GAVI
THE GLOBAL ALLIANCE FOR VACCINES & IMMUNIZATION

Partnering with The Vaccine Fund

Progress Report

to the
Global Alliance for Vaccines and Immunization (GAVI)
and
The Vaccine Fund
by the Government of

COUNTRY: Cambodia

Date of submission: Tuesday 30th September 2003

Reporting period: January—December 2002

(Tick only one) :

Inception report	
First annual progress report	
Second annual progress report	✓
Third annual progress report	
Fourth annual progress report	
Fifth annual progress report	

Text boxes supplied in this report are meant only to be used as guides. Please feel free to add text beyond the space provided.
**Unless otherwise specified, documents may be shared with the GAVI partners and collaborators*

Progress Report Form: Table of Contents

1. Report on progress made during the previous calendar year

To be filled in by the country for each type of support received from GAVI/The Vaccine Fund.

1.1 Immunization Services Support (ISS)

1.1.1 Management of ISS Funds

Please describe the mechanism for management of ISS funds, including the role of the Inter-Agency Co-ordinating Committee (ICC). Please report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

First Immunization Services Support (ISS) funds were received in February 2002, and disbursement of funds began in quarter three. Funding was used to support such areas as regular technical supervision, planning meetings, training, IEC activities and materials, community representatives register births, and piloting incentives for health workers achieving and documenting certain outcomes.

The Ministry of Health (MoH) holds all Vaccine Fund monies in a separate bank account with the National Immunization Program (NIP) being responsible for developing and submitting a plan for using these funds, based partially on provincial and district plans, and requesting disbursements from the MoH. The NIP develops the plan in consultation with the Technical Working Group (TWG) and the Immunization Coordination Sub-Committee (ICSC). Funds are managed through the Senior Finance Officer.

GAVI funds were underspent in 2002 with the NIP electing to evaluate the initial use of funds and review targeting for 2003. In 2003, there will be a shift in emphasis from training and management to innovations in service delivery and IEC. Service delivery funds are invested in outreach agreements, Coverage Improvement Planning (CIP), and first quarter outreach funds. This budgeting is in response to the strategic objective of the NIP which is to increase coverage to 75% DTP3 to achieve the GAVI target.

The Ministry of Health requests that the 3rd ISS payment be split into two payments. The first payment of 50% ($334,300) should arrive as soon as possible, preferably in December 2003, along with Injection Safety funds. The second payment of 50% ($334,300) should arrive in early December 2004. The timing of these payments is vital for supporting immunization activities in the first quarter, when access to populations is the easiest and access to funding is the most difficult.

REF	PLAN COMPONENTS AND KEY ACTIVITIES	TOTAL EXPENDITURE ISS FUNDS 2002
1.0	Human Resources	
1.1	Training of Trainer	$25,577.70
1.2	Health centre Training	$3,878.95
1.3	Provincial Workshop	$2,014.20
	TOTAL	$31,470.85
2.0	Routine and Supplemental Immunization Services	

2.2	Field visit travel - Provincial and District	$17,751.40
2.3	Outreach (Catch up campaign routine immunization)	$17,612.70
2.4	Volunteer - Printing of T Shirt	$32,000.00
2.5	Print village birth registers	$8,700.00
	TOTAL	$91,549.70
	TOTAL EXPENDITURE FOR ALL ACTIVITIES 2002 (US$)	$123,020.55
	TOTAL RECEIVED	$334,300.00
	BUDGET REMAINING	$211,279.45

1.1.2 Use of Immunization Services Support

In the past year, the following major areas of activities have been funded with the GAVI/Vaccine Fund contribution.

Funds received during the reporting year US$334,300
Remaining funds (carry over) from the previous year 0

Table 1 : Use of funds during reported calendar year 2002

Area of Immunization Services Support	Total amount in US $	Amount of funds			
		PUBLIC SECTOR			PRIVATE SECTOR & Other
		Central	Region/State/Province	District	
Vaccines					
Injection supplies					
Personnel					
Transportation					
Maintenance and overheads					
Training	31,470.85		11,668.96	19,801.89	
IEC / social mobilization	40,700.00			40,700.00	
Outreach	17,612.40		540.00	17,072.40	
Supervision	17,751.70		7,570.00	10,181.70	
Monitoring and evaluation	15,485.60		1,410.00	14,075.60	

Epidemiological surveillance					
Vehicles					
Cold chain equipment					
Other ……. *(specify)*					
Total:	123,020.55				
Remaining funds for next year:	211,279.45				

If no information is available because of block grants, please indicate under 'other'.
Please attach the minutes of the ICC meeting(s) when the allocation of funds was discussed.

Please report on major activities conducted to strengthen immunization, as well as, problems encountered in relation to your multi-year plan.

- Introduction of AD syringes and safe disposal mechanism in routine activities starting 4th quarter 2002;
- Quarterly district meetings between Operational Districts (OD) and health centre staff to review progress for immunization;
- Support and strengthen supervision activity at all level;
- Initial implementation of the 2001 cold chain review recommendation;
- Regular TWG meeting;
- NIP/NGO meeting to co-ordinate support for outreach for the ODs and to share experience for accelerating immunization;
- Financial Sustainability Plan signed and submitted by MoH and MoEF at the GAVI Dakar meeting in November 2002;
- Conducted Functional Analysis with Personnel Department;
- Assessment of vaccine arrival system;
- KAP survey in Kampong Chhnang Province;
- GAVI FSP Guideline Testing;
- Assessment of NNT surveillance;
- Coordinated Rotary Japan District 2650 support for outreach in land mine-affected areas in 3 provinces;
- Conduct nationwide training to all health centers on injection safety, vaccine safety and conducting outreach;
- Produced IEC materials;
- Coordinated support from USAID, ECHO, AusAID, Government of Japan, CIDA, WHO, UNICEF, CVP/PATH and other donors;
- Pregnancy and birth registration tool introduced;
- NIP policy amended for DTP vaccination in thigh instead of arm, multidose vial policy, and addition of HepB birth dose to vaccine schedule;
- Post-Activity Assessment activities increased to help improve reporting quality
- Started 5-OD pilot of incentives to HW for each fully-immunized child-mother pair;
- Draft training strategy developed

- Work on communication strategy begun
- Training for new cold chain policy/guidelines delayed until 2003 to coincide with introduction of new equipment

Minutes of ICSC meetings attached as an annex.

1.1.3 Immunization Data Quality Audit (DQA) (*If it has been implemented in your country)*

Has a plan of action to improve the reporting system based on the recommendations from the DQA been prepared?
If yes, please attach the plan.

- Post Activity Assessment (PAA) initiated in 2002 to validate the reported coverage from the last outreach session and to evaluate the quality of the immunization session; the result is locally discussed at the OD/HC level and preliminary report to the HC and OD concerned for future improvement PAA helps address the gap in DQA of data quality between session (village) and register at HC;
- Strengthening system reporting by using the official MoH Health Information System;
- No DQA was implemented in 2002. DQA was conducted in August 2003.

YES ☐ *NO* ☒

If yes, please attach the plan and report on the degree of its implementation.

Please attach the minutes of the ICC meeting where the plan of action for the DQA was discussed and endorsed by the ICC.

Please list studies conducted regarding EPI issues during the last year (for example, coverage surveys, cold chain assessment, EPI review).

- No meeting to discuss DQA in ICSC meeting in 2002. Price Water House Coopers conducted the Official DQA in June 2003; the preliminary result was presented in the ICSC meeting 26 July 2003.
- No major evaluation or studies were conducted in 2002 except KAP survey in Kampong Chhnang Province which confirmed that while parents generally have positive views of vaccination, they have their children immunized opportunistically rather than actively seeking out immunization. Parents biggest concerns are side effects and lack of awareness of outreach sessions;
- Conducted Functional Analysis with Personnel Department
- Assessment of vaccine arrival system;
- CDC-supported evaluation of measles SIA and estimation of measles mortality;
- National injection safety assessment (both preventative and curative);
- FSP Guideline Testing

- Assessment of NNT surveillance

1.2 GAVI/Vaccine Fund New & Under-used Vaccines Support

1.2.1 Receipt of new and under-used vaccines during the previous calendar year

Please report on receipt of vaccines provided by GAVI/VF, including problems encountered.

In May 2002, NIP received 135,500 doses of combined DTP-HepB through UNICEF procurement service. All the vaccine arrived in the country without facing any problem. The vaccine arrival report was completed and sent to UNICEF.

1.2.2 Major activities

Please outline major activities that have been or will be undertaken, in relation to, introduction, phasing-in, service strengthening, etc. and report on problems encountered.

DTP-HepB introduction expanded to Kampong Tralach OD, as planned, in August 2002 to cover the remaining 11 of the 34 health centres in Kampong Chhnang province, a total provincial target population under 1 year of about 15,000. This August training covered over 80 health personnel and was used as a pilot for the nationwide training on immunization safety (including introduction of AD syringes and safety boxes into the routine program) and organisation of outreach sessions. DTP3 coverage for province was 76% in 2002.

In March 2002, a community/health worker KAP survey was conducted in preparation for IEC/social mobilization activities. Vaccine wastage monitoring has been implemented (remains high around 50% due to outreach activities) and is finally being intensified in 2003, when implementation and studying of strategies to reduce wastage will take place in Kg Chhnang.

NIP hosted a one-day seminar on Hepatitis B led by a trainer from Glaxo SmithKline. Invitees included a few EPI staff from different provinces, directors from the major hospitals, and several departments in the MOH in addition to many NIP staff.

Expansion to 3 other provinces to reach 25% national target occurred in 1st quarter 2003, and initial results indicate increased coverage in these provinces. The HepB birth dose will be introduced in 2003 in all health facilities in Phnom Penh and referral hospitals in other provinces with DTP-HepB. A pilot was conducted in Kampong Chhnang Province and in health centres to examine the feasibility of providing it at rural health centres.

Cambodia expects to develop plan for introduction of birth dose nationwide and to submit an application in April 2004 to GAVI for support of monovalent HepB for 5 years.

1.2.3 Use of GAVI/The Vaccine Fund financial support (US$100,000) for the introduction of the new vaccine

Please report on the proportion of 100,000 US$ used, activities undertaken, and problems encountered such as delay in availability of funds for programme use.

USD100,000 funds received for new vaccines was budgeted for use after an assessment in 2003 of the pilot introduction activities and then will be used to support national expansion of combined DTP-HepB vaccine in 2004.

1.3 Injection Safety

1.3.1 Receipt of injection safety support

Please report on receipt of injection safety support provided by GAVI/VF, including problems encountered

The injection devices, consisting of 334,500 AD syringes for BCG, 1,514,960 other AD syringes, 65,500 reconstitution syringes and 21,300 safety boxes were received in March 2002 without incident.

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

Please report on the progress based on the indicators chosen by your country in the proposal for GAVI/VF support.

Indicators	Targets	Achievements	Constraints	Updated targets
1. % of Health Centres with 100% AD use for all EPI vaccines and safe disposal practices; 2. % of Operational Districts with adequate access to appropriate disposal system, including exchange mechanism for new and used injection equipment; 3. % of Operational Districts with adequate stocks of injection equipment for the whole year; 4. (%) of AD used in excess of vaccine doses given, by Operational District.	Target for indicators 1-3 is 80% by 2003 and 100% by 2005. No target for indicator 4 in original plan.	1. 100% 2. 100% ODs have access to a functioning incinerator. Only 25/75 ODs have an incinerator but provide access to all via transportation support. 3. Assume 100%. No stock-out or special request reported. 4. n/a	1. Supervision report does not always include the use of AD and safe disposal of used syringes. 2. Transportation of used syringes in the safety boxes to the incinerator sites (long distance, large quantity). Little monitoring of safe disposal system. 3. Supervision report does not include information on stock usage. 4. A mix-up with AD used in SIA has made the figure difficult to calculate for routine.	1. Achieved 2. Keep the same 3. Keep the same 4. 10% nationwide rather than focus on OD level

1.3.3 Statement on use of GAVI/The Vaccine Fund injection safety support (if received in the form of a cash contribution)

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

The monetary portion of this award ($91,100) was received in February 2002 with the other sets of funds, and this funding was primarily used for injection safety training (vaccinators and incinerator operators) and the production of supporting materials for education.

Introduction of the safe injection supplies occurred along the lines of the national plan submitted to GAVI September 2001 with the Inception Report. The introduction

into the routine program started October 2002 in all operational districts in the country including installation of incinerators in 23 out of 24 provinces by end of 2002.

Auto-disable syringes and safety boxes for used syringes with a safe disposal mechanism have been used in routine immunizations since October 2002. The introduction was successfully implemented with training of 221 province and district level in the training of trainer (TOT) followed by training of 2,610 health centre staff using the participants from the TOT as the trainers.

MoH organised and hosted annual SIGN meeting in October 2002.

2. Financial sustainability

Inception Report :	Outline timetable and major steps taken towards improving financial sustainability and the development of a financial sustainability plan.
First Annual Report :	Report progress on steps taken and update timetable for improving financial sustainability Submit completed financial sustainability plan by given deadline and describe assistance that will be needed for financial sustainability planning.
Second Annual Progress Report :	Append financial sustainability action plan and describe any progress to date. Describe indicators selected for monitoring financial sustainability plans and include baseline and current values for each indicator.
Subsequent reports:	Summarize progress made against the FSP strategic plan. Describe successes, difficulties and how challenges encountered were addressed. Include future planned action steps, their timing and persons responsible. Report current values for indicators selected to monitor progress towards financial sustainability. Describe the reasons for the evolution of these indicators in relation to the baseline and previous year values. Update the estimates on program costs and financing with a focus on the last year, the current year and the next 3 years. For the last year and current year, update the estimates of expected funding provided in the FSP tables with actual funds received since. For the next 3 years, update any changes in the costing and financing projections. The updates should be reported using the same standardized tables and tools used for the development of the FSP (latest versions available on http://www.gaviftf.org under FSP guidelines and annexes). Highlight assistance needed from partners at local, regional and/or global level

Cambodia was one of two countries to conduct a pre-test of the Financial Sustainability Plan (FSP) Guidelines. The team, provided by the GAVI Financing Task Force, conducted the study in March 2002.

During 2002, the WHO and World Bank provided support to the NIP through a local accounting consultant to focus on improved management capacity of the NIP in order to sustain the FSP process.

The NIP hosted a consultant (July 2002) to support the development of the FSP. A draft 7-year plan was discussed with the Immunization Coordination Sub-Committee (ICSC) on 26 July. The FSP consultant returned in November 2002 and facilitated the completion of the FSP which was presented and approved by the ICSC on 14 November 2002. Cambodia was one of the first countries to successfully develop a FSP for GAVI and the plan was approved in April 2003.

The Plan outlines current and forecasted financial expenditures on immunization with projections extending to 2009. The Plan includes six key areas for action:

1. Increase national government financial contribution to immunization services;
2. Increase provincial level expenditures for immunization services;
3. Increase donor funding for immunization;
4. Increase reliability of funding for immunization at all times;
5. Reduce vaccine wastage; and
6. Improve efficiency of outreach sessions.

In 2002, the Ministry of Health Cambodia invested $152,600 for vaccine purchase for the National Immunization Program. In 2003, the Ministry of Finance and Ministry of Health approved $450,000 for vaccine and immunization supplies. The government planned contribution in 2003 amounts to 35% of the overall NIP budget needs (excluding supplementary). The NIP attributes this large increase in government investment in immunization in part to the advocacy to high levels of government that has been associated with the financial sustainability process. 2002 and into 2003 was a challenging period for financing of the NIP in Cambodia. Release of 2003 funds from the Ministry of Finance to the health and other sectors was significantly delayed, impacting delivery of services and coverage. Similarly, UNICEF has received less funds which can be made available for outreach support outside of six target provinces. AusAID, traditionally one of the largest supporters of immunization, implemented a central policy change to dis-invest from the health sector across the region.

Follow-up implementation has focussed on initiating activities, which will move these key areas forward including integrating supporting activities and objectives from the FSP into the NIP Program Plan. Moreover, additional technical support will be provided to promote local ownership of the FSP through integration with local planning systems and by building the capacity of the NIP for self-reliance in FSP analysis and presentation.

(a) Assist the NIP to develop a 3-year rolling plan, based on new Ministry of Health (MoH) planning guidelines. This plan is based on six key areas in the sector plan including human resource development, institutional development, health financing, service delivery, quality improvement and behaviour change. All central programs and provincial health departments will set objectives/indicators for a 3-year period based on these key areas. The first year includes costed activities with financial projections for years two and three. There is an obvious association between the FSP and the new planning system in terms of identification of financing as a key area for development and 3-year financial projections for service delivery/programs. (expect completion mid-2003)

(b) Integrate FSP objectives into NIP Plan. Financing is one of the six key areas of the health sector plan and consequently the NIP 3-year rolling plan. For the FSP to be a useful and sustainable tool, the strategies need to be integrated into the Plan. Currently, the FSP is being used extensively for NIP Planning. (expect completion mid-2003)

(c) Strengthen the capacity of the NIP to update the FSP. The NIP has specifically indicated that it would like to develop an internal capacity to update and adapt the FSP. This refers in particular to regular updates of the funding gap analysis. Technical assistance will be required during 2003 to increase the capacity of the NIP to do this including mentoring of financial and administration staff. Data management tools for the FSP have been updated and introduced to the NIP. (Ongoing 2003)

(d) Make a cost estimate of improving coverage. Based on current FSP, the cost of a DTP3 immunised child in Cambodia is USD11.14. This is an initial estimate

and may be an overestimation because it includes cost for the delivery of several other services. The Coverage Improvement Planning (CIP) process is providing additional data on the costs of immunising every child in Cambodia and a comparative of the costs between immunization activities in remote as compared to urban areas. The CIP is currently targeted in 10 Operational Districts and the NIP intend to extend a modified CIP to all provinces in 2004 after an evaluation (using ISS funds). This establishes an important link between financial sustainability and improved coverage, and is a critical advocacy strategy. (ongoing 2003)

(e) Conduct a provincial level financial needs analysis. 80% of coverage is obtained through outreach activity. Outreach funding is managed through Provincial Health Departments and disbursed through District Health Offices. As with the above strategy, this would furnish information on the cost of immunising every child in Cambodia.

(f) Develop presentation of health financing/health economics indicators based on the findings of the FSP. Presentation of clear health economics information, eg cost per immunised child in Cambodia, that has the potential to inform policy and resource allocation to influence major donors. The current FSP is of value in terms of it's identification of the financial gap and recommendations for key activities to address the gap. These activities are more likely to occur if there is direct evidence of the cost effectiveness of intervention.

(g) Develop advocacy tools in order to assist the NIP to access resources which address the identified funding gaps. Technical assistance was provided by CVP and the GAVI FTF to develop advocacy strategies for national implementation (July 2003). Some progress on implementing these strategies has already been made including advocacy to the MoH by WHO and UNICEF for increased funds for vaccines using the Vaccine Independence Initiative (VII) mechanism, and the inclusion of two immunization indicators in the Cambodia Poverty Reduction Plan.

(h) Provide advocacy tools for monitoring and management support terms to advocate at provincial level regarding coverage rates and outreach funding. The NIP is in the process of establishing regional monitoring and management support teams in order to provide a boost for routine immunization and to support introduction of CIP. (ongoing)

(i) Introduction of senior level management monitoring and management support system. This system was introduced in mid-2003 with senior level NIP managers reporting on health financing. The monitoring system allow questions to be asked as to how to improve the flow of funds and to report aggregated data to the MoH. (2003)

(j) Establishment of Performance Based Outreach agreements.

The GAVI Independent Review Committee made a number of comments on the original FSP, including the need to consider further analysis of the financing gap. This has been done, suggesting that the gap, while seemingly large, is tempered by some assumptions of the future. Among the analyses:

- Overall positive economic growth (2-6% per year) is forecasted, with allocations to the health sector increasing even faster
- Vaccines comprise $2.1 million or approximately 28% of the overall gap post-2006. However this gap presumes a fixed price for vaccines and injection supplies.

The NIP has prioritized strategies within the FSP to increase the impact of approaches. Priority strategies have been:

1. Increase national government commitment to NIP
2. Provide reliable funding of strategies at all times. This eventually may lead to increases in resources from the Provincial Health System, but focuses on reliable funds from central levels to implement outreach activities.

More specific details are appended as an annex to this report.

3. Request for new and under-used vaccines for year 2004

*Section 3 is related to the request for new and under used vaccines and injection safety for the **forthcoming year**.*

3.1. Up-dated immunization targets

Confirm/update basic data (= surviving infants, DTP3 targets, New vaccination targets) approved with country application: revised Table 4 of approved application form.

DTP3 reported figures are expected to be consistent with those reported in the WHO/UNICEF Joint Reporting Forms. Any changes and/or discrepancies **MUST** be justified in the space provided (page 10) . Targets for future years **MUST** be provided.

Table 2 : Baseline and annual targets

Number of	Baseline and targets							
	2000	2001	2002	2003	2004	2005	2006	2007
DENOMINATORS								
Births	485, 923	497,780	477,287	489,172	501,352	513,836	526,630	539,744
Infants' deaths	51,150	52,398	50,241	51,492	52,774	54,088	55,435	56,815
Surviving infants	434,774	445,382	427,046	437,680	448,578	459,748	471,196	482,928
Infants vaccinated with DTP3*								
Infants vaccinated with DTP3: administrative figure reported in the WHO/UNICEF Joint Reporting Form	342,472	299,952	266,193	240,724	179,431	0	0	0
NEW VACCINES								
Infants vaccinated with DTP-HepB3*	0	479	8,916	87,536	179,431	367,798	376,956	386,342
Wastage rate of DTP-HepB**			52	35	35	30	25	25
INJECTION SAFETY								
Pregnant women vaccinated with TT	196,068	200,349	207,519	342,420	426,149	436,760	447,635	458,781
Infants vaccinated with BCG	342,472	319,836	318,761	328,260	358,862	367,798	376,956	386,342
Infants vaccinated with Measles	283,827	284,925	265,540	328,260	358,862	367,798	376,956	386,342

* Indicate actual number of children vaccinated in past years and updated targets **(WHO/UNICEF Joint Reporting Form has DTP3 and DTP-HepB3 combined under DTP3).**

** Indicate actual wastage rate obtained in past years

Please provide justification on changes to baseline, targets, wastage rate, vaccine presentation, etc. from the previously approved plan, and on reported figures which differ from those reported in the WHO/UNICEF Joint Reporting Form in the space provided below.

Denominators in 2002 were the same as Joint WHO/UNICEF Annual Report 2002 which is based on the National Health Statistic Report 2001 with estimated annual increase in population growth of 2.49%. This figure is lower than the estimation included in the previous report because the government has provided a new estimation of the population.

3.2 Confirmed/Revised request for new vaccine *(to be shared with UNICEF Supply Division)* **for the year 2004**

Please indicate that UNICEF Supply Division has assured the availability of the new quantity of supply according to new changes.

In 2004, Combined DTP-Hepatitis B vaccines 837,100 doses have been assured by UNICEF Supply Division with the planed delivery of 418,500 doses in March and 418,600 doses delivery in September.

Table 3: Estimated number of doses of DTP-HepB vaccine*(specify for one presentation only)*:

		Formula	For year 2004
A	**Number of children to receive new vaccine**		179,431*

Remarks

- **Phasing:** Please adjust estimates of target number of children to receive new vaccines, if a phased introduction is intended. If targets for hep B3 and Hib3

B	**Percentage of vaccines requested from The Vaccine Fund taking into consideration the Financial Sustainability Plan**	*%*	100
C	**Number of doses per child**		3
D	**Number of doses**	*A x B/100 x C*	538,293
E	**Estimated wastage factor**	*(see list in table 3)*	1.54
F	**Number of doses (incl. wastage)**	*A x C x E x B/100*	828,144
G	**Vaccines buffer stock**	*F x 0.25*	207,036
H	**Anticipated vaccines in stock at start of year 2004**		288,000
I	**Total vaccine doses requested** [1]	*F + G - H*	837,100
J	**Number of doses per vial**		10
K	**Number of AD syringes (+ 10% wastage)**	*(D + G – H) x 1.11*	607,446
L	**Reconstitution syringes (+ 10% wastage)**	*I / J x 1.11*	-
M	**Total of safety boxes (+ 10% of extra need)**	*(K + L) / 100 x 1.11*	6,743

[1] While the formula in line I give 747,180 doses, Cambodia will require the full allotment of 837,100 doses to help offset the 224,620 doses required Q1 2005 (3 months, 80% coverage, and 30% wastage for 57% of country [equivalent to 50% of population with 2004 phase-in schedule]) before the first supply of 2005 DTP-HepB arrives. Cambodia would appreciate any additional supply, and could easily accommodate an additional 25,000-200,000 doses, to help maintain buffer stock and accelerate vaccine introduction.

Table 3 : Wastage rates and factors

Vaccine wastage rate	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%
Equivalent wastage factor	1.05	1.11	1.18	1.25	1.33	1.43	1.54	1.67	1.82	2.00	2.22	2.50

**Please report the same figure as in table 1.*

3.3 Confirmed/revised request for injection safety support for the year 2004

Table 4: Estimated supplies for safety of vaccination for the next year with BCG

1

		Formula	For year 2004
A	Target of children for BCG vaccination	#	358,862
B	Number of doses per child	#	1
C	Number of BCG doses	A x B	358,862
D	AD syringes (+10% wastage)	C x 1.11	398,337
E	AD syringes buffer stock 2	D x 0.25	0
F	Total AD syringes	D + E	398,337
G	Number of doses per vial	#	20
H	Vaccine wastage factor 4	*Either 2 or 1.6*	2
I	Number of reconstitution 3 syringes (+10% wastage)	*C x H x 1.11 / G*	39,834
J	Number of safety boxes (+10% of extra need)	*(F + I) x 1.11 / 100*	4,864

Table 5: Estimated supplies for safety of vaccination for the next two years with DTP

		Formula	For year 2004
A	Target of children for DTP vaccination	#	179,431
B	Number of doses per child	#	3
C	Number of DTP doses	A x B	538,293
D	AD syringes (+10% wastage)	C x 1.11	597,505

[2] The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area. Write zero for other y0ears.

[3] Only for lyophilized vaccines. Write zero for other vaccines

4 Standard wastage factor will be used for calculation of re-constitution syringes. It will be 2 for BCG, 1.6 for measles and YF.

E	**AD syringes buffer stock 4**	D x 0.25	0
F	**Total AD syringes**	D + E	597,505
G	**Number of doses per vial**	#	10
H	**Vaccine wastage factor 4**	*Either 2 or 1.6*	
I	**Number of reconstitution 5 syringes (+10% wastage)**	*C x H x 1.11 / G*	
J	**Number of safety boxes (+10% of extra need)**	*(F + I) x 1.11 / 100*	6,632

Table 6: Estimated supplies for safety of vaccination for the next two years with MEASLES

		Formula	**For year 2004**
A	**Target of children for MEASLES vaccination**	#	358,862
B	**Number of doses per child**	#	1
C	**Number of MEASLES doses**	A x B	358,862
D	**AD syringes (+10% wastage)**	C x 1.11	398,337
E	**AD syringes buffer stock**6	D x 0.25	0
F	**Total AD syringes**	D + E	398,337
G	**Number of doses per vial**	#	10
H	**Vaccine wastage factor** 4	*Either 2 or 1.6*	1.6
I	**Number of reconstitution** 7 **syringes (+10% wastage)**	*C x H x 1.11 / G*	63,734
J	**Number of safety boxes (+10% of extra need)**	*(F + I) x 1.11 / 100*	5,129

Table 7: Estimated supplies for safety of vaccination for the next two years with TT

		Formula	**For year 2004**
A	**Target of children for TT vaccination (for TT: target of pregnant women)**8	#	426,149

[4] The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area. Write zero for other years.

[5] Only for lyophilized vaccines. Write zero for other vaccines

4 Standard wastage factor will be used for calculation of re-constitution syringes. It will be 2 for BCG, 1.6 for measles and YF.

[6] The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area. Write zero for other years.

[7] Only for lyophilized vaccines. Write zero for other vaccines

4 Standard wastage factor will be used for calculation of re-constitution syringes. It will be 2 for BCG, 1.6 for measles and YF.

[8] GAVI will fund the procurement of AD syringes to deliver 2 doses of TT to pregnant women. If the immunization policy of the country includes all Women of Child Bearing Age (WCBA), GAVI/The Vaccine Fund will contribute to a maximum of 2 doses for Pregnant Women (estimated as total births).

B	**Number of doses per child (for TT woman)**	#	2
C	**Number of TT doses**	A x B	852,298
D	**AD syringes (+10% wastage)**	C x 1.11	946,051
E	**AD syringes buffer stock**9	D x 0.25	0
F	**Total AD syringes**	D + E	946,051
G	**Number of doses per vial**	#	20
H	**Vaccine wastage factor** 4	*Either 2 or 1.6*	
I	**Number of reconstitution** 10 **syringes (+10% wastage)**	*C x H x 1.11 / G*	
J	**Number of safety boxes (+10% of extra need)**	*(F + I) x 1.11 / 100*	10,501

ITEM		For the year 2004	
Total AD syringes	for BCG	398,337	supplies
	for other vaccines*	1,941,893	cash equivalent
Total of BCG reconstitution syringes		39,834	supplies
Total of Measles reconstitution syringes		57,418	supplies
Total of safety boxes*		27,303	cash equivalent

* Supplies of 0.5ml AD syringes and safety boxes should be converted to cash equivalent.

If quantity of current request differs from the GAVI letter of approval, please present the justification for that difference.

The new projected quantity of injection devices for 2004 is lower than the quantities originally approved by GAVI. The new denominator used for projected coverage in 2004 was the same as the Joint WHO/UNICEF Annual Report 2002 by using the source from the National health Statistic Report 2001 with the estimated the annual population growth rate of 2.49%.

As indicated in Cambodia's 2003 Annual Report, additional support for injection safety equipment was a possibility for 2004. Because of Japan Grant Aid support for 2004, Cambodia is only requesting supplies be delivered for BCG 0.1ml AD syringes and reconstitution syringes for BCG and measles. The remaining support (0.5ml AD syringes and safety boxes) are requested to be given in cash equivalent to further support Cambodia's improvements to routine immunization and injection safety.

[9] The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area. Write zero for other years.
[10] Only for lyophilized vaccines. Write zero for other vaccines
4 Standard wastage factor will be used for calculation of re-constitution syringes. It will be 2 for BCG, 1.6 for measles and YF.

Finally, Cambodia would like to reiterate the point made in the 2003 Annual Report: the wastage factors for BCG (2.0) and measles (1.6) set by GAVI could result in an undersupply of reconstitution syringes since many immunizations are given through outreach to villages with target populations of 5 or less per month for these 1-dose-schedule vaccines. Increasing coverage by improving access to some hard-to reach locations might increase vaccine wastage, and until GAVI can arrange for BCG and measles to come in smaller vial presentations, wastage factors will remain high at 3.0 and greater.

4. Please report on progress since submission of the last Progress Report based on the indicators selected by your country in the proposal for GAVI/VF support

Indicators	Targets	Achievements	Constraints	Updated targets
(DTP1-DTP3)/DTP1*100	5% drop-out by 2003 3% drop-out by 2005	11% in 2002	Irregular access to outreach budget results in poor quality outreach sessions with little active follow-up Insufficient IEC to counter fears of side effects, especially fever after DTP AD syringe not introduced yet Major flooding	
AFP cases reported per 100,000 under-15 year-olds	1 per 100,000 under-15 year-olds	3.39 per 100,000 185 cases (52 expected)	Delayed sample collection Delayed sample shipments	Achieved annually
% of health centres using only ADs for all EPI vaccines and with safe disposal	80% by 2003; 100% by 2005	AD syringes introduced in 100% of HCs in Q4 2002 with access to safe disposal	Limited monitoring/reporting through supervision Transport of safety boxes difficult in some areas Limited global supply/late arrival of BCG AD syringes	Achieved

5. Checklist

Checklist of completed form:

Form Requirement:	Completed	Comments
Date of submission		

Reporting Period (consistent with previous calendar year)		
Table 1 filled-in		
DQA reported on		
Reported on use of 100,000 US$		
Injection Safety Reported on		
FSP Reported on (progress against country FSP indicators)		
Table 2 filled-in		
New Vaccine Request completed		
Revised request for injection safety completed (where applicable)		
ICC minutes attached to the report		
Government signatures		
ICC endorsed		

6. Comments

ICC comments:

7. Signatures

For the Government of the Kingdom of Cambodia

Signature: Dr MAM BUNHENG

Title: Secretary of state

Date: 29 September 2003

We, the undersigned members of the Inter-Agency Co-ordinating Committee 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.

Financial accountability forms an integral part of GAVI/The Vaccine Fund monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form. The ICC Members confirm that the funds received have been audited and accounted for according to standard government or partner requirements.

Agency/Organisation	Name/Title	Date	Signature	Agency/Organisation	Name/Title	Date	Signature
WHO	Kohei Toda M.D. Technical officer	23.Sep03		PATH / CVP	Stephen Croll Country Program Leader	29/9/03	
UNICEF	Tomoo Hozumi Senior Prog. Coordinator	24 Sept 03					
JICA	A.R.R TSUYOSHI YUSA	24 Sept 03					
AUSAID	R. Dixon Second Secretary	24 Sept 03					
USAID	Ngudup Parker MCH Advisor	24 Sept. 03					

~ End ~

~ End ~