campaigns were not include in the 10-OD-HSS.
9. PW visit at least ANC2 at the nationally.	60	HIS-MoH 2006	90		41	81	83	72	86	HIS-MoH	
10. PW visit at least ANC2 in the 10-OD-HSS.	49	DHS 2005	90		55	72	81	76	100	HIS-MoH	There has been about 50% improvement from the baseline, the target has been reached in 10-OD-HSS.

11. Delivery by trained health personnel(Nat.)	44	HIS-MoH 2006	90		47	58	63	69		HIS-MoH	Substantial improvement from the baseline, but the target has not yet been reached.
12. Delivery by trained health personnel(OD)	35	HIS-MoH 2006	90		40	47	58	67	62	HIS-MoH	Substantial improvement from the baseline (rates have doubled), but the target has not yet been reached.
13. Delivery at health facilities (Nationnally).	14	HIS-MoH 2006			25	39	44	52		HIS-MoH	Significant improvement from the baseline (rates have more than 4 times), but the target has not yet been reached.
14. Delivery at health facilities (OD-HSS).	14	N/A			21	34	44	51	53	HIS-MoH	Significant improvement from the baseline (rates have tripled), but the target has not yet been reached.
15.Facility implementing full MPA at nationnally.	N/A	N/A			48	69	78	100	100	CDC Report	All health centre staff had been trained at least two staff and implemented IMCI.
16. IMCI consultation for <5 YL at nationnally.	N/A	N/A	1,5		N/A	1.1	1.00	1.50	1.57	HIS-MoH	There is atleast one child age under 5 year old had access health facility for IMCI consultation according to MoH guideline.
17. IMCI consultation for < 5YL in the 10-OD-HSS.	N/A	N/A	1,5		N/A	0.33	0.85	1.34	1.53	HIS-MoH	There is atleast one child age under 5 year old had access health facility for IMCI consultation according to MoH guideline.
18. HC had trained/implemtned IMCI(10-OD-HSS).	N/A	10-OD-HSS			N/A	N/A	90	100	100	HIS-MoH	There is atleast one child age under 5 year old had access health facility for IMCI consultation according to MoH guideline.
19.HC had trained/implemtned IMCI (Nationnally).	N/A	HIS-MoH 2006			3	7	9	10	10	CDC Report	All health centre staff had been trained (at least two staff ieach HC implementing IMCI in 10-OD-HSS. reach ed the target, but quality needs to improve.

20. Facility implementing full MPA(Nationnally)	470	N/A	972		967	967	984	997	1004	PHD/OD-HSS	All health centres in 10-OD-HSS had been implemented full PMA packages of activities.
21. Facility implementing full MPA(10-OD-HSS)	N/A	HIS-MoH 2006			N/A	N/A	127	149	149	HIS-MoH	Number of 7 health centres had been built and equiped in 2011.
23. Immunization at fixed site at the nationnally.	20-25	HIS-MoH	40		20	32	37	45	39	HIS-MoH	There was a 6% drop from last year, but almost reach the target comparing to the original target of 40% for 2015.
24. Immunization at fixed site in the 10-OD-HSS.	20-25	10-OD-HSS	40		20	37	48	41	45	HIS-MoH, NIP Data	Fixed site utilization has doubled since the baseline, and has achieved the 2015 target.
25. Approved budget reaching heath facilities.	1	AOP Budget Allocated Report	10		10	10	10	10	10	DEB-MoH Report	100% of planned budget through GAVI/HSS was received by all the 10-OD-HSS. The financial monitoring sytem to measure planned budgets and implementation are regularly monitored and technicallly supported.
26. OD have reached performance contracts.	1	10-OD-HSS	10		3	7	9	10	10	NIP/HSS	All OD-HSS had implemented with compliance of the contract signed between HSS-HSSP2/MoH and PHD/ODs.

9.4. Programme implementation in 2011

9.4.1. Please provide a narrative on major accomplishments in 2011, especially impacts on health service programs, notably the organization program

Achievement of Implementation in 2011

Impacts on the health service program and EPI.

Generally, since baseline results in 2007, the number of service contacts has continued to increase. The exception to this was immunization in 2011, which saw a fall numbers from 2010. Nevertheless, the overall increase for the majority of indicators would support the findings of a research study and DQA conducted in 2011, which demonstrated that both the population and the health staff are reporting increased utilization and quality of health care services. It should be noted that in evaluating performance, the original 10 HSS ODs were selected based on lowest performance and absence of development partner and NGO support. Despite changes in the population denominator over this time, and introduction of two new ODS in 2010, analysis of increased numbers of contacts also demonstrates increased utilization of fixed facilities for immunisation and MCH services. The drop in immunization numbers in 2011 is most likely attributable to drop in the frequency and/or quality of health outreach services.

Details of performance for each indicator in 2011 are recorded below.

1. At the 10-OD-HSS, DPT-HepB, Hib3 coverage has increased from a baseline of 70% in 2006 to 90% in 2010 and dropped to 83% in 2011. This 7% less than in 2010. At National level there was a 2% increase. The reasons for this drop will be investigated during an internal review in 2012.
2. At national level, Measles coverage has improved from a baseline of 70% in 2006 to 93% in 2011. It is the same achievement as 2010. However, Measles coverage has increased from baseline coverage of 67% in 2006 to 89% in 2010 and dropped to 80%. It dropped by 9% in the 10-OD-HSS. Reasons provided for the drop in coverage at a recent HSS workshop included system factors (lack of human resources and infrastructure in some locations), inadequate budget for outreach and transport and lack of an effective communication strategy with volunteers. As stated above, the reasons for this drop in coverage will be investigated through an internal review in 2012.
3. In 2010, at national level, 66 of 77 ODs reached target >= 80% dropped to 64 of 77 ODs in 2011. All 10 OD-HSS has DPT3 coverage reach target of 80% in 2011 (compared to only 1 in 10 ODs at baseline in 2007).
4. ANC2 coverage has also exceeded baseline measures by a significant amount in both National and the 10-OD-HSS. At national, ANC2 coverage improved from baseline 60% in 2005 to 86.24% in 2011. However, the 10-OD-HSS has remarkably improved 51% from the baseline of 49% in 2006 to 100% in 2011.
5. At national level, the proportion of deliveries attended by trained health staff has increased from baseline of 44% in 2005 to 71.66% in 2011. There has been an increase in deliveries by trained health staff from 35% in 2006 to 62% in 2011. This is 2% less than last than 2010 in the 10 HSS ODs.
6. Delivery rates at facilities are continuing to rise steadily in both national and 10-OD-HSS from a baseline of 14% in 2006 to 61.39% [National] and 53% [10-OD-HSS] in 2011.
7. There has been an increase from 30% [National] to 71% of coverage of Hepatitis Birth Dose (24 hours) between 2006 and 2011.
8. In the 10 HSS ODs, there are 149 Health Centers. Between 2009 and 2011, in all of these HCs, at least 2 persons in each health centre have received IMCI training and practice through GAVI funded support.
9. All 10-OD-HSS had reached performance targets according to the contract sign between project director of HSS-HSSP2-MoH and Directors of PHD-OD.
10. There are 7 new health centres that were built in 2011. 2 of those buildings [HCs] belong to the 10-OD-HSS [OD Kraochmar]. So that the number of facilities [HC] implementing full MPA increased from baseline 470 in 2006 to 1004 in 2011. At current status, the number of health centres in the 10-OD-HSS that have fully functioning MPA is 151 HCs (with 24 hour opening confirmed by independent research study by SBK in 2011 - see Annex).
11. The national target for 2015 in the original
11. Fixed site immunization has increased from a baseline of 20% in 2007 to 45% in 2011 in the 10 HSS ODS.
12. The approved budget plan reaching health facilities in 10 PHD-OD-HSS and its HCs was 100% according to the contract in the 10-OD-HSS. The financial and budget monitoring system was developed and put into practice to measure planned budget and implementation based on quarterly monitoring system.
- of level of health has continued 13. Capacity building in planning: Most provincial health department had conducted training for Data-base of HIS for Planning unit officer in total 157 participants (8 for Planning officer at PHD, 52 Planning officer from OD, 11 planning officers from referral hospital and other 86 from health centres).
14. Data quality has improved from 67% in 2008, 73% in 2010 and 86% in 2011. The HIS Unit of DPHI/MoH this year collaborated with the National Centre for Maternal and Child Health Centre and conducted 5 courses on HIS management and data use for 125 HIS officers and PHD HIS-Office. HIS Unit also conducted training on HIS Management and Data use for officer from private sector and NGO partner in total of 54 persons.
15. Financial Management, Auditing and Capacity Building: The MOH has engaged an audit firm (PricewaterhouseCooper) to audit the 2010 GAVI funds including GAVI HSS, GAVI ISS and Vaccine Introduction Grant. The auditor has audited the GAVI 2010 overall financial statements during July 2011. The final auditor's report has been finalized and submitted to GAVI secretariat. At the end of 2011, a Workshop on Financial Management and Sharing finding of Auditing in 2010 was conducted with participants from Central,

PHD, OD and NGO partners. There were 24 accountants from provincial health department and 77 accountants from operational district had learned the concept of financial management and daily cash and budget management. This workshop support by GAVI-HSS for the opportunity of PHD/ODs learned and shared experience form each other in budget and financial management and in following the MOH financial guideline.

Other Impacts on health service programs and EPI:

- Nationally, There is number of 324,628 [94%] child age under 1 year old immunised DPT-HepB, Hib3.
- Nationally, BCG 101.21% [2011]
- Nationally, OPV3 coverage increased from 82%[2007] to 94.10%[2011]
- Nationally, TT+2 coverage increased from 50% in [2007] to 63.69% [2011]
- Nationally,VitamineA,1st dose 105.80%[2011]
- Nationally,VitamineA,2nd dose 91.75%[2011]
- Number of IMCI consultation for child age under 5 year old reached 2,289,475 [1.57] and 10-OD-HSS reached 292,193 [1.53] in 2011.
- Number per contact to public health facility for child age under 5 for IMCI consultation increased from 1, 1 [2008] to 1.57 [2011] at National and 10-OD-HSS increased from 0.33[2008] to 1.53 in 2011.
- Nationally, Number of modern birth spacing user 581,901[29,07%] in 2011.

Main Activities of National Immunization in 2011:

- National and local level launching ceremonies of Vaccination Measles Second Dose, Mass Communication, Social Mobilisation, Integrated activities with other services, Training on Policy and Workshop
- Coverage of Area of Vaccination: At school, market and communities.
- Development of Mass Communication: Leaflets, Billboards/ flyers,T-Shirts,Radio and TV Spots.
- Social Mobilization: Inform the local authorities, public and community on the events [date and time]
- Conduct the awareness education in high risk communities.
- Integrated Activities: During the outreach activities the services cover immunization, maternal and child health care, reproductive health, family planning or birth spacing, food safety and immigration and or mobilization from one to another place.
- Meeting and Policy Dialogue: Organise roundtable meeting discussion in order to develop and ensure effective implementation of immunization strategies, including Policy, Action Plan and Advocacy with the participants from different level of National, Provincial, and District, Health Centre, Community and NGO partners.

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

Data Quality - The DHS survey shows that there is a 10% gap between reported and survey coverage for measles. There is concern that as GAVI HSS is a performance based system, there could be inflation of coverage rates. For this reason, the Department of Planning and Health Information conducted data quality assessment training for the 10HSS ODs, with all ODS implementing the DQA studies. Based on the findings of this DQA, management interventions will be designed to improve the quality of data

Impact and effectiveness of GAVI HSS - GAVI HSS has now been implemented since the last quarter of 2007. Even though there have been 2 consultant reviews, it was considered essential to obtain a more thorough health system research study to understand the effects of GAVI HSS on improved utilization and performance. These results were finished in May 2011.

Integrated Supervision - Integrated supervision of the Program Monitoring Team has proved to be difficult from central level, as there is no clear system for this as yet. Responsibility for supervision of the program has therefore shifted to the provincial and District level, with the central level providing the main support for systems development, financial disbursement and DQA.

GAVI HSS Internal Review 2012

GAVI HSS has been implemented since the last quarter of 2007. The objectives are to improve immunization and MCH service coverage through strengthening of planning, financial management and service delivery systems. Funds are disbursed quarterly to districts (and annually to PHD from National level) with targets and roles and responsibilities identified in a service contract. The service contract is performance based, with payments made according to the number of service contacts for 5 main indicators.

Although there have been significant improvements to coverage in the last 4 years, in 2011, immunization numbers have commenced to fall. At the HSS meeting in March, ODs indicated that health system factors, lack of transport and infrequency of outreach were some of the contributing factors to lower coverage rates. The floods in that year and measles campaign activities were also referred to as reasons for lower EPI (Pentavalent and Measles) in 2011 by ODs. An evaluation published in 2011 also indicated that, although overall service delivery and coverage had improved through HSS, (SBK Report 2011) there was insufficient attention placed on health outreach and high risk micro-planning to ensure the hardest to reach are reached in the HSS ODs. Despite DQA results in 2011 which demonstrated a reasonable level of match of data between registers and community household checks (most indicators with 10% variation), there are still concerns about quality of data due to the performance based mechanism of payment.

For this reason, an internal review is now considered in order to review and refine the HSS strategy and contract mechanisms in order to ensure improved EPI/MCH services and alignment with MOH strategy.

Objective of Review:

1. To assess effectiveness of HSS contract mechanisms and strategies for EPI/MCH coverage improvement in 10 HSS ODs, especially for high risk populations.
2. On the basis of these findings, to make recommendations to the Ministry of Health on HSS Strategy in relation to improve access for high risk populations

Process:

The evaluation will be undertaken by the HSS Monitoring group with findings disseminated to the TWGH and the MOH. Main activities will include:

1. Field Visits to each of the 10 HSS ODs using an evaluation questionnaire (OD Office and 1 high risk HC/Village)
2. Presentation of Results (Report) and recommendations for coverage improvement for each OD
3. Presentations of findings at PHD/OD forum in mid year
4. Adjustment to HSS strategy and contracts based on the findings of the review and consultation meeting with PHD/OD (amendments to contracts mid 2012 or new contract design 2013).

Expected Outcomes of Review:

1. Report on main barriers and solutions for improved coverage(EPI/MCH) in 10 HSS ODs

2. Recommendations to MOH on HSS Strategy and contract mechanism.

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

Central level:

- Integrated supervision from join of Program Monitoring Team once per quarter
- Health Systems Research is tendered at central level and implemented by an independent agency
- The Central level (Department of Planning and Health Information) has the responsibility to trained Provincial and District health staff in DQA, and oversee implementation
- Health information data is managed through DPHI. NIP and GAVI HSS indicators are part of the monitoring and evaluation framework
- The Central level, through the office of the Second Health Sector Support Program, designs and updates management and service delivery contracts
- The Central level, through the Department of Budget and Finance designs and monitors financial management procedures. Funds are externally audited
- The finding of external audit shared during the workshop
- At the central level, there is an annual and mid-term review of GAVI HSS
- NIP Technical Working Group conducts every Monday of the week with participation
- Program Monitoring Team Working Group[HSS-Working Group]

Provincial level:

Technical bureau at the provincial level implements programs of integrated supervision among core staff from EPI,HIS,MCH, Accountant and Technical bureau including Director/Deputy of PHD

Activities are monitored through quarterly meetings

All GAVI HSS activities, funds and indicators are reflected in the annual operation planning system of the Ministry of Health at each level of the health system.

Operational District Level:

- 1.The OD implements programs of integrated supervision among core staff from EPI,HIS,MCH, Accountant and Technical bureau including Director/Deputy of OD
- 2.Activities are monitored through monthly meetings with health centers and field supervision
- 3.All GAVI HSS activities, funds and indicators are reflected in the annual operation planning system of the Ministry of Health at each level of the health system.
- 4.Financial disbursements are issued based on health information reports and targets identified in the health contracts
- 5.The Technical Working Group for Health (Peak Government Donor Forum, it is similar to ICC) and Immunization Coordination Committee also review the APR annually including the HSS component.

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

Integration with National M & E

Indicators from national M & E framework. All data collecting through the existing of PHD/OD-HIS based on regularly quarterly and annually report. For M&E Framework is also regularly updated the progress made by the 10-OD-HSS for closely monitoring the indicators contract with HSS-HSSP2 and ODs. This approach is ensuring the validating and delaying of sending the core report to MoH//DPHI usually delayed and late as schedule mentioned. Usually, the data have to valid with 3 sources [HIS-MoH,NIP,Moh and PHD-OD-HIS] to make sure data is accurate and agreed upon with all stakeholders.

Other studies, conducted in 2010 are relevant to M & E for HSS and these include:

- (a) DHS Survey 2010 was finished in 2011
- (b) Data Quality Audit DPHI 2011 10 HSS ODS finished and distribution in (March-April 2011)
- (c) Health System Evaluation GAVI HSS 2011 finished and distributed in (March- April 2011)

From 2010 and 2011, monitoring and evaluation through the health information system is being supplemented by a Data Quality Audit being conducted by the Department of Planning and Health Information. Routine monitoring is now also being supplemented by health system research studies (as described earlier, an independent study to evaluate GAVI HSS is being conducted in March and April 2010). It is proposed that one independent study will be conducted each year.

Reporting

All reporting is through the Second Health Sector Support Program-HSSP2.

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

Stakeholders

NGOs such as RHAC, RACHA, Save Children and other NGOs are co-implementers in selected HSS districts .Local authorities are the key partner in empowering communities' participation and assisting in updating the population and providing more information of population registration. This information is useful for ODs to calculate clearly their plan.

Central Departments as described throughout this report provide technical guidance in defined areas (Planning, Health Information Management, Financial Management, IMCI, Immunization)

The GAVI HSS is managed according to the administrative procedures of the central Office of the Health Sector Support program Provincial and District Health managers and health centre teams are overall responsible for management and implementation of service contracts

Development partners (WHO, UNICEF, World Bank, NGOs and others) provide technical comment through the Technical Working Group for Health and Immunization Coordination Committee.

Cambodian Research companies (SBK) is a partner in health system research in 2010-2011.

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

N/A

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

- Whether the management of HSS funds has been effective
- Constraints to internal fund disbursement, if any

- Actions taken to address any issues and to improve management
- Any changes to management processes in the coming year

The 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 (AOP), 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 2011.

9.5. Planned HSS activities for 2012

Please use **Table 9.5** to provide information on progress on activities in 2012. If you are proposing changes to your activities and budget in 2012 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2012

Major Activities (insert as many rows as necessary)	Planned Activity for 2012	Original budget for 2012 (as approved in the HSS proposal or as adjusted during past annual progress reviews)	2012 actual expenditure (as at April 2012)	Revised activity (if relevant)	Explanation for proposed changes to activities or budget (if relevant)	Revised budget for 2012 (if relevant)
1. Health Service Delivery Contracts	Establish and Implement AOP in the 10-OD-HSS.	616041	167009	The activities keep the same.	The budget in 2012 is less than 2011 for HC MPA Contract; the budget for these activities has been reduced by the amount 50,000 in order to match budget availability in 2012. I budget of 2012..	615157
2. Management contract for PHD/OD	Implementing the contracts.	136220	0	It is revised to fit the actual need.	This amount of budget is adjusted to the need of the OD Management Teams for supervision. This activity was spent for Priority Operational Cost (POC) in Central level (PMT).	152580
3. Coverage Improvement Planning.	Implementing the CIP in the target ODs.	70000	70474	The same as above.	This activity is being maintained at a higher level than the original budget proposal in order to improve health outreach services, especially for hard to reach areas.	21664

4. Fixed Site
Strategy

Implement
and Evaluate
fixed site in 10
-OD-HSS.

25000

420

The same as
above.

18000

5. Financial Management System	Conduct & Monitor the MPA financial management.	10000	53811	The same as above.	The majority of funds for HSS are for service delivery contracts. To sustain the contracts systems, more investment is needed in central and PHD level systems development (this applies to financial management, planning and supervision). This expenditure including Mid-Year Review WS for 77 ODs/24 Provinces (Chief Accountant, Chief OD, Cashier, EPI)	29007
6. Planning System Development	Build the AOP planning capacity and implementing.	45000	14659	The same as above.	The majority of funds for HSS are for service delivery contracts. To sustain the contracts systems, more investment is needed in central and PHD level systems development (this applies to financial management, planning and supervision).	83890

7.Integrated Supportive Supervision	Conduct integrated supportive supervision.	69776	79349	The same as above.	The majority of funds for HSS are for service delivery contracts. To sustain the contracts systems, more investment is needed in central and PHD level systems development (this applies to financial management, planning and supervision).	111904
8.Research/Assessment of HSD	Conduct the operational Assessment of HSD.	20000	0	The same as above.	To conduct one study a year (qualitative research studies) with a national research company with international TA cost approximately. \$30,000 - \$40,000.	15000
9.Middle Level Management	Conduct the capacity building for MLM.	46000	539	The same as above.	The majority of funds for HSS are for service delivery contracts. To sustain the contracts systems, more investment is needed in central and PHD level systems development (this applies to financial management, planning and supervision).	61303
10. IMCI Services	Conduct training for IMCI and EPI programmes.	0	12250	The same as above.	IMCI investments to be made continuously for monitoring and supervision to accommodate the high turnover of staff and to sustain the IMCI initiative, which has resulted in a sharp increase in 0-4 outpatient contacts in HSS ODs.	63470
11.Child Survival	N/A	0	0		N/A	0
12.Private Sector Cooperation	Implement and collaboration with private sectors.	10000	0	No revised		10000
13.Project Management	Support to project management.	72802	19429	Budget is revised based on AOP 2012.	The budget has been adjusted from the original proposal due to the need to maintain annual and midyear program reviews, and to support a HSS coordinator, Administration & Accountant Assistant to and short term technical assistance and other office supplies, internet fee including project miscellaneous, (CPs,LCD and Car=148,700\$UD).	270664
		1120839	417940			1452639

9.6. Planned HSS activities for 2013

Please use **Table 9.6** to outline planned activities for 2013. If you are proposing changes to your activities and budget (reprogramming) please explain these changes in the table below and provide explanations for each change so that the IRC can approve the revised budget and activities.

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

Table 9.6: Planned HSS Activities for 2013

Major Activities (insert as many rows as necessary)	Planned Activity for 2013	Original budget for 2013 (as approved in the HSS proposal or as adjusted during past annual progress reviews)	Revised activity (if relevant)	Explanation for proposed changes to activities or budget (if relevant)	Revised budget for 2013 (if relevant)
1.1. Health Service Delivery Contracts	Implement Health Service Delivery Contracts.	539035	The budget is revised to fit the actual need.	Budget in 2013 will be over the original plan of 112,555 for HC MPA Contracts of 151HCs (2013) and 149 HCs (2012) under 10 OD-HSS. This is due to the fact that the service contracts through the contract system have been higher than expected.	615,157
1.2. Management Contracts for PHD/OD.	Implement the AOP contracts.	136220	As above.	This amount of budget is adjusted to the need of OD Management teams for supervision	152,580
1.3. Coverage Improvement Planning.	Implement integrated Coverage Planning in MPA.	60000		N/A	21,664
1.4. Fixed Site Strategy.	Implement/Monitor Fixed Site Strategy.	25000		N/A	18,000
2.1. Financial Management System.	Implement/Monitor FMS Guidelines.	10000	As above.	The majority of funds for HSS are for service delivery contracts. To sustain the contracts systems, more investment is needed in central and PHD level systems development (this applies to financial management, planning and supervision)	29,007
2.2. Planning System Development.	Implement AOP at HC-MPA as AOP Guideline.	45000	As above.	The majority of funds for HSS are for service delivery contracts. To sustain the contracts systems, more investment is needed in central and PHD level systems development (this applies to financial management, planning and supervision)	83,890
2.3. Integrated Supportive Supervision.	Implement integrated Supervision at PHD/OD.	69776	As above.	The majority of funds for HSS are for service delivery contracts. To sustain the contracts systems, more investment is needed in central and PHD level systems development (this applies to financial management, planning and supervision)	111,904
2.4. HSS Research/Assessment.	Conduct HSS/HSD Research/Assessment.	20000	As above.	To conduct one study a year (qualitative research studies) with a national research company with international TA cost approx. \$30,000 - \$40,000.	24,331
3.1. Middle Level Management.	Conduct capacity building for MLM staff.	46000		N/A	61,303
3.2. IMCI Service	Training on IMCI Skills to HCs.	0		IMCI investments to be made continuously for monitoring and supervision to accommodate the high turnover of staff.	63,470
3.3. Child Survival.	N/A	0		N/A	0
3.4. Public Private Mixed.	Workshop on Public and Private Collaboration.	10000		N/A	10,000
3.5. Project Management.	Support Workshops, Evaluations and TAs, Office etc.	136904		The budget has been adjusted (less than) from the original proposal due to the need to maintain annual and Mid-year program reviews, and to support a HSS coordinator and short term technical assistance.	122,964
		1097935			

9.6.1. If you are reprogramming, please justify why you are doing so.

No reprogramming is planned at this stage, although an internal review to be conducted in May and June 2012 may lead to some redesign of the contract system.

9.6.2. If you are reprogramming, please outline the decision making process for any proposed changes

If reprogramming results from the review, changes will be discussed in the Technical Working Group for Health (the main government and DP coordination mechanism) with approval through the Health Sector Coordination Committee.

9.6.3. Did you propose changes to your planned activities and/or budget for 2013 in **Table 9.6** ? **No**

9.7. Revised indicators in case of reprogramming

If the proposed changes to your activities and budget for 2013 affect the indicators used to measure progress, please use **Table 9.7** to propose revised indicators for the remainder of your HSS grant for IRC approval.

Table 9.7: Revised indicators for HSS grant in case of reprogramming

Name of Objective or Indicator (Insert as many rows as necessary)	Numerator	Denominator	Data Source	Baseline value and date	Baseline Source	Agreed target till end of support in original HSS application	2013 Target
N/A							

9.7.1. Please provide justification for proposed changes in the **definition, denominator and data source of the indicators** proposed in Table 9.6

There are no changes to denominators in 2011.

Some of the indicators have changed from the original proposal, but these changes were reported on and approved through a previous APR submission.

9.7.2. Please explain how the changes in indicators outlined in Table 9.7 will allow you to achieve your targets

N/A.

9.8. Other sources of funding for HSS

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

Table 9.8: Sources of HSS funds in your country

Donor	Amount in US\$	Duration of support	Type of activities funded
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.	20119	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."

NGOs Partners Working in the Operational District	15	2009-2011	NGOs Partners that operate their projects in the Operational District follow the Royal Government 's Policy by supporting for a service package of delivery and reproductive health with \$15.
Second Health Sector Support Program-HSSP2	1405	2009 - 2013	The Second 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.
The Royal Government of Cambodia	3580580	2011	The Royal 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. In 2011 it was calculated that amount of 3.580.580 USD was spent for delivery incentive. For 10-OD-HSS, it was 364.380 USD was spent for delivery incentive at HC.

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

9.9. Reporting on the HSS grant

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

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

Table 9.9: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
National Health Information System	Currently being validated through DQA System (see Annex to this APR) The Preliminary DHS report (attached) provides additional information on EPI and MCH coverage The SBK health system research project provides additional qualitative data on the impacts of GAVI HSS to date. CDHS-2010	When analyzing M & E of GAVI HSS, it should be recalled that the original 10 HSS ODs were selected based on lower EPI performance and absence of NGO support. Also, 2 new ODs were included in 2010, which effects the M & E system to some extent. The M & E system still enables monitoring of the program with or without inclusion of these two ODs in the data set. The change of denominator over the years also has created some difficulty with M & E. This is being managed through more careful monitoring of numbers of service contacts, and not only coverage.

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

The form is generally useful to use for reporting but there is some difficulty related to saving data(cannot put more words), especially in the part 9 of HSS.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2010?? 1

Please attach:

1. The minutes from all the HSCC meetings held in 2010, including those of the meeting which discussed/endorsed this report (**Document Number: 23**)
2. The latest Health Sector Review report (**Document Number:**)

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

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

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

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

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

11. Comments from ICC/HSCC Chairs

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

Comments from ICSC, TWGH and HSSC is attached in the minutes in the attached session.

12. Annexes

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

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

I. All countries that have received ISS /new vaccine introduction grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2011, 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 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR ISS AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS

1

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	Value in USD *
Balance brought forward from 2010 (balance as of 31Decembre 2010)	25,392,830	53,000
Summary of income received during 2011		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	Budget in USD	Actual in CFA	Actual in USD	Variance in CFA	Variance in USD
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

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

I. All countries that have received HSS grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2011, 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 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR HSS FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	Value in USD *
Balance brought forward from 2010 (balance as of 31Decembre 2010)	25,392,830	53,000
Summary of income received during 2011		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	Budget in USD	Actual in CFA	Actual in USD	Variance in CFA	Variance in USD
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

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

I. All countries that have received CSO 'Type B' grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2011, 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 2011 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 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR CSO 'Type B' FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	Value in USD *
Balance brought forward from 2010 (balance as of 31Decembre 2010)	25,392,830	53,000
Summary of income received during 2011		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	Budget in USD	Actual in CFA	Actual in USD	Variance in CFA	Variance in USD
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1		APR-2011-MOH Sign.jpg File desc: Signature of Minister of Health Date/time: 5/10/2012 10:33:00 PM Size: 522779
2	Signature of Minister of Finance (or delegated authority)	2.1		Cambodia-MoH-MEF-APR-Signatures-2012.jpg File desc: File description... Date/time: 6/15/2012 3:36:04 AM Size: 126914
3	Signatures of members of ICC	2.2		Signatory List -TWGH-12-Apr-2012-Cambodia.pdf File desc: Signatures of members of TWGH Meeting 12-Apr-2012-Cambodia Date/time: 5/2/2012 6:41:38 AM Size: 526645
4	Signatures of members of HSCC	2.3		Signature List-HSSC-17-Apr-2012-Cambodia.doc File desc: Signatures of members of HSSC Meeting 17-Apr-2012-Cambodia Date/time: 5/2/2012 6:44:14 AM Size: 389120
5	Minutes of ICC meetings in 2011	2.2		Minutes of TWGH-Meeting-13-April-2011.pdf File desc: Minutes of TWGH Meeting on 13 Apr-2011-Cambodia Date/time: 5/2/2012 10:03:13 PM Size: 385880
6	Minutes of ICC meeting in 2012 endorsing APR 2011	2.2		Minutes for TWGH Meeting on 12-Apr-2012.doc File desc: Minutes of TWGH Meeting in 2012 For Endorsing APR 2011-Cambodia Date/time: 5/10/2012 10:26:59 PM Size: 378880
7	Minutes of HSCC meetings in 2011	2.3		Minutes of HSSC-Meeting-26th-April-2011.pdf File desc: Minutes of HSSC Meeting on 26th-Apr-2011-Cambodia Date/time: 5/2/2012 9:52:44 PM Size: 415371
8	Minutes of HSCC meeting in 2012 endorsing APR 2011	9.9.3		17-04-12-Minutes of the Meeting of the Health Sector Steering Committee.pdf File desc: Minutes of HSSC Meeting in 17-04-2012-Cambodia Date/time: 5/16/2012 11:18:03 PM Size: 188300
9	Financial Statement for HSS grant APR 2011	9.1.3		Finacial Statement for HSS-NVS-APR-2011-Cambodia.pdf File desc: Financial Statement for HSS-APR-2011-Cambodia

				Date/time: 4/2/2012 1:04:24 AM Size: 169630
10	new cMYP APR 2011	7.7	✓	UPDATED cMYP NIP [2011] 2008-2015.pdf File desc: New cMYP-APR-2011-Cambodia Date/time: 5/8/2012 3:20:46 AM Size: 718162
11	new cMYP costing tool APR 2011	7.8	✓	UPDATED 2011 COSTING cMYP for Cambodia EPI 2000-2015 Final.xls File desc: New cMYP Costing Tool APR-2011-Cambodia Date/time: 5/8/2012 3:24:27 AM Size: 568320
13	Financial Statement for ISS grant APR 2011	6.2.1	✗	Financial Statement for ISS-Grant-2011.pdf File desc: Financial Statement for ISS Grant APR 2011-Cambodia Date/time: 5/21/2012 4:38:43 AM Size: 276638
14	Financial Statement for NVS introduction grant in 2011 APR 2011	7.3.1	✓	Financial Statement for HSS-NVS-APR-2011-Cambodia.pdf File desc: Financial Statement for NVS-APR-2011-Cambodia Date/time: 4/2/2012 1:06:03 AM Size: 169630
15	EVSM/VMA/EVM report APR 2011	7.5	✓	EVM_report-Cambodia - Final 13 Mar 2012.pdf File desc: EVM Report APR -2011-Cambodia Date/time: 5/8/2012 3:29:55 AM Size: 1960066
16	EVSM/VMA/EVM improvement plan APR 2011	7.5	✓	EVM-Improvement-plan-Cambodia-2012 - Final.pdf File desc: EVM-Improvement Planning-Cambodia Date/time: 3/29/2012 11:00:40 PM Size: 8075
17	EVSM/VMA/EVM improvement implementation status APR 2011	7.5	✓	EVM_report-Cambodia - Final 13 Mar 2012.pdf File desc: EVM improvement implementation status APR 2011 Date/time: 5/21/2012 11:56:29 PM Size: 1918826
19	External Audit Report (Fiscal Year 2011) for ISS grant	6.2.3	✗	External Audit Report ISS-2011.doc File desc: External Audit Report ISS-2011 [will be reported] Date/time: 5/21/2012 11:42:42 PM Size: 30208
20	Post Introduction Evaluation Report	7.2.2	✓	Penta PIE CAM v3.doc File desc: Post Introduction Evaluation Report Date/time: 5/22/2012 4:00:08 AM Size: 62976
				Minutes for TWGH Meeting on 12-Apr-2012.doc

21	Minutes ICC meeting endorsing extension of vaccine support	7.8		File desc: Minutes ICC(TWGH) Meeting Endorsing for extension of vaccine supports Date/time: 5/22/2012 12:38:58 AM Size: 378880
22	External Audit Report (Fiscal Year 2011) for HSS grant	9.1.3		External Audit-HSS- 2011-Report.doc File desc: External Audit-HSS-2011-Cambodia[Will be reported] Date/time: 5/21/2012 11:45:01 PM Size: 30208
23	HSS Health Sector review report	9.9.3		GAVI Final Assessment Survey of 24 Hours Opening MPA-HSS-June-2011-Cambodia.pdf File desc: Part of HSS Health Sector Review-2011 Cambodia Date/time: 5/21/2012 11:48:45 PM Size: 1483324