Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analysed, and explained where relevant.

Country	Cambodia
Reporting period	*January to December 2015 (updates up to June 2016 also included)*
Fiscal period	*January to December 2015*
If the country reporting period deviates from the fiscal period, please provide a short explanation	*Not applicable*
Comprehensive Multi Year Plan (cMYP) duration	*2016-20*
National Health Strategic Plan (NHSP) duration	*2016-20*

1. SUMMARY OF RENEWAL REQUESTS

[These tables will be pre-populated by the Gavi Secretariat. If there are any changes to be made, this should be discussed as a group during the joint appraisal and flagged in the report – see the guidance document for more details]

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
PCV in existing presentation	*Extension*	*2017-2018*	*As per vaccine renewal request*	*US$*	*US$ 2,660,500*
Pentavalent vaccine in existing presentation	*Extension*	*2017-2018*	*As per vaccine renewal request*	*US$*	*US$ 1,577,00*
HPV demo	*Renewal*	*2017*	*Pilot districts*	*US$*	*US$*
IPV	*Renewal*	*2017*	*As per Gavi rules*		*US$ 795,500*

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	Measles-Rubella follow-up campaign	*2016*	*2017*
	Cold chain equipment optimization platform	*2017*	*2018*
	Japanese encephalitis vaccine (routine)	*Probably not eligible*	*2017*

**Not applicable for countries in final year of Gavi support*

2. COUNTRY CONTEXT *(maximum 1 page)*

This section does not need to be completed for joint appraisal update in interim years

[If relevant, comment only on any changes since the previous joint appraisal to key contextual

factors that directly affect the performance of Gavi grants – see guidance document for more details]

The oversight of both EPI and HSS programs is provided by the Technical Working Group on Health (TWGH). The TWGH meets every month, is chaired by Secretary of State, has members from the Government (both National and Provincial) and development partners, and its decisions are followed up for the required actions.

There is high level political commitment for immunization as evidenced by significant domestic funding. There was still a challenge to obtain the overall funding for routine immunization especially for the sub-national level funding/expenditures. The domestic fund spent for vaccines was around 30% of the total vaccine costs in 2015.

Based on the 2014 DHS survey, immunization coverage for the third dose pentavalent vaccine (DTP-HepB-Hib) and first dose measles containing vaccine was 83.7% and 78.6% respectively, with significant difference among different wealth quintiles (e.g. 96.2% among the highest vs 71.2% among the lowest for MCV1). There was also huge discrepancy in the coverage among the provinces (97.9 in Takeo, 55.9% in Rattanak Kiri) and between mothers with post-secondary education (98.8%), mothers with no education (69%).

Various programme reviews organized by MOH have indicated that the most un/under-vaccinated children are from the high-risk communities (HRC), including remote rural locations, urban poor, migrants and mobile workers and ethnic minority groups.

The Ministry of Health (MOH). Cambodia has developed and implemented an immunization high-risk community strategy to address this issue with 1,832 high-risk communities identified; and the existing HSS (since 2014) and the new HSS grant provide funding support to implementation of the HRC strategy. In 2015, three rounds of outreach activities conducted in 1,832 high-risk communities achieving additional 17,862 of Penta3 (about 5%) of the annual Penta3 doses.

It has been reported by NIP, after issue of Sub-decree 216 in 2014; routine outreach immunization services and implementation of the HRC strategy have been both largely stopped in the past several months. On 03 August 2015, the Ministry of Economic and Finance issued a letter to the MoH allowing to use the national budget for outreach activities for far villages within the administrative district. There was also report of less number of outreach activities implemented due to the new higher per diem rate. Given about 31% vaccination services are provided through outreach services in the country in 2015, both NIP and the key EPI partners have raised a deep concern on possible sharp decline of immunization coverage. Cambodia experienced VDPV in early 2015 and two small measles outbreaks in early 2016.

3. GRANT PERFORMANCE AND CHALLENGES *(maximum 3-4 pages)*

Describe only what has changed since the previous year's joint appraisal. For those countries conducting the joint appraisal 'update', only include information relevant to upcoming needs and strategic actions described in section 5

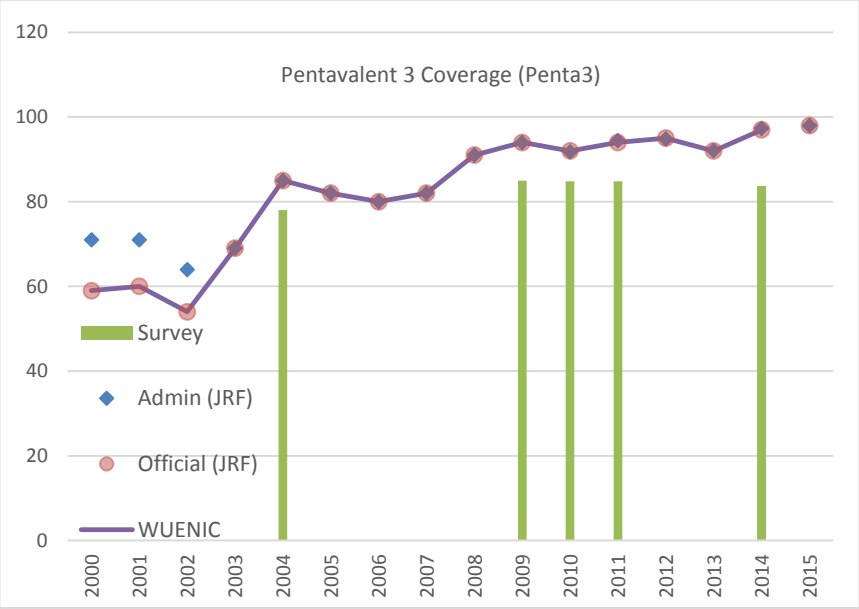
3.1. New and underused vaccine (NVS) support

3.1.1. Grant performance, lessons and challenges

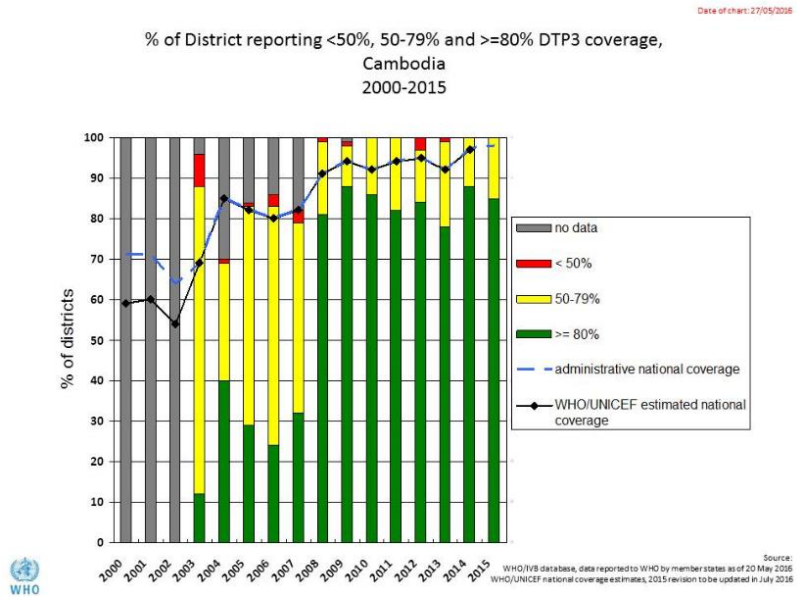
[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: programmatic performance of each vaccine programme against approved targets and planned activities,

including progress and bottlenecks in implementation; actual versus planned financial expenditure, associated challenges, proposals for using unspent funds, and complementarity between all cash grants]

- Cambodia has been sustaining its polio eradication status since 2000. In March 2015, Regional Verification Commission for measles elimination verified that the country has achieved measles elimination status. It is also noted that few sporadic cases of measles were reported as importations and have been managed, retaining the elimination status. In June 2015, WHO validated Maternal and Neonatal Tetanus Elimination (MNTE).
- By introducing three vaccines (PCV, JE and IPV) from January 2015 to March 2016, Cambodia also achieved a goal of "all low- and middle-income countries introduce one or more new or underutilized vaccines by 2020" set in Regional Framework for Implementation of the Global Vaccine Action Plan in the Western Pacific.
- The Pneumococcal Conjugate Vaccine (PCV) and Inactivated Polio Vaccine (IPV) were introduced into routine immunization system nationally in January and December 2015 respectively. Japanese Encephalitis vaccine mass campaign targeted aged 9 months to 14 years old children have been conducted in March 2016. A total of 4,172,432 children 9 months to 14 years were immunized by JE vaccine in the campaign. Cambodia wishes to have a seamless transition to routine introduction of JE vaccine for this year funded by government and would welcome Gavi support from middle of 2017 as was informed during the appraisal mission.
- Cambodia successfully completed the switch from tOPV to bOPV in April 2016.
- As per JRF, the coverage for routine vaccines used in routine system in 2015 have been stable or slightly declined. For example, HepB birth dose (<24 hours) coverage is 84% in 2015 compared to 87% in 2014. There was a slight reduction in MCV coverage from 73% to 72%. Though PCV vaccine was introduced in January 2015, 77% children were immunized by third dose of PCV vaccine in same reporting year.



- A total of 54 ODs and 48 ODs achieved more than 95% coverage of Penta3 and MR1 coverage in 2015 respectively compared to 44 and 36 ODs in 2014.



- Following the recommendations from WHO and the measles 2nd dose post introduction evaluation (PIE) conducted in June-July 2014, the MOH replaced the 2nd routine dose of measles vaccine with MR vaccine from 2015. Since 2015, the measles and rubella routine vaccination schedule has been (i) MR-1 at 9 months of age and (ii) MR-2 at 18 months of age.
- There is no report of stock-out of any vaccine in 2015. The country is procuring additional doses for JE vaccine to ensure full coverage with the SIA, which added MR and Polio vaccines in selected provinces/districts.

Challenges:

- Stopping of routine outreach activities in most provinces in 2015 (refer to 2015 JA report) and funds are still not available in many operational districts (ODs). This underscores a systematic weakness with program operations by health department of the provincial government.
- Coverage with MCV2 has slowly progressed from 63% in 2013 to 72% in 2015. Majority of the provinces lag behind in attaining the set target (≥95%) for MCV 2 coverage, with only 2 (8%) provinces reaching this target in 2015.
- Still to achieve ≥90% district coverage for all vaccines in the immunization programme set in Regional Framework for implementation of GVAP in Western Pacific endorsed by Regional Committee Meeting (RCM) in 2014.
- Monitoring of immunization coverage is likely to be affected by quality issues, primarily in terms of denominator but also in terms of numerator. Most recent DHS (2014) showed coverage level lower than reported coverage and WHO-UNICEF estimates have been slightly revised downward.
- Transfer of funds for procurement of traditional vaccine and ancillaries' cost to UNICEF is delayed in 2016.
- While routinely and closely monitored, drop-out continues to pose a challenge. For example, JRF data shows drop out as 6% for Penta1-3, 25% for PCV1-3 and 24% for MR1-2.

3.1.2. NVS future plans and priorities

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: for existing vaccines - reasonableness of targets for next implementation year, plans for any changes in presentation or type, risks to future implementation and mitigating actions; for new applications – any

expected future applications (include in table 1 above), emerging new priorities for the national immunisation programme]

- Cambodia does have sentinel surveillance for Rotavirus disease in place (1,090 reported cases of which 553 tested positive). Following a review of available data and evidence and a consideration of other priorities, Rotavirus vaccine introduction is not being considered as yet in the near time horizon.
- Cambodia has adopted a national target of ≥95% coverage for Penta3 and MCV1 and 90% of districts with Penta3 coverage ≥80% by 2020. These are appropriate targets given current performance and provide assurances of continued prioritisation of immunisation by the Government of Cambodia.
- HPV demo project will be launched in December 2016. Adequate preparations are in place for the introduction.

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

[Comment on the extent to which the HSS grant contributes to improve coverage and equity in access to immunisation, and how it helps to address the technical, health systems and financial bottlenecks that might jeopardize the sustainability of these gains. See guidance document for more details]

With regards to the main objective of GAVI HSS to support addressing the bottlenecks of the system to achieve better immunization outcomes, including increased vaccination coverage and more equitable access to immunization, Cambodian HSS grant was designed with the following five objectives:

1. Increase immunization coverage in high risk communities;

2. Strengthen cold chain system through improved equipment and management;

3. Increase community awareness of, and demand for, immunization;

4. Strengthen the surveillance of vaccine-preventable diseases (VPDs);

5. Strengthen management capacity to support EPI.

Cambodia received its first HSS grant tranche of $4,299,456 at the beginning of February 2016. The national immunization programme (NIP) and other recipient departments developed the annual operating plan (AOP) and semester plan, received approval from Ministry of Health and started implementing the activities from May 2016.

Cambodia has achieved substantial progress in increasing immunization coverage over the last decade. However, as per CDHS 2014, 27 percent of children remain unvaccinated from basic vaccines. Most of these children are located in high risk communities (HRC).

The objectives laid out in the original HSS grant proposal remain relevant for current bottlenecks and particularly Cambodia's targets to improve coverage and equity (particularly geographical equity).

The immunization supply chain system is at risk because of most equipment is very old. There is also low storage capacity in few Operational Districts. Maintenance remains major challenges.

Substantial proportion of the population in rural areas, and especially in high-risk communities, have low formal education and literacy levels. There is poor understanding of immunization, especially among mothers, and concerns around decreasing demand for immunization.

The vaccine-preventable disease surveillance system is still weak and quality widely varies across provinces. There is less capacity among lower level staff and to manage the system on a more sustainable basis.

There are number of weaknesses in the management of NIP. There is low capacity to analyze and use data in planning. Effective coordination with other departments at central level and sub-national level remains challenge for immunization program to be implemented with greater efficiency and impact.

Activities listed in HSS grant from 2016-2020 will allow to remove the bottlenecks and facilitate to improve the system development and increase the immunization coverage.

3.2.2. Grant performance and challenges

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: achievements of targets and intermediate results; actual versus planned activity implementation and financial expenditure; use of PBF reward and budgets/plans; degree of participation of key stakeholders in implementation of HSS proposal; implementation bottlenecks and key challenges regarding financial management of HSS grant; compliance with data quality and survey requirements]

NIP conducted three rounds of High Risk Communities' outreach immunization services in 2015 and substantial numbers of children were immunized by all the vaccines used in immunization programme (i.e.:OPV3-18,243, PCV3, 17,541, Penta3- 17,862, MR1-22,132, MR2-29,454). This information was provided during the field visit though unclear how this is collected. However, according to 2014 CDHS, 27% children remain to receive basic vaccination. As per the administrative data in 2015, 14 ODs are having less than 80% and 38 ODs are having less than 95% coverage for penta3 in compare to 10 ODs and 37 ODs in 2014. Similarly, 44 ODs are having less than 95% coverage for MR1 compare to 44 ODs in 2014. VPD cases detection and reporting were good in 2015 though relying on incentives. However, some performance indicators for measles are still low.

In the year 2015, the Internal Audit Department (IAD) has audited 9 PHDs, 10 ODs, and 30 HCs on five indicators as stated in the agreement on the strengthening of health system. Findings were compiled and recommendations were made to improve programme and financial issues.

Six programme/departments such as NIP, Department of Planning and Health Information (DPHI), Communicable Disease Control Department (CDC), Department of Budget and Finance (DBF), Preventive Medicine Department (PMD), and the Ministry of Health (MoH) Internal Audit Department (IAD) was the recipient of previous HSS grant.

With respect to the new HSS grant 2016-2020, the National Maternal and Child health center (NMCHC) is the responsible agency for financial management. However, due to delayed Programme Capacity Assessment (PCA) by Gavi, it was decided to continue to manage Gavi funds by the Department of Budget and Finance (DBF) and once assessment done, NMCHC will take over the responsibilities. The assessment has been scheduled in second half of September 2016.

Funds will be disbursed to Provincial Health Departments (PHDs), other departments of Ministry of Health and NIP on a yearly basis. The disbursement system for operational districts and health centers remains unchanged i.e. monthly) As the HSS grant was designed in 2014, Joint Appraisal team discussed and agreed to have some minor adjustments in some areas of immunization programme.

Due to the delay in starting this HSS grant, reporting against agreed metrics in their grant performance framework will only start in 2017. During the JA mission, all metrics were discussed, Several definitions of indicators were improved upon, data sources were re-confirmed and importantly, targets discussed. The country was asked to consider the feasibility of setting additional equity related targets beyond geographic equity.

Cambodia will have an EPI and VPD surveillance review in late 2016 / 2017. The last DHS was

conducted in 2014 and the EPI coverage survey planned in 2016 will provide an additional opportunity to understand coverage levels (although the methodology to be used for this survey is still being finalised). There has not been a thorough data quality assessment conducted in recent years and there are notable discrepancies in recent coverage estimates:

Administrative data	97% (2014); 98% (2015)
Official estimate	97% (2014); 98% (2015)
Survey data	84% (DHS 2014)
WUENIC	97% (2014)

During the JA, the possibility of focus on data related issues as part of the EPI review was discussed in order to develop a more focused data quality improvement plan based on the results of the review (particularly in view of recognition of concerns with denominators and numerators, as highlighted above). While a data quality improvement plan does exist for the broader HMIS, this is very high-level and does not have timelines nor a workplan with associated responsibilities attached to it.

Challenges:

- Immunization coverage by ODs showed, many ODs did not achieve desire target 95% for many antigens
- There is a lack of robust monitoring and measuring impact of activities to address HRC. While facilities do collect data on numbers vaccinated in these areas, they do not report this data separately or aggregate to show overall impact. How important are these high risk communities for overall coverage rates? How are they measuring the number of HRC become non-HRC?
- Outdated cold chain equipment and maintenance remains as major challenge. Recent EVM assessment recommendations require a timely implementation. The field trip emphasised that many provinces may be functioning at full capacity with current cold chain at provincial level – would need additional cold chain to support further vaccine introductions / more additions to their schedule.
- Inadequate staff capacity at peripheral levels on programme management
- Inadequate co-ordination between central NIP and sub-national staff
- Challenges with data quality and the need for a thorough assessment with time-bound recommendations to be taken forward
- Expenditures for NIP's reliant on donor funding.

3.2.3. Describe any changes to HSS funding and plans for future HSS applications

[Present the rationale for a new tranche of HSS funds (and the associated amount as per table in section 1) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming]

The second tranche for the HSS funding is already endorsed by the IRC. However, considering low utilization of funds from the first tranche of funds, the disbursement timing for next tranche will be reviewed in end-November 2016 taking into account the actual expenditures incurred.

Since the first tranche of HSS funds was received by the country in January 2015, the 2014 performance is not eligible for performance based reward.

During the JA, questions were raised about utilization of Gavi HSS funds for critical activities like hiring of staff like Finance officer, Finance assistant for which limited funds would be required. It was clarified that Cambodia could utilize the existing grant, if required after checking with the Senior Country Manager. Re-allocation or reprogramming is not necessary till it is determined that a major change in the objectivities or activities involving substantial funds

is required. The original grant design includes large array of the activities including staff hiring. An example for a major change is a probable new application for a future Gavi CCEOP support if the country determines that country co-investment should come from Gavi HSS support.

3.3. Transition planning *(if relevant)*

[Comment on all bolded areas listed in the table in this section of the guidance document, e.g. progress of implementation of planned activities; implementation bottlenecks; changes required to the transition plan for coming years, including rationale and costing/proposed financing]

As the country with lowest GNI per capita in Western Pacific region, Cambodia is far from transition. It does not require ramped up co-financing for the vaccines. Cambodia has never defaulted on its co-financing commitments. As such this section of the report is not applicable.

3.4. Financial management of all cash grants *(e.g. HSS, VIG, campaign operational cost grant, transition grant)*

[Comment on the bolded areas listed in the table in this section of the guidance document, e.g.: cash utilization performance and financial capacity constraints; modifications to financial management arrangements; major issues arising from cash programme audits or monitoring review; degree of compliance with Financial Management Requirements]

Currently, cash grants are managed in three streams – HSS, VIG/OC and ISS. Given the nature of the HSS application made by the country, it was determined that Gavi funds would be operated through a single financial management mechanism to be operated by National Maternal and Child Health center (NMCHC) which also manages the NIP. Gavi is yet to conduct the Program capacity assessment (PCA) which has delayed transition to the new arrangement. Consequently, the first tranche was transferred to the earlier HSS account. Government is keen that this assessment is completed by Gavi as soon as possible to allow the Government adopting the new financial management mechanism. A draft financial management protocol has been prepared and the country wishes to incorporate any particular requirements emerging from the PCA before adopting this.

According to financial status as of end March 2016, a balances of $21,000, $221,000 and $226,000 were available under ISS, previous HSS and VIG/OC heads respectively. These are in addition to $4.2million of the first tranche of the new HSS grant available in the Government account. During last year's JA, it was recommended that unspent balances should be transferred to the new account in NMCHC for a unified financial management. This action is pending since the program capacity assessment is yet to be completed by Gavi.

The Government complies with quarterly financial reporting and annual audit timelines. The financial reporting will shift to six monthly intervals. The audit for year 2015 is completed and the draft report by the contracted auditor is being reviewed by the Government before its submission to Gavi.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

[Status of top 5 prioritised strategic actions from previous joint appraisal and any additional IRC or HLRP recommendations (if relevant)]

Actions	Current status

1. Vaccine management • Regular physical count of pentavalent vaccine stock at central medical store (CMS) • MOH does not need to procure AD syringes (0.5ml) only for year 2016 • Ensure proper storing of vaccines	As per CMS staff, physical count of all vaccines conducted every month. No records of physical verification Done without any negative consequence Storage of vaccines need additional space in the CMS, however, EPI designated stores should avoid to store other items
2. Outreach activities: • Ensure routine and high risk strategies' for outreach services *(Note:* • *Almost 40% of immunization coverage is from outreach activities for routine and high risk communities stopped after issue of sub-decree 216 related to DSA – refer to 2015 JA report.* • *Concern about possible sharp decline in coverage may lead to disease outbreaks (measles, diphtheria)*	Three rounds of HRC outreach services were conducted in 2015. New guidelines for routine outreach were developed and implemented. The funding is inadequate for conducting routine outreach in many ODs and these activities
3. Human resource capacity • Recruit two additional accountants for NIP for new HSS grant. • Recruit two officers (cold chain officer and cold chain technician) in NIP.	On board since I July 2016 Not yet done.
4. Financial management: • ISS and VIG funds should be utilized; if not done by end 2015, transfer the balance to new account • 295K USD of HSS balance to be utilized for • Evaluation of existing grant • Orientation and operational planning for new grant • Evaluation of incentives system *(If HSS existing grant cannot be used by 2015, needs to be transferred to the new account)*	Not yet done. Orientation and operational planning for new grant was conducted in 2015. Evaluation is planned to be conducted from July to September 2016. The TORs to be shared with Gavi in advance

5. PRIORITISED COUNTRY NEEDS[1]

[Summarise the highest priority country needs and strategic actions that could significantly improve coverage, equity and financial sustainability; the timeline for completing the actions and the type of technical assistance needed if applicable – see guidance document for more details]

[1] Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

Prioritized needs and strategic actions	Associated timeline for completing the actions	Does this require technical assistance?* *(yes/no)* If yes, indicate type of assistance needed
Priority tasks for next year: • Sustain/improve coverage through fixed site, routine and high risk communities' outreach immunization activities • Improve the quality of immunization services • Build staff capacity and community awareness • Implementation of HPV demo project • EVM Improvement plan implementation • Conduct EPI coverage survey and EPI review • Strengthen NIP management capacity and timely procurement	2016-17	Government, WHO and UNICEF work as a team in Cambodia incorporating the technical support. It is difficult to segregate the activities by organizations.
<u>WHO</u> Technical support will be provided to NIP/MOH to implement HSS objectives 1, 2,3, 4 and 5 with following focus **Increase national wide immunization coverage especially in implementation of high risk communities' strategies; strengthening VPD surveillance system; and building staff knowledge and capacity to maintain NIP's achieved goals and attain new goals:** 50 activities and 97% HSS funds will be handled by the National Immunization Programme throughout the grant period. Therefore, NIP needs regular technical support and huge amount of staff-time investment from WHO. Given the human resource capacity in WHO CO- Cambodia, there is critical need to get additional support. (1) WHO will hire one additional international professional staff/consultant to support NIP for timely implementation of the HSS activities with quality with especial focus on creating demand for immunization and reducing the number of high risk communities and ensuring that geographic	2017-18	50% salary of one additional international professional staff/consultant

and wealth disparities in coverage are minimized; and improving knowledge and staff capacity including management. (2) Current National Professional Officer (NPO) will actively involve in VPD surveillance activities under HSS with an aim to reduce the variation of quality across the country and improve the performance indicators of VPD surveillance; and in development of NIP's staff capacity across the country for various areas of EPI. However, at present, there is no allocation of particular funds for the NPO and there is an insecurity of funds in coming years too.		Full-time WHO CO National Professional Officer
<u>UNICEF:</u> Technical support to implement the HSS objectives 1,2,3 and 5, with following focus: **Improvement of immunization supply chain with focus on cold chain maintenance**: In 2016, UNICEF will hire an international consultant to conduct the cold chain maintenance system and at the same time will hired a national cold chain maintenance technician to support the NIP to carry out activities to improve the cold chain maintenance system. UNICEF need to maintain the national cold chain maintenance technician. The national consultant will work closely with the technician of the National Immunization Programme and the working group to undertake the following tasks: Provide technical support to the NIP cold chain technician to develop the capacity provincial and district level managers in small cold chain maintenance. Provide technical support to NIP managers for maintaining up to date cold chain inventory and use for replacement purpose. Provide technical support to NIP for installing new refrigerators based on the	2017-18	From technical assistance envelope

NIP cold chain replacement plan. **<u>UNICEF Country Office (CO) National Health Officer:</u>** UNICEF has been facing a significant HR constraint in supporting immunization programme with only one national staff responsible to provide technical support to the NIP to carry out the implementation of EVM Improvement Plan, provide technical support to implement high risk immunization strategy as well as promote demand for immunization.		Full-time National Officer

**Technical assistance not applicable for countries in final year of Gavi support*

6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS

This section does not need to be completed for joint appraisal update in interim years, instead the EPI manager is expected to endorse the joint appraisal report.

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	The meeting of the Technical Working Group for Health (TWG-H), which works as ICC, was held on 7 July 2016. The Joint Appraisal team prepared the presentation for sharing Gavi support, findings, issues and recommendations. On behalf of team, Mr. Ork Vichit, NIP manager provided the presentation to TWG-H. The members of TWG-H endorsed the JA report (please see meeting minutes)
Issues raised during debrief of joint appraisal findings to national coordination mechanism	One of the member raised question why the Gavi fund could not be spent (underutilization) and what is the plan for unspent money? Same member also asked that in field she found there was stock-out of IPV vaccine in April, why? Another member asked, DPT coverage of 2013-2015 showed very high but there are many children remained unvaccinated in high risk and hard to reach areas, pockets. What action has been taken to reach un-immunized children? EPI Manager Mr Ork Vichit appropriately answered all the questions raised. Moreover, Prof . Eng Huot, chair of the TWG-H also supplemented answering question on Gavi unspent funds
Any additional comments from: • **Ministry of Health** • **Gavi Alliance partners** • **Gavi Senior Country Manager**	

Annex A. Description of joint appraisal process (e.g. team composition, how information was gathered, how discussions were held)

The time period for the JA was chosen in consultation with the Government and the partners in January 2016 during the Regional working Group meeting. The team composition consisted of Gavi (Senior Country Manager, M&E Officer), WHO (Regional Adviser and Technical Officer from WPRO) and in-country WHO and UNICEF colleagues. The JA mission was planned and conducted with overall collaboration and guidance of the Government. Key activities of the mission consisted of meetings with NIP/NMCHC, workshop with Government stakeholders, field visit to a province/operational district/health center, visit to the National Vaccine store and a debrief with the Secretary of State. The TWGH which represents both ICC and HSCC in Cambodia is scheduled for its monthly meeting on 7st July. In-country officials and partners would present the JA observations/recommendations.

The information was largely drawn from the Gavi country portal launched earlier this year. It included the required information from the latest joint reporting format. The JA mission opportunity was also utilized to go through the information and process on the portal to ensure that in-country colleagues are comfortable with this format for annual reporting, review and renewal.

During the JA process, it was felt that the JA template could be drafted even before a mission which could be used to focus on major issues/bottlenecks and/or advocacy for immunization performance, coverage and equity. Moving forward, it could be more effective to plan biannual Gavi missions linking up with activities like an EPI review, PIE or vaccine introduction. A deeper dive into provincial visits could get richer information on implementation of the high risk strategy, the mainstay of Gavi HSS support.