Memorandum on the Kingdom of Cambodia Programme Audit report

The attached Audit and Investigations report sets out the conclusions of the programme audit of Gavi's support to the Kingdom of Cambodia's Ministry of Health (MoH), executed by the National Immunisation Programme (NIP), along with other implementing partners.

The audit team reviewed the NIP and implementing partners' management of Gavi support to the routine immunisation programme provided during the period 1 January 2020 to 31 December 2024. The audit scope included the following grants: Health Systems Strengthening, COVID-19 Vaccine Delivery Support funds, Human Papilloma Virus, MR supplementary immunisation activities, Equity Acceleratory Funds, Rota vaccine, as well as other vaccines and cold chain equipment.

Funds directly executed by WHO and UNICEF were not subject to our programme audit and were considered out of scope, in accordance with the United Nations single audit principle.

The report's executive summary (pages 3 to 7) summarises the key conclusions, details of which are set out in the body of the report:

1. There is an overall audit rating of **"Needs significant improvement",** which means, "Internal controls, governance and risk management practices have some weaknesses in design or operating effectiveness such that, until they are addressed, there is not yet reasonable assurance that the objectives are likely to be met".
2. In total, 13 issues were identified in the following areas: (i) governance and oversight; (ii) programme management; (iii) vaccine supply chain management; (iv) data management systems; and (v) fixed asset management.
3. To address the risks associated with the issues, the audit team raised 13 recommendations, of which 6 were rated as high priority.
4. Key findings were that:
    a. The Technical Working Group on Health (TWGH) and its Sub-Technical Working Group for Maternal and Child Health which are mandated to oversee the National Immunisation Programme have not effectively fulfilled their roles in reviewing or monitoring implementation progress, budget utilisation, or Gavi grant performance. Meetings are held irregularly, and there is no structured mechanism to ensure that approved activities are carried out as planned. Additionally, the newly established National Immunisation Technical Advisory Group lacks sufficient independence, as its leadership includes senior Ministry of Health officials who are also members of the TWGH. This overlap undermines the impartiality expected of a technical advisory body.
    b. Cambodia's National Immunisation Strategy (NIS) 2021–2025, which was developed during the COVID-19 pandemic, is no longer fully aligned with current immunisation priorities. Its monitoring and evaluation framework lacks measurable timelines, qualitative indicators, and evidence of the planned annual or mid-term reviews. As a result, progress on NIS implementation is not routinely assessed or reported to any oversight body, weakening accountability. Furthermore, development of the NIS 2026–2030 has been delayed because the

planned mid-term review did not take place, leaving no documented lessons to inform the next strategy.

c. The translation of strategic goals into action has been weakened by recurring delays in developing and approving Annual Operational Plans. These plans are frequently finalised mid-year, compressing implementation timeframes, slowing fund disbursement, and contributing to low budget absorption—averaging just 32% in 2020 and 58% in 2024. As a result, activities have been cancelled or postponed, human and financial resources have been used inefficiently, and service delivery has become fragmented.

d. The Country's response to the resurgence of measles remains inadequate to maintain its previous elimination status. Although declared measles-free in 2015, the country has seen a sharp rise in cases since 2022, with more than 2,700 confirmed infections reported in the first half of 2025. Routine coverage for both MR1 and MR2 remains below the 95% threshold required for herd immunity, and despite a nationwide supplementary immunisation campaign in 2024 that reported high administrative coverage, measles transmission persisted particularly in Phnom Penh and border provinces. The continued rise in cases highlights gaps in routine immunisation, declining parental awareness, cross-border movement of unvaccinated populations, and delays in outbreak detection and response.

e. Vaccine-preventable disease surveillance remains a significant challenge, as the system relies heavily on World Health Organisation staff, a dependency that raises sustainability concerns in an environment of declining external funding. Surveillance efforts are further hindered by delays in transporting specimens for testing, uncoordinated reporting caused by weaknesses in the current reporting tools, and limited engagement from private health providers.

f. The Electronic Immunisation Registry remains in the pilot phase and is not yet aligned with global standards for immunisation registry design. Only two of the seven core functional components are operational, and the system does not interface with the national Health Management Information System, resulting in fragmented and inconsistent reporting. Implementation has been further slowed by the absence of a dedicated digital-health project manager and inactive digital-governance structures, limiting oversight and accountability.

g. Fixed-asset management controls require substantial strengthening. The audit found limited evidence of routine physical verification of assets procured with Gavi funds, along with inconsistent tagging using donor identification logos. Several assets could not be located during field visits, while others were found in unrecorded locations or listed as functional despite being broken. In some cases, items observed in the field were missing from the Fixed Asset Register. These gaps point to inadequate oversight, poor record-keeping, and the absence of standardised procedures for asset management.

The findings of the programme audit were discussed with the Ministry of Health and implementing partners. They accepted the audit findings, acknowledged the weaknesses identified, and committed to implementing a detailed management action plan.

The Gavi Secretariat remains committed to working with the Kingdom of Cambodia and providing the appropriate assistance to mitigate the risks noted in this audit.

Geneva, May 2026

PROGRAMME AUDIT REPORT

Kingdom of Cambodia
March 2026

Gavi
The Vaccine Alliance

Table of Contents

1. Executive Summary

1.1 Overall audit opinion

Audit opinion:

The audit team assessed the Ministry of Health's management of Gavi support during the period 1 January 2020 to 31 December 2024 as "Needs significant improvement" which means, "One or few significant issues noted, internal controls, governance and risk management practices have some weaknesses in design or operating effectiveness such that, until they are addressed, there is not yet reasonable assurance that the objectives are likely to be met".

Through our audit procedures, we identified high risk issues relating to governance and oversight, programme management; digital immunisation information systems, budget and fixed assets management.

To address the risks associated with these issues, the audit team raised 13 recommendations, of which 6(46%) were rated as high risk. These recommendations need to be addressed by implementing remedial measures according to the agreed management actions.

1.2 Summary of key audit issues

** The audit ratings attributed to each section of this report, the level of risk assigned to each audit issue and each recommendation, are defined in Annex 2 of this report.*

1.3 Summary of issues

Through our audit procedures, we identified 13 issues (6 high risk, 7 medium risk) relating to the use and management of Gavi support. Section 3 of this report provides details of the Kingdom of Cambodia's context and specific challenges in delivering its immunisation programme. The high risk issues are summarised below, followed by the detailed observations in Section 4 of this report.

Governance and oversight
The Technical Working Group on Health (TWGH) and its Sub-Technical Working Group for Maternal and Child Health (MCH) are responsible for overseeing the National Immunisation Programme (NIP). However, these committees have not effectively reviewed or monitored implementation progress, budget absorption, or grant performance for Gavi support. Meetings have been irregular, and no structured mechanism exists to verify that approved activities are executed as planned. The recently established National Immunisation Technical Advisory Group (NITAG) also lacks independence, as its leadership includes senior Ministry of Health officials who simultaneously serve on the TWGH. This dual role compromises the impartiality expected of a technical advisory body.

Failure to clarify mandates, formalise linkages, and ensure independent, transparent decision-making—supported by systematic follow-up—could compromise programme integrity and impact. If governance gaps persist, oversight and accountability for Gavi funding will remain weak, increasing the risk of misaligned decisions and inefficient use of resources, and diminished trust among stakeholders.

Programme management
Cambodia's National Immunisation Strategy (NIS) 2021–2025, developed during the COVID-19 pandemic, is no longer fully aligned with current immunisation priorities. Its monitoring and evaluation plan lacks measurable timelines, qualitative indicators, and evidence of the annual or mid-term reviews envisaged. Consequently, progress on NIS implementation is not routinely assessed or reported to any oversight body, weakening accountability. Also, development of the NIS 2026 to 2030 was delayed as the planned midterm review did not occur, so there were no documented lessons learned.

The translation of strategic goals into action has been further undermined by repeated delays in developing and approving Annual Operational Plans (AOPs). These plans are often finalised mid-year, compressing implementation timeframes, slowing fund disbursement, and contributing to low budget absorption (averaging only 32 per cent in 2020 and 58 per cent in 2024). Delays have led to cancelled or postponed activities, inefficient use of human and financial resources, and fragmented delivery of services.

The national response to measles resurgence remains insufficient to sustain Cambodia's previous elimination status. Although verified as measles-free in 2015, the country has experienced a sharp increase in cases since 2022, with more than 2,700 confirmed infections in the first half of 2025. Routine coverage for both MR1 and MR2 remains below the 95 per cent threshold required for herd immunity, and despite a 2024 nationwide supplementary immunisation campaign that reported high administrative coverage, measles transmission continued, particularly in Phnom Penh and border provinces. The rise in cases reflects gaps in routine immunisation, reduced parental awareness, cross-border movement of unvaccinated populations, and delays in outbreak detection and response.

Vaccine preventable disease (VPD) surveillance also remains a challenge as the process is significantly reliant on World Health Organisation (WHO) staff, in itself an eminent sustainability challenge in the reduced funding environment. This is further challenged by delays in transportation of specimens for testing, uncoordinated reporting of results due to weakness of the reporting tool used and limited private sector engagement.

Unless the NIS is updated for the 2026 to 2030 period, to strengthen routine immunisation services with emphasis on closing the MR2 coverage gaps, expand outreach to underserved populations, intensify communication to address vaccine hesitancy, and reinforce routine coverage and surveillance, recurrent outbreaks will continue to divert resources from other programme areas and weaken progress made in immunisation programming.

Data management systems

The Electronic Immunisation Registry (EIR), a flagship digital health initiative, remains at pilot stage and lacks alignment with global standards for registry design. Only two of seven core functions are currently operational, and the system does not integrate with the national Health Management Information System (HMIS), resulting in fragmented reporting. The absence of a dedicated digital health project manager and inactive digital-governance structures have further slowed implementation and limited accountability.

Without clear leadership and interoperability, the EIR will continue to fall short of its intended role in delivering reliable, real-time data for decision-making. Failure to operationalise Cambodia's digital-health governance framework, appoint technical leadership, and align the EIR with international standards risks fragmentation, limited scalability, and unsustainable systems—ultimately undermining data-driven health outcomes.

Fixed asset management

Fixed-asset management controls also require significant improvement. The audit found limited evidence of routine physical verification of assets procured with Gavi funds and inconsistent tagging with donor identification logos. Several assets could not be located during field visits, while others were found at unrecorded locations or listed as functional despite being broken. Some items discovered in the field were not included in the Fixed Asset Register (FAR), indicating incomplete registration. These weaknesses reflect inadequate oversight, poor record-keeping, and absence of standardised procedures for asset transfers and updates to the FAR.

Until fixed assets management is strengthened through asset verification and maintenance of accurate records, Gavi-funded assets remain exposed to misuse or misallocation and their continued use for immunisation purposes may be jeopardised.

1.5 Cash balances

Table 1: Gavi funds unspent, at central level by implementer as of 30 June 2025

Implementer	GAVI Grants	Amount (USD)	Source of Information
NIP	HSS3	760,015	As verified from the bank register maintained by NIP as on 30th June 2025
	CDSIII	191	
	HPV	90,276	
	MR-SIA	116,914	
	EAF	22,635	
	ROTA	249,777	
	Total	**1,239,808**	As verified from the Bank statement. The balance is as on 30th June 2025.

2. Objectives and scope

2.1 Audit objectives

In line with the Partnership Framework Agreement between Gavi and the Government of the Kingdom of Cambodia (acting through the Ministry of Health and the Ministry of Economy and Finance), signed on 6 November 2013 (the PFA) and with Gavi's transparency and accountability policy, countries that receive Gavi's support are periodically subject to a programme audit, for which the primary objective is to provide reasonable assurance that Gavi's resources and support were used for intended purposes in accordance with Gavi's agreed terms and conditions and in line with the designated programme objectives.

As a result, the audit team assessed the design and operating effectiveness of several key areas, including programme management and implementation arrangements including the technical assistance supporting the strengthening of resilient health systems; vaccine supply chain management systems and processes to ensure visibility, accountability, and delivery of viable vaccines to intended recipients; immunisation data reporting and assurance processes to guarantee the accuracy of data used in decision-making; governance arrangements providing oversight and guidance to the immunisation programme management and implementation; and budgeting, financial management, and assurance processes to ensure accountability for Gavi cash grants.

The team also reviewed the relevance and reliability of the internal control systems, relative to the accuracy and integrity of the books and records, management and operational information; the effectiveness of operations; the physical security of assets and resources; and compliance with national procedures and regulations.

2.2 Audit scope

The audit team applied a risk-based approach, guided by an assessment of risks across Gavi-supported immunisation programme areas in the Kingdom of Cambodia. These included governance and oversight, programme management (with a focus on surveillance and outbreak response to vaccine preventable diseases and support supervision arrangements), vaccine supply chain management, immunisation data management, immunisation data systems development and implementation, budgeting and financial management, and fixed asset management. The review also examined Gavi's supplemental Covid-19 support especially cash disbursements as well as the effectiveness of targeted country assistance.

The audit covered the five-year period from 1 January 2020 to 31 December 2024. Details of the total cash, vaccine, and ancillary support provided by Gavi to the kingdom of Cambodia as of 31 December 2024 are shown in Table 2 below.

Table 2: Cash, technical assistance, equipment, and vaccine support in USD (2020 – 2024)

Cash grants	2020	2021	2022	2023	2024	Total Amount
Total Cash (a)	***2,915,381***	***1,291,523***	***1,973,254***	***8,270,651***	***4,245,809***	***18,696,618***
COVAX TCA				*759,644*	*26,442*	*786,087*
PEF TCA	*916,595*	*778,494*	*1,124,880*	*994,562*	*1,210,575*	*5,025,107*
Total PEF TCA (b)	***916,595***	***778,494***	***1,124,880***	***1,754,207***	***1,237,017***	***5,811,193***
CCEOP		*393,555*	*598,777*	*(53,301)*	*480,828*	*1,419,859*
COVAX		*456,182*	*(29,480)*			*426,702*
Total Equipment (c)		***849,737***	***569,297***	***(53,301)***	***480,828***	***1,846,561***
COVAX		*15,208,165*	*20,091,975*	*5,273,811*	*1,821,158*	*42,395,109*
HPV				*1,120,736*	*1,041,589*	*2,162,325*
IPV	*955,058*	*1,793,347*	*547,470*	*1,208,190*	*255,000*	*4,759,066*
MR					*1,530,508*	*1,530,508*
PCV	*3,308,037*	*3,025,251*	*2,708,011*	*3,702,143*	*1,173,220*	*13,916,662*
PENTA	*1,206,140*	*1,401,317*	*1,430,896*	*699,204*	*521,854*	*5,259,411*
Total Vaccine (d)	***5,469,235***	***21,428,081***	***24,778,352***	***12,004,084***	***6,343,329***	***70,023,081***
Total (a+b+c+d)	***9,301,212***	***24,347,834***	***28,445,783***	***21,975,641***	***12,306,984***	***96,377,454***

2.3 Audit approach

The audit was conducted in two phases: an initial audit planning visit from 5 to 8 May 2025 and three weeks field work from 14 to 31 July 2025. The team adopted a risk-based approach to determine the audit objectives. The team visited the Central Medical Store (CMS) which houses the Central Vaccine Store, the National Institute of Public Health Laboratory (NIPHL), Phnom Penh Municipal Health Office, Phnom Penh Vaccine Store, 4 Provincial Health Directorates (PHDs) and Vaccine Stores, 8 Operational District (OD) Health Offices and Vaccine Stores and 31 health facilities. See Annex 4 for details

During the audit, the team interacted with key stakeholders including senior officials in National Immunisation Programme (NIP)/National Maternal and Child Health Center (NMCHC); the internal audit team within the Ministry of Health; PHD and OD immunisation teams; Gavi Alliance partners including WHO, UNICEF; Gavi Expanded partners such as CHAI, CSOs including RHAC, KHANA and PLAN and the Gavi Assurance Provider (PwC).

Gavi's support to the Kingdom of Cambodia over the audit period (2020 - 2024) was channelled through MoH/NMCHC, Gavi alliance partners, expanded partners and CSOs.

For the audit period, Gavi disbursed funds amounting to USD 12.3 million to partners (core and expanded) as illustrated in Annex 5b .

2.4 Exchange rate

Grant-related expenditures were incurred in United States Dollars (USD). If any expenditure was incurred in local currency, Cambodian Riel (KHR), it was converted into USD at the time of the expense claim. The expenditure was booked in the respective books of accounts in USD. The MoH Cambodia typically uses the official exchange rate published daily by the National Bank of Cambodia with an average of 1 USD to 4100 KHR throughout the period.

3. Background

3.1 Introduction

The Kingdom of Cambodia, located in the southern part of the Indochina Peninsula in Southeast Asia, borders Thailand, Vietnam, and Laos, with a coastline along the Gulf of Thailand.

Administrative arrangements

Cambodia's administrative structure is organised into multiple tiers under a decentralisation framework, with the central government overseeing national policy and ministries, including the Ministry of Interior and Ministry of Health. At the first sub-national level, the country is divided into 24 provinces (khaet) and the autonomous municipality of Phnom Penh, each with equivalent status. Provinces are subdivided into districts (srok) and urban municipalities (krong), while Phnom Penh is divided into khans. At the third level, districts/municipalities and khans are split into communes (khum) in rural areas and sangkats in urban areas. Operational districts form part of the Country's administrative framework, designed to manage public services and decentralise governance, especially in the health and education sectors. They generally align with district boundaries but are defined through government sub-decrees, reflecting decisions by the Ministry of Interior and guided by laws on administrative management.

The fourth level is villages (phum), and in some urban areas there is a fifth informal level called blocks (krom). Each administrative tier has elected councils for local law-making and appointed boards of governors for executive functions, with Phnom Penh enjoying special municipal autonomy but aligned with provincial structures. This hierarchy is designed to enable local governance, service delivery, and coordination between central and sub-national authorities.

Economy and demographics

The Kingdom of Cambodia has an estimated population of 17.8 million people as of 2025[1]. The country's annual growth rate is around 1.2–1.6%. The last census (2019) reported a population of just over 15.5 million, highlighting significant growth in recent years. Cambodia has a young and predominantly rural population of which about one-third are under 15 years, two-thirds are of working age, and only 7% are 65 or older, with an average household size of 4.1. Urbanisation is moderate, with around 42% of women and 43% of men living in towns and cities, and internal migration is common, largely driven by employment. Fertility stands at 2.7 children per woman, teenage pregnancy affects 9% of girls 15-19, and maternal health coverage is high, with 99% of recent births attended by skilled personnel. Child mortality is relatively low (under-five mortality at 16 per 1,000). The economy shows a shift from agriculture toward industry and services, yet 21% of employed women and 28% of men still work in agriculture, and nearly half of working women are self-employed, much of it informal. Basic infrastructure access is improving with 92% of households having electricity, 80% have basic sanitation and 89% basic drinking water. Internet use is increasingly widespread (64% of women, 77% of men), however, financial inclusion (bank or mobile account) covers just over a quarter of adults.

Cambodia's economy is experiencing steady growth, with 2025 GDP projected at about $49.6 billion and growth rates around 5.8- 6.1%, driven by exports (garments, footwear, bicycles, travel goods), a recovering tourism sector, and strong industrial and service activity[2]. Agriculture's share is declining as the economy diversifies, while inflation is expected to remain stable at about 3.7%. Infrastructure investment, digital transformation, and foreign direct investment mainly from China are boosting development, though risks include global economic uncertainty, trade tensions, a weak property sector, and tighter credit. The government is focusing on higher-value manufacturing, green energy, tourism, and digital sectors to sustain growth and resilience.

[1] UN. Dept. of Economic and Social Affairs - Population Division. World Population Prospects: The 2024 Revision. (Medium-fertility variant).
[2] World bank indicators

3.2 National health sector

Cambodia's health sector has improved in coverage, maternal and child health, and disease control, but significant urban rural gaps and high out-of-pocket costs persist. Public facilities serve mainly low-income rural populations, while private providers dominate overall care. Social protection schemes such as Health Equity Funds and the National Social Security Fund are expanding toward the universal health coverage goal by 2035, yet only a minority benefit so far. The country faces a double burden of infectious diseases and rising non-communicable diseases, with life expectancy at about 70.7 years. Government investment approximating about US$ 550 million in 2025[3] targets service quality, workforce training, infrastructure, and digital health, but challenges remain, including unregulated private care, counterfeit medicines, and inequitable access.

3.3 Immunisation in Cambodia

Cambodia's immunisation program has made major strides over the past decades, targeting childhood diseases and more recently integrating COVID-19 vaccination. The NIP established in 1986, delivers routine vaccines to approximately 700,000 children under two years each year and aims to reach the most vulnerable and remote populations[4].

However, immunisation coverage for measles and rubella (MR) has recently fallen short of targets. According to WHO/UNICEF Estimates of National Immunisation Coverage (WUENIC) for 2024, the MR vaccine coverage for the first dose (MR1) was 83%, and the second dose (MR2) was only 64% well below the 95% threshold required for herd immunity and outbreak prevention. Routine immunisation was disrupted during the COVID-19 pandemic, contributing to coverage gaps which led to a resurgence of measles. This resurgence prompted a nationwide measles-rubella supplementary campaign in late 2024 to immunise over 1.5 million children aged 9 to 59 months, targeting not just routine coverage but also boosters, especially for children in high-risk, remote, and mobile communities. From January to May 2025, Cambodia reported 2,762 confirmed measles cases across all 25 provinces which is over four times the number from 2024 (666 cases).

3.4 Vaccine supply chain management structure

Cambodia's vaccine supply chain structure is organised in a tiered system that ensures vaccines are safely stored, transported, and delivered from the Central Medical Store (CMS) to health facilities across the country. The CMS receives vaccines from manufacturers or donors. At the CMS, vaccine inventory was managed using a combination of manual (stock cards) and an electronic system, the National Drug and Inventory Database (NATDID[5]) system. NATDID is operational only at the CMS and allows recording of vaccines received from suppliers and issuances to the peripheral stores. Vaccines are distributed from CMS to Provincial Health Department vaccine stores then to Operational District vaccine stores before being sent to the health facilities, the service delivery points.

3.5 Gavi's relationship with Cambodia

Cambodia is classified as a core country[6] is in the preparatory transition phase of Gavi's eligibility, transition and cofinancing policy, and has received significant funding from Gavi to support its national immunisation program. During the Gavi 5.0 strategic period (2021–2025), Cambodia was eligible for up to USD 13,223,184 for HSS, USD 11,033,194 for the core approval cap, USD 1,906,513 for Equity Accelerator Funding (EAF), and USD 779,811 for CCE support, amounting to a total ceiling of roughly USD 26.9 million for this five-year phase[7].

[3] Budget in brief

[5] NATDID is Cambodia's centralised computerised system developed and scaled up from the early 2000s for managing drug inventory including vaccines within the public health sector.

6 A core country is a nation that is eligible for Gavi support based primarily on its national income and health system characteristics, receives Gavi financial and technical support to improve immunisation coverage and strengthen health systems, but are not considered critical for meeting Gavi's global goals solely due to their size or birth cohort

7 Gavi-5.0-Ceilings-by-country-and-support-type

At the national level, Cambodia's immunisation program is coordinated and managed through the Ministry of Health's NIP, which sets strategy, policy guidance, and oversees progress. PHDs play a critical role in the execution and monitoring of immunisation services, adapting interventions to local challenges. Gavi's engagement has increasingly emphasised decentralisation, supporting local authorities while maintaining strong national coordination.

Financial support from Gavi is managed through performance-based grants and targeted technical programs to ensure accountability and effectiveness in reaching immunisation goals.

3.6 Entities involved in the executing and managing Gavi's funds.

During the audit review period, Gavi grants in Cambodia were received by the National Immunisation Program (NIP) under the National Maternal and Child Health Center(NMCHC) within the MoH; Gavi Alliance partners the World Health Organisation (WHO) and the United Nations International Children's Emergency Fund (UNICEF); Gavi extended partners include the Clinton Health Access Initiative (CHAI), and Civil Society Organisations (CSOs) including the Reproductive Health Association of Cambodia (RHAC), PLAN International, and (receiving funds after the audit period) KHANA. In line with Gavi's requirement that at least 10% of immunisation grant funds be directed to CSO-led activities, these organisations actively collaborate with international partners and government bodies to deliver Gavi-supported programs. The MoH, through the NIP, oversees and coordinates all immunisation activities, while WHO, UNICEF, and CHAI provide technical expertise, policy guidance, programme monitoring, vaccine rollout support, logistics, and health system strengthening. CSOs play a crucial role in community engagement, outreach, awareness raising, and reaching underserved populations. Additionally Gavi engaged a monitoring agent, CARDNO during the Covid19 period and engaged an assurance provider, PwC in 2024.

3.7 Progress on previously identified audit issues

Gavi conducted its last programme audit in Cambodia in 2019, (published in 2020) and the audit report rated the management of Gavi's support as partially satisfactory based on the results of testing over various areas in scope, including governance and oversight, programme management, vaccine supply management, budgetary and financial management, procurement, and fixed asset management.

This audit corroborated whenever possible on the ongoing recommendations and all outstanding recommendations from the previous audit will be superseded by recommendations articulated in the present audit report (see annex 6c) as this audit has considered the current country context, governance mechanisms and available funding within NIP and MoH to provide updated recommendations.

3.8 Good Practices

The audit team noted the following good practices while executing the audit:

- **Establishment of the National Immunisation Technical Advisory Group (NITAG)** - In 2025, the country established the NITAG, a scientific advisory committee to guide data and research driven decisions around immunisation in 2025 and first meeting held in July 2025. The committee consists of a chairperson, 2 vice chairpersons and 10 members.
- **Alignment of the National Immunisation Strategy to the 2030 Immunisation Agenda (IA)** - Cambodia's National Immunisation Strategy 2021–2025 is aligned with, and meets, the key requirements and priorities of the Immunisation Agenda 2030. The strategy reflects IA2030's vision and principles both in design and in operational intent
- **CSO strategy alignment to the Gavi CSO strategy** - The approach used in Cambodia for engaging CSOs in immunisation shows strong alignment with the core elements of the Gavi CSO Strategy (reaching underserved, community engagement, demand generation, data use and capacity building).
- **Comprehensive VPD surveillance and reporting system** - The country has a well-structured VPD surveillance system guided by operational guidelines with clear case definitions and classification criteria for all VPDs. Surveillance focal persons are designated at all levels to coordinate activities, supported by

the availability of standard case investigation forms for specimen collection and case follow-up. Laboratory confirmation is ensured through testing at the ISO 15189-accredited NIPHL. Data reporting requirements mandate both weekly and monthly submissions on VPD cases and AEFIs, with zero reporting in the absence of cases. To promote accountability and transparency, the country also publishes annual bulletins summarising the performance and outcomes of the VPD surveillance system.

- **Adequate design of supportive supervision process** - In 2023, an assessment of the supportive supervision model for immunisation was conducted, leading to key recommendations such as developing comprehensive support supervision guidelines, assessing staff capacity, utilising a programme management dashboard to guide support supervision visits, establishing a centralised database for recording support supervision findings, and updating the existing support supervision checklist. By 2024, guidelines for implementing supportive supervision were available, including specific checklists tailored for PHDs, ODs, and HCs.
- **HMIS coverage** - Coverage of the HMIS system is up to HC level with every health centre having its own login / access credentials and therefore able to upload their data in a timely manner.
- **Development and implementation of a stock monitoring tool -** Since 2024, the country has been using an Excel-based stock monitoring tool at the CMS to continuously track vaccine availability and pipeline supplies. This tool provides real-time visibility of stock levels and pipeline orders, and through its color-coded system, it indicates whether stock levels fall within the established minimum and maximum thresholds. Records showed that the CMS has not experienced stock-outs of the sampled vaccines (Pentavalent, IPV, MR, PCV, and BCG) over the past three years demonstrating consistent stock availability at the central level.
- **Availability of vaccine and cold chain management SOPs** - All vaccine and cold chain management activities are guided by Standard Operating Procedures (SOPs) covering vaccine handling and cooling systems. These SOPs are available at the central level, provincial level, OD, and in most health facilities.
- **Vaccine-containing CCE were all functional** - All CCE with vaccines at CMS, Provincial Health Departments (PHDs), Operational Districts (ODs), and Health Centers (HCs) was found to be functional and in good working condition. The equipment is installed in clean, safe, and secure locations, and at all subnational vaccine handling points, cold boxes and ice packs were available to facilitate transportation and provide backup protection in the event of equipment failure.
- **Availability of a remote temperature monitoring system at CMS** - Temperature monitoring at the CMS has improved with the installation of a Beyond Wireless Remote Temperature Monitoring System that connects all walk-in cold rooms, automatically records temperatures, and sends alerts to designated personnel. Similarly, at subnational vaccine handling points, all CCE containing vaccines has been fitted with temperature loggers or monitors to enable continuous tracking at regular intervals. To support its extensive cold chain infrastructure which includes 30 Walk-in Cold Rooms (WICRs), 4 Walk-in Freezer Rooms (WIFRs), and 16 Ultra Cold Chain (UCC) units, the CMS has contracted a third-party service provider to carry out regular preventive maintenance, ensuring equipment remains in good condition and prolonging its operational lifespan.
- **Sustainable distribution practices** - The CMS follows a well-structured distribution schedule that outlines the timelines for supplying vaccines and related commodities to provincial levels. The audit further noted that the Government of Cambodia fully funds the vaccine distribution budget across all levels, marking an important step toward ensuring the program’s long-term sustainability.

4. Findings

4.1 Governance and oversight

4.1.1 The design of national immunisation governance mechanisms needs strengthening

Context and Criteria

Cambodia's immunisation governance framework comprises strategic coordination, technical advisory, and programme management mechanisms led by the Ministry of Health (MoH) and supported by national and sub-national stakeholders. Key governance bodies include:

- Technical Working Group for Health (TWGH): provides strategic oversight, coordination, and stakeholder engagement at a national health level. In Cambodia, the country decided that all duties of the Interagency Coordinating Committee (ICC) would remain the responsibility of this group to keep immunisation discussions within the overall health discussions and ensure synergies from adequate stakeholder engagement for overall health systems strengthening. Also, the members of this body would also be on ICC.
- National Immunisation Technical Advisory Group (NITAG): a multidisciplinary body that offers independent, evidence-based advice on vaccine policy, schedules, and priorities.
- Sub-Technical Working Group for Maternal and Child Health (NMCH) and NIP Working Group: responsible for thematic and operational coordination.

At sub-national level, Provincial Health Departments (PHDs) plan, supervise, and manage immunisation activities, while Operational Districts (ODs) oversee logistics, cold chain, and service delivery at health facilities.

According to WHO guidance, NITAGs should be composed of independent experts who provide evidence-based recommendations to national decision-makers. The chairperson should be independent from the MoH and the national immunisation programme to ensure impartiality. Each governance body should have formalised Terms of Reference (ToRs), regular meeting schedules, documented minutes, and defined linkages between national and sub-national structures.

Condition

***NITAG not chaired by an independent member*:** Cambodia established a NITAG in 2025 following significant advocacy by WHO. The committee comprises a chairperson, two vice-chairpersons, and ten members. The audit noted that the chair and both vice-chairpersons are Secretaries of State within the MoH (See Annex 6a) and also serve as participating members of the TWGH—the same body to which the NITAG is mandated to provide independent recommendations.

***Gaps in design and operationalisation of TWGH and NMCH sub-TWG*:** We noted limited discussion of routine immunisation performance, budget absorption, donor alignment, or NIS implementation on review of four sets of TWGH meeting minutes provided for our review which focussed primarily on approval of Gavi support. (See Annex 6b). Also, while MoH committed to revising the TWGH and NMCH sub-TWG[8] ToRs, these have not been finalised since 2016.

Additionally, the NMCH sub-TWG provided only one meeting record (30 June 2023), focused mainly on COVID-19 vaccination. There was no documented evidence available for NIP TWG meetings between 2020 and 2024, making it difficult to conclude on whether these meetings were held or addressed ongoing immunisation issues.

Recommendation 1

To strengthen the independence and functionality of national immunisation governance bodies MoH should:

- Include independent leadership to chair the NITAG to adhere to WHO guidance. To adhere to the national administrative protocols, NITAG decisions are sanctioned by the TWGH, which is chaired by the minister.
- Finalise and operationalise ToRs for all governance bodies, clearly defining mandates, reporting lines, and meeting frequency.
- Establish a secretariat responsible for convening meetings, recording minutes, maintaining documentation, and tracking action points.

[8] Based on recommendations of the 2016 Programme Capacity Assessment.

<table>
<tr><td>Insufficient integration and collaboration between the Provincial and National TWGs: The audit found no clear coordination between the Provincial Technical Working Groups (Pro-TWGs) and the NIP TWG. Meeting documentation was missing in 4 out of 5 Provincial Health Departments (PHDs) and 6 out of 8 Operational Districts (ODs) visited. Pro-TWG meetings were convened on an ad hoc basis, often without a predefined agenda, and rarely included discussions on the immunisation program. In addition, attendance records were not maintained, making it impossible to verify stakeholder participation.

Unclear reporting lines and oversight over the CSOs: The oversight mechanism for CSOs at the national level remains undefined, as the oversight body referenced in contracts and agreements is not operational. Moreover, there was no documented evidence of CSO participation in sub-national technical working group meetings.</td><td>• Strengthen linkages between national and sub-national TWGs, requiring regular reporting and structured feedback mechanisms.
• Operationalise the CSO oversight body within the existing TWGH by including CSOs on the agenda and allowing participation in meetings where agenda items will be discussed. Additionally, CSOs should be participate in meetings subnational levels where operationalisation of their mandate occurs.</td></tr>
<tr><td>Root Cause

• The TWGH historically performed both the NITAG and Interagency Coordination Committee (ICC) functions, creating overlapping mandates and insufficient independence. Also, with consideration for the Cambodia country context, appointment of high-ranking officials to NITAG leadership was intended to ensure continued authority at senior leadership levels.
• Formalisation and enforcement of ToRs for TWGHs has not been prioritised, resulting in inconsistent operations. Additionally, the lack of a designated secretariat function has led to irregular meetings and inadequate documentation.
• Immunisation has not been systematically included in TWGH agendas, limiting oversight of Gavi grant performance.
• The CSO oversight mechanism was not established, creating engagement and accountability gaps.</td><td>Management comments

See detailed management responses - Annex 10</td></tr>
<tr><td>Risk / Impact / Implications
• Absence of independence within the NITAG is not compliant with WHO recommendations and may result in conflicts of interest, as members try to balance their technical advisory and political roles.
• Delays in the formalisation of the TWGH ToRs has resulted in insufficient oversight over immunisation activities and non-performance of other core ICC activities like fundraising to close funding gaps across the health sector and particular to immunisation. Also, the TWGH is unable to hold the operational committees accountable to meet and escalate operational issues for decision.
• In the absence of robust immunisation governance structures, effective planning, programme performance, and resource management for Gavi grants may be compromised, hindering the achievement of intended objectives</td><td>Responsibility

See detailed management responses - Annex 10</td><td>Deadline / Timetable

See detailed management responses - Annex 10</td></tr>
</table>

4.1.2 Challenges in internal audit and assurance arrangements

Context and Criteria

Annex 6 of the PFA (May 2017 version) outlines the Grant Management Requirements (GMRs) governing the management and oversight of vaccines, related supplies, and financial support provided by Gavi to the Government of Cambodia. Under Section K, titled "Internal Audit Plan and Reports," the Ministry of Health's internal audit unit is required to share its annual risk-based audit work plan explicitly indicating planned coverage of Gavi-supported programs and to make all relevant internal audit reports available to Gavi.
The Internal Audit Department (IAD) formalised its role in Gavi grant oversight through a Memorandum of Understanding (MoU) with NMCHC, mandating routine internal audits of Gavi-supported activities.

In November 2024, Gavi appointed an Assurance Provider (AP) to strengthen financial oversight, promote country ownership, and enhance fiduciary risk assurance across Gavi grants. The AP's work is guided by Gavi's Assurance Framework and its own Terms of Reference, requiring close collaboration with the IAD, NMCHC, and NIP to improve compliance and build sustainable internal capacities.

Condition

***The internal audit function is not effective*:** The internal audit function of the MoH has not yet achieved the effectiveness required to meet the GMRs set out under Annex 6 of the PFA. The IAD did not consistently perform the mandatory annual audits of Gavi grants. Only one audit, covering the year 2021, was completed during the review period. The 2023 audit scheduled for June to December 2024 and intended to cover 11 Provincial Health Departments (PHDs)—was not conducted as planned. At the time of fieldwork, the 2024 internal audit had only recently commenced.

The audit noted that the IAD's planning processes were not risk-based, as required by the GMRs. The selection of 14 PHDs for audit in 2024 was done randomly, with no documented justification or criteria. Similarly, the 2025 Memorandum of Understanding (MoU) between IAD and NMCHC did not specify the rationale for site selection, and the annual audit work plan lacked details on audit scope, methodology, and criteria.

The scope of internal audit coverage was narrow. Audit activities were primarily confined to the PHD level in 2021, 2023, with NMCHC added in 2024. There was no evidence that operational districts were included, although this is a specific GMR requirement. The 2021 report provided only high-level summaries, without PHD-specific analysis, quantification of sample coverage, or classification of findings by severity. Non-financial and programme-related aspects were excluded, despite being explicitly required under the GMRs. Moreover, internal audit reports lacked actionable recommendations and findings were not prioritised.

Finally, internal audit reports were not adequately shared or discussed. The 2021 report was not presented to the Gavi Secretariat, nor reviewed by the Technical Working Group on Health (TWGH) or its sub-groups. Recommendations were also not shared with the respective PHDs audited, resulting in limited awareness and follow-up at the implementation level.

***Previous audit and review recommendations remain outstanding*:** Progress in implementing audit and review recommendations remains low. As of July 2025, only 28% of prior audit and review recommendations had been implemented. Over 20% of earlier audit findings remained unresolved for more than 32 months. From the 2019 Gavi programme audit, 10 agreed management actions were

Recommendation 2

To strengthen the internal audit and assurance functions and improve oversight and follow-up of recommendations, the MoH through NMCHC/NIP should:

- Enhance IAD capacity through targeted training and mentoring, with AP support, on risk-based audit planning, evidence-based reporting, and prioritisation of findings.
- Institutionalise coordination between the IAD and AP, including joint annual planning, harmonised risk assessments, and coordinated follow-up of recommendations.
- Establish a centralised tracking system for all audit and review recommendations, with clear responsibilities, defined timelines, and escalation protocols for overdue actions.
- Work with Gavi country team to review, understand and align AP's scope of work with the current operational context to maintain the independence and assurance functions of the AP.

identified; by mid-2025, 8 remained either not started or still in progress. Likewise, only 56% of the 16 recommendations from the external audit were either not started or still in progress. Several issues identified in the previous programme audit have recurred in the current review including gaps in governance and oversight, inadequate documentation of physical inventory counts, and the need to update the support supervision tool to incorporate compliance with SOPs.

Table 3: Status of implementation of audit and review recommendations

Nature of Audit	Not started	In progress	Implemented
Programme Audit 2020	2	6	2
External Audits	2	7	7
Internal Audits	0	6	8
Assurance Provider Reviews	2	23	2
Overall	**6**	**42**	**19**
Overall (%)	**9%**	**63%**	**28%**

Refer to Annex 6c for details on the status for the recommendations.

***Assurance Provider engagement not fully aligned with mandate*:** The Assurance Provider (AP), appointed in November 2024, had submitted five quarterly reports to Gavi as of July 2025. The audit review of the AP's reports and discussions with stakeholders revealed that:

- The AP had not conducted reviews at the Central Medical Store (CMS) or on the fixed asset management system, both included in its scope of work. Although limitations in access was cited, these challenges were not disclosed in reports.
- The AP identified variances between budgeted and actual expenditure but did not consistently record reasons for under- or over-utilisation of funds exceeding 10%.
- Reports presented the implementation status of prior recommendations but did not include an ageing analysis, making it difficult to track timeliness of follow-up.
- Documentation of review and verification procedures was incomplete, limiting assurance over the AP's conclusions.
- While consolidated responses from NIP were captured, the AP's verification comments for each recommendation were missing, reducing transparency of review results.

Root Cause

- The IAD is limited by insufficient resources - staffing, skills - to perform regular, risk-based audits and provide targeted recommendations.
- No joint audit planning, risk assessment, or knowledge sharing to ensure complementary assurance coverage between the IAD and AP.
- Lack of a central system or focal unit within NMCHC/NIP for tracking and escalating outstanding recommendations.
- The AP mechanism is new within the country and its scope and operational expectations are not fully appreciated by the country, which expects the AP to build capacity rather than focus on its core duties to provide assurance for Gavi.

Management comments

See detailed management responses - Annex 10

Risk / Impact / Implications	Responsibility	Deadline / Timetable
• Ineffective internal audit and assurance mechanisms reduce MoH's ability to detect control gaps and financial risks. This limited the MoH's ability to assess the pervasiveness and impact of identified issues. • Incomplete follow-up of audit and review recommendations perpetuates operational inefficiencies and fiduciary risks. • Overlaps and lack of coordination between assurance providers reduce overall effectiveness of oversight.	See detailed management responses - Annex 10	See detailed management responses - Annex 10

4.2 Programme management

4.2.1 Strategic and operational planning needs to be strengthened to achieve programme objectives

Context and Criteria

To improve coordination and accountability in the management of immunisation programmes, Gavi adopted the National Immunisation Strategy (NIS) framework developed by the World Health Organisation (WHO). The NIS serves as a unified five-year strategic and operational plan defining a country's immunisation vision, measurable objectives, and priority strategies, including costed interventions and risk mitigation measures. It aims to reduce fragmentation, strengthen alignment among partners, and serve as a key advocacy instrument to hold stakeholders accountable for delivery and performance.

The development of each NIS is guided by WHO's Immunisation Agenda 2030 (IA2030), which outlines seven strategic priorities—programme management and financing; human resource management; vaccine supply, quality, and logistics; service delivery; immunisation coverage and AEFI monitoring; disease surveillance; and demand generation—underpinned by four core principles applicable at national, sub-national, and service-delivery levels.

Cambodia developed its first NIS 2021–2025, with a long-term vision extending to 2030. To operationalise this strategy, Annual Operational Plans (AOPs) are prepared with inputs from all 24 provinces and Phnom Penh, coordinated by MoH through NIP. Each PHD submits its operational plan to NIP for review and consolidation. These AOPs detail activities, budgets, and stakeholder responsibilities, ensuring alignment with Gavi-funded programme objectives. At national level, the Project Manager coordinates technical planning, while the Finance Manager ensures budget accuracy and compliance with Gavi guidelines. The AOP is formally approved by the Project Director and the MoH Secretary prior to implementation.

Condition

The existing NIS is near expiry and does not reflect current context, also there are delays in development of the 2026 to 2030 NIS: The NIS 2021–2025 was launched in 2022, a year after its intended implementation period had begun. It was developed during the COVID-19 pandemic and was heavily shaped by pandemic-response priorities. For example, strategies were focused on COVID-19 integration across governance and programme management, human resources, vaccine supply and management, cold chain and logistics, service delivery and new vaccine introduction, demand generation and communication and financing, which while appropriate for the conditions at the time, are no longer fully aligned with the current post-pandemic immunisation landscape or emerging programmatic priorities. At the time of the audit, the audit team was informed that the development of the new NIS would commence in September 2025 with support from WHO.

Limitations in the 2021-2025 monitoring and evaluation plan*:* The NIS M&E framework does not specify timelines for measuring indicators. Although it connects strategic objectives to annual actions through the AOPs, the indicators are not aligned with quarterly, annual, or end-of-year targets. Furthermore, while the strategy provided for annual and mid-term reviews—including a planned 2023 mid-term review—no such reviews had taken place at the time of the audit.

Low absorption of Gavi support due to delays in preparation and approval of AOPs**:** The AOP development process begins in July or August of the year preceding implementation, with the goal of securing approval before January. However, approvals have consistently been delayed, resulting in compressed implementation periods. For instance, the 2022 AOP was approved in June 2022, the 2023 AOP in August 2023, and although the 2024 AOP showed some improvement, it was still approved only in February 2024. These delays have led to late initiation of activities, in some cases, cancellation of planned interventions. For example, in 2023 under the HSS3 grant, delays contributed to halted recruitment of eight planned staff positions, deferred

Recommendation 3

To enhance strategic and operational planning for immunisation MoH/NMCHC/NIP should:

- Hasten the development of the 2026–2030 NIS, applying lessons from the NIS 2021–2025 by ensuring that the development is country-led, participatory, and reflective of the current immunisation landscape.
- Strengthen the M&E framework within the next NIS by incorporating clear indicator timelines, qualitative feedback mechanisms, and a formal schedule for annual and mid-term reviews.
- Develop a structured planning calendar with defined milestones, roles, and responsibilities to ensure timely preparation, review, and presentation for approval of AOPs to the respective stakeholders and committees before the start of each fiscal year.

procurement of motorbikes for outreach activities, and postponed development of e-learning materials for training. Similarly, in 2024, procurement delays totalled USD 5,395,774.10, primarily for activities managed by UNICEF.

Table 4: Low absorption/utilisation of Gavi provided funds

Year	Budget (USD)	Actual Expenditure Incurred (USD)	Variance (USD)	Budget absoprtion %
2020	7,748,750	5,238,082	2,510,668	68%
2021	5,765,495	4,377,988	1,387,507	75%
2022	8,227,023	5,010,342	3,216,680	61%
2023	7,070,915	2,941,944	4,128,971	41%
2024	11,158,035	5,445,090	5,712,945	49%

Root Cause

- The NIS 2021–2025 was developed during the COVID-19 emergency through an external consultant-led process that prioritised pandemic-response needs. This approach limited stakeholder ownership and ongoing strategic oversight.
- Absence of a structured national planning calendar with defined milestones, responsibilities, and review checkpoints has led to recurrent delays in the preparation, validation, and approval of AOPs.
- Delayed submission of AOPs to the NIP TWG for approval which may be partly due to the committee's irregular meetings as outlined in Section 4.1.1

Management comments

See detailed management responses - Annex 10

Risk / Impact / Implications

- Misalignment between the NIS and the current country context may reduce its effectiveness as a strategic and operational guide and undermine its relevance to future Gavi funding cycles, which are linked to national immunisation strategies.
- Limited monitoring and review reduce opportunities for learning, adaptive management, and early course correction during implementation.
- Delayed approval of AOPs constrains implementation timelines, resulting in low budget utilisation, deferred delivery of planned activities, and reduced programme performance.

Responsibility

See detailed management responses - Annex 10

Deadline / Timetable

See detailed management responses - Annex 10

4.2.2 National response to growing incidence of measles cases should be intensified

Context and Criteria

Measles remains one of the most contagious human diseases and can result in severe complications and death, particularly among unvaccinated children. Although Cambodia was verified as having eliminated measles in 2015, periodic outbreaks have re-emerged due to declining routine immunisation coverage and the accumulation of susceptible populations.

According to WHO/UNICEF (WUENIC) estimates, first-dose measles-containing vaccine (MCV1) coverage reached 87% in 2022 and 89% in 2023, while second-dose coverage (MCV2) remained lower at 84%, both below the 95% threshold required for sustained measles elimination.

Regional measles transmission risk also remains high, given ongoing outbreaks in neighbouring countries with varying coverage levels and porous borders that enable frequent population movement.

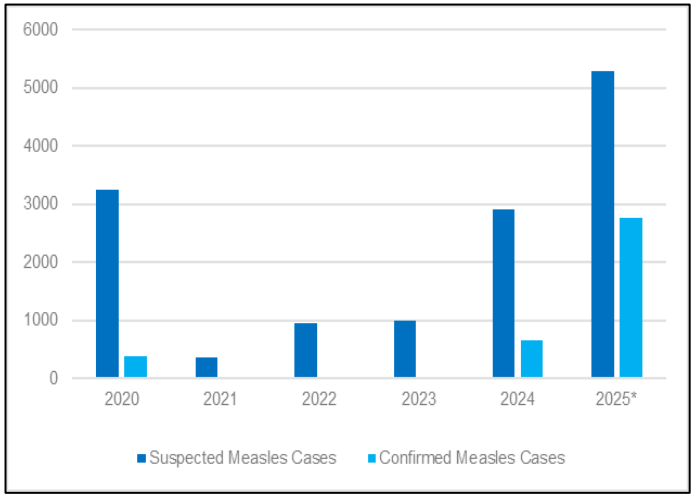
- Vietnam achieved over 95% coverage for MCV1 but lagged on MCV2 at around 92%, with large outbreaks in 2019 and 2022 due to urban immunity gaps.
- Lao PDR maintained fragile coverage (MCV1 ~85%, MCV2 ~78%), facing recurrent outbreaks, especially in rural highland areas.
- Thailand reported relatively high coverage (MCV1 ~94%, MCV2 ~91%), yet sporadic outbreaks continue, often affecting migrant and ethnic minority communities near border areas.
- Myanmar recorded some of the lowest regional coverage (MCV1 ~82%, MCV2 ~70%), with widespread outbreaks exacerbated by ongoing health system disruptions since 2021.

The Immunisation Agenda 2030 (IA2030) identifies measles elimination as a core impact goal, requiring countries to achieve ≥95% coverage with two doses of measles-containing vaccine. Similarly, the Measles–Rubella Strategic Framework (2021–2030) highlights the need for countries to maintain high population immunity through robust surveillance, equitable service delivery, and rapid outbreak response. For Cambodia, this entails addressing persistent immunity gaps, strengthening cross-border collaboration, and ensuring that both Supplementary Immunisation Activities (SIAs) and routine services reach remote, migrant, and underserved communities.

Condition

Measles cases continue to rise nationally*: *While the country was well on the way to eliminate measles in the past, Cambodia now grapples with increases in both suspected and confirmed measles cases. In 2020, the country registered 3,236 suspected cases, of which 11.7% were confirmed positive. Although suspected cases declined temporarily in 2021, they rose again in 2022 (957 cases), 2023 (988 cases), and 2024 (2,909 cases). Refer to Figure 1.

In 2024, a nationwide Measles–Rubella (MR) Supplemental Immunisation Activity (SIA) was implemented in two phases (1–13 November and 25 November–6 December), reaching approximately 1.45 million children (98.8% administrative coverage. Subnational MR SIAs and localised response activities have been carried out as part of efforts to contain measles transmission in the country.



Recommendation 4

To reduce the surge in the number of measles cases in the Country, MoH/NIP in collaboration with PHDs should:

- Ensure routine immunisation services consistently reach children at the recommended ages (9 and 18 months) and prioritise follow-up of those who missed doses through facility-based and outreach sessions.
- Expand outreach to underserved populations, including urban poor, ethnic minorities, migrants, and border communities, by deploying mobile teams and integrating vaccination with other health services including work done by the CSOs.
- Intensify health education and community engagement, implementing targeted communication campaigns to address vaccine hesitancy, reinforce the benefits of complete vaccination, and counter misinformation.

Figure 1: Number of suspected and confirmed measles cases 2020 - 2024

While coverage appeared high, the campaign did not achieve its primary objective of interrupting transmission. A significant outbreak in Phnom Penh persisted into 2025, with over 2,000 confirmed cases reported in the first four months alone. As of May 2025, the number of suspected measles cases had exceeded 5,000, with 2,762 confirmed, meaning over 50% of all suspected cases were laboratory-confirmed. These figures represent the highest measles incidence since the country's 2015 elimination verification.

Herd immunity threshold not attained: Review of WUENIC and administrative data for 2020–2024 showed consistent shortfalls in MR1 and MR2 coverage. Both datasets indicated a decline in MR1 coverage in 2023. In 2024, WUENIC showed a coverage of 83% and administrative data overreporting at 108%, suggesting denominator inaccuracies. Similarly, MR2 coverage fell from 72% in 2020 to 64% in 2023, remaining far below the 95% herd immunity threshold. While 2024 administrative data showed an increase (MR1: 108%, MR2: 104%), these were not corroborated by WUENIC, which continued to report low coverage.

Table 5: WUNEIC and Administrative coverage over the period 2020 – 2024

Vaccine	Data Source	2020	2021	2022	2023	2024
MR1	WUNEIC	83%	83%	83%	79%	83%
	Administrative	107%	103%	102%	96%	108%
MR2	WUNEIC	72%	63%	69%	64%	64%
	Administrative	91%	82%	88%	83%	104%

- Strengthen VPD surveillance systems (as detailed in Section 4.2.3 to ensure rapid case detection, reporting, and outbreak investigation, enabling early response and containment.
- Train health personnel in active case finding, outbreak investigation, and micro-planning to improve field response and surveillance sensitivity.

Root Cause

- Reduced immunisation coverage following the COVID-19 pandemic, when routine services were disrupted and catch-up campaigns delayed, resulting in large pockets of unvaccinated children.
- Low parental awareness and vaccine hesitancy, driven by misconceptions about vaccine safety and limited understanding of measles risks.
- High population mobility across provincial and international borders, leading to missed follow-up doses and reintroduction of measles from neighbouring endemic countries.
- Limitations in VPD surveillance as highlighted in 4.2.3 as well as ongoing difficulties in rapid case identification have reduced the ability to detect and contain outbreaks quickly, especially when cases are imported or arise among mobile and underserved populations.

Management comments

See detailed management responses - Annex 10

Risk / Impact / Implications

- Recurrent outbreaks have required repeated nationwide and subnational SIAs, including the 2024 national MR campaign and planned 2025 campaigns in nine provinces (Phnom Penh, Banteay Meanchey, Battambang, Kampong Cham, Kampong Thom, Kandal, Siem Reap, Preah Sihanouk, and Stung Treng).
- Campaigns divert staff and resources from routine immunisation, as the same personnel manage campaign logistics, registration, training, supervision, and daily monitoring, leading to service interruptions at health facilities.

Responsibility

See detailed management responses - Annex 10

Deadline / Timetable

See detailed management responses - Annex 10

• Failure to achieve 95% coverage and sustain high two-dose uptake results in inadequate population immunity, allowing continued transmission and increasing the likelihood of endemic persistence and regional spread.		

4.2.3 Vaccine Preventable Disease (VPD) surveillance systems need strengthening to ensure timely detection and response

Context and Criteria

Cambodia's National Immunisation Programme (NIP) targets several Vaccine-Preventable Diseases (VPDs), including polio, measles, rubella, congenital rubella syndrome (CRS), neonatal tetanus (NT), pertussis, diphtheria, and Japanese encephalitis (JE). The country has progressively expanded its surveillance capacity since the 1990s, beginning with acute flaccid paralysis (AFP) surveillance in 1994, followed by measles in 1999, NT, diphtheria, and pertussis in 2000, sentinel surveillance for meningoencephalitis (ME) and JE in 2006, and CRS in 2012.

VPD surveillance operates across three administrative levels:

- Central level: The NIP, six national hospitals, and a maternal and child health centre coordinate national surveillance activity.
- Provincial level: Surveillance is carried out by 25 Provincial Health Departments (PHDs) and provincial hospitals.
- Operational District (OD) level: Surveillance involves 103 ODs, 96 referral hospitals, 1,285 health centres, and approximately 14,388 villages.

Health workers at each level (i.e., EPI managers, surveillance officers, focal points, health centre staff, and Village Health Support Groups (VHSGs)) are responsible for case detection, notification, and public awareness. Laboratory confirmation is central to the system: the National Institute of Public Health (NIPH) serves as the reference laboratory for measles, rubella, JE, and CRS, supported by regional laboratories such as Japan's National Institute of Infectious Diseases (for polio testing) and the Research Institute of Tropical Medicine in the Philippines (for environmental poliovirus surveillance).

In alignment with WHO guidance, Cambodia's VPD surveillance system is expected to ensure:

- Timely case identification, investigation, and specimen collection within 48 hours of notification.
- Reliable laboratory confirmation within five days of specimen receipt.
- Comprehensive data reporting through WHO's Measles-Rubella Surveillance Reporting System (MRSRS) v2.3.

Given the recent rise in measles cases (see Section 4.2.2), the audit focused specifically on measles–rubella (MR) surveillance performance.

The standard specimen collection and reporting procedures for suspected measles and rubella cases are outlined in national surveillance guidelines (see Annex 7a), which require health facilities and ODs to ensure case investigation and specimen transport within prescribed timeframes.

Condition	Recommendation 5
Limitations in data entry and management in the WHO MR Reporting System (MRSRS) v 2.3: The audit reviewed the specimen collection workflow, from case detection to laboratory testing. Significant system constraints were identified: data entry into MRSRS v2.3 is limited to a single user at a time, and the absence of offline functionality means poor internet connectivity severely delays updates. Furthermore, analysis of the data revealed anomalies such as negative intervals between symptom onset and specimen collection, and inconsistencies between specimen collection and laboratory dispatch timelines—issues that highlight critical weaknesses in the system's design and reliability see (Annex 7b). ***Delays between symptom onset, specimen collection, and laboratory receipt*:** A significant proportion of positive samples were collected beyond the 48-hour target window after notification of suspected cases; 34% in 2020, 38% in 2022, 36% in 2023, and 23% as of May 2025. Additionally, 32% of positive specimens in 2023 and 41% as of May 2025, reached the laboratory beyond the five-day target (See Annex 7b, Annex 7c and Annex 7d). ***Limited private sector engagement in surveillance***: Interviews with VPD surveillance focal persons revealed that private health facilities were not participating in VPD reporting in 3 of 5 PHDs and 5 of 8 ODs reviewed. Given that the private sector provides approximately 65% of all primary healthcare services, this exclusion significantly limits case detection coverage and weakens early outbreak warning capacity. ***Restrictions on specimen collection by health centre staff*:** Health centre staff are not authorised to collect specimens independently during case investigations. Under the current protocol, they must notify the OD, which then deploys personnel for specimen collection. This arrangement creates avoidable delays and increases the risk of missed opportunities for testing when OD teams are unable to respond promptly. ***Over reliance on WHO Staff:*** In Cambodia, the health system remains heavily dependent on WHO personnel for critical surveillance functions, including data compilation, epidemiological analysis, and preparation of surveillance bulletins.	To strengthen VPD surveillance performance, timeliness, and coverage, the MoH/NIP, in collaboration with PHDs and ODs, should: • Engage WHO to expand user access rights for MRSRS v2.3 and explore enhancements such as offline functionality and multi-user capability. This engagement should include an understanding of data ownership and sustainable access to the data for the country within the reduced funding environment and ownership/retention of country data. • Designate national focal points within NIP to progressively assume WHO's current roles in VPD data collection, analysis, reporting, and publication to promote sustainability. • Identify and train health centre-based surveillance focal persons to manage case investigation, specimen handling, and data reporting. • Strengthen private-sector participation by issuing guidance, providing training, and distributing VPD surveillance tools and reporting templates, with regular follow-up to ensure compliance. • Review and revise specimen-collection protocols to allow trained health centre staff to collect and submit specimens directly, where capacity and infrastructure permit, reducing delays in response.
Root Cause	Management comments
• Inadequate system design and requirements planning for MRSRS, resulting in a platform that lacks offline capability and multi-user functionality, making it unsuitable for low-connectivity environments and high-volume workflows. • Resource limitations were the primary driver behind the absence of a formal requirement and accountability mechanism for appointing dedicated VPD surveillance focal persons. These constraints led to reliance on existing staff, under the assumption they could absorb additional responsibilities—resulting in significant gaps in surveillance capacity. There were no dedicated VPD surveillance at 1 of 5 PHDs and 6 of 8 ODs reviewed. Surveillance functions were often delegated to NIP Managers already burdened with other responsibilities.	See detailed management responses - Annex 10

• The absence of a formal policy or regulatory framework mandating private-provider participation, combined with inadequate planning for private-sector engagement, has resulted in limited awareness and lack of incentives for involvement • Overly centralised and rigid specimen-collection protocols, stemming from policy design, resulting in limited delegation of authority to health centre staff and delayed response times. • Gaps in surveillance capacity at national and sub national level for example no trainings were conducted in 2024 and 2025 for staff in 1 of 5 PHDs, 2 of 8 ODs, and 18 of 31 health centres. Consequently, in 6 health centres, staff could not accurately define a suspected measles or AFP case.		
Risk / Impact / Implications • Slow data entry and transmission hinder laboratory testing, causing delays which reduce the timeliness of laboratory confirmation, constrain rapid response, and increase outbreak risk and response. • Inadequate private-sector participation and limited trained personnel weaken the system's ability to detect and investigate suspected cases comprehensively. • Restrictive specimen-collection protocols increase the risk of uninvestigated or untested suspected cases, allowing ongoing transmission in communities. • Continued reliance on WHO staff for central-level operations raises sustainability concerns particularly considering ongoing funding reductions.	Responsibility See detailed management responses - Annex 10	Deadline / Timetable See detailed management responses - Annex 10

4.2.4 CSO engagement and coordination requires strengthening

Context and Criteria

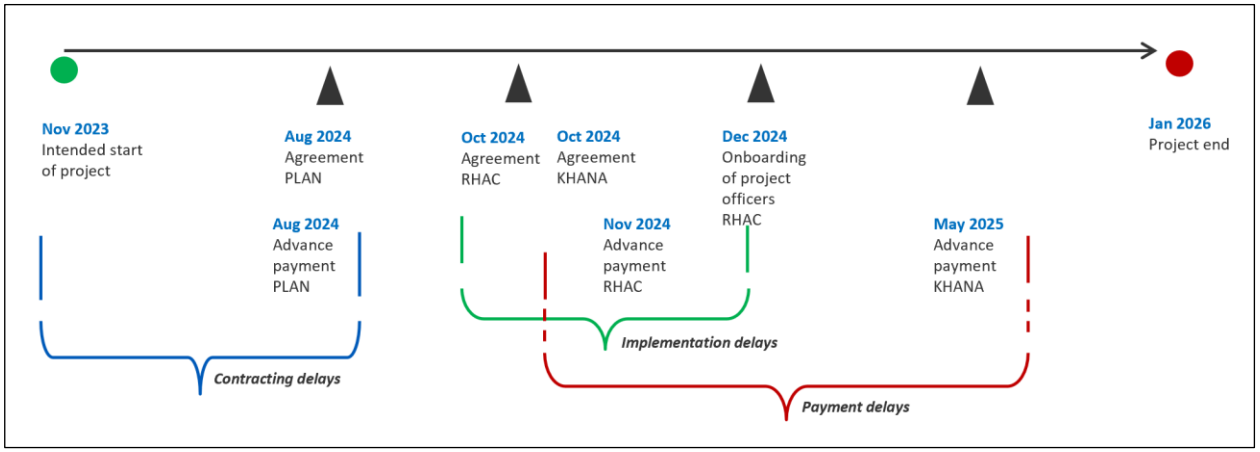
In December 2021, the Gavi Board approved the Civil Society and Community Engagement (CSCE) Strategy, requiring countries to allocate at least 10% of their combined Health Systems Strengthening (HSS), Equity Accelerator Funding (EAF), and Targeted Country Assistance (TCA) ceilings to CSO-led implementation, unless a strong rationale is provided for exemption. This policy aims to strengthen country-led community engagement, promote equity, and reach zero-dose and under-immunised children through CSO partnerships.

In Cambodia, the National Immunisation Programme (NIP) engaged three CSOs (Reproductive Health Association of Cambodia (RHAC), Khmer HIV/AIDS NGO Alliance (KHANA), and PLAN International) to implement interventions targeting a 50% reduction in zero-dose children by 2025. This approach aligns with Gavi's CSO Strategy pillars: reaching underserved populations, community engagement, demand generation, data use, and capacity building.

Condition

The audit noted significant delays and coordination weaknesses that affected timely implementation of CSO-led zero-dose projects. These delays occurred across contracting, implementation, and payment stages, as illustrated in Figure 2 below.

Figure 2: Timeline for CSO project



***Delays in project Commencement and contracting*:** The project was originally intended to start in November 2023 for a 26-month period. Initially, the NIP had planned to manage the CSO component through UNICEF under the PEF mechanism, but this was later revised to use the Gavi Fund Manager, and subsequently the Gavi CSO Constituency. These multiple shifts in management approach led to substantial contracting delays, with final agreements concluded only in August 2024.

Furthermore, implementation did not begin immediately after contracting, as CSOs required time to recruit staff and establish operational systems. For example, RHAC completed recruitment of project officers only in December 2024, and KHANA held

Recommendation 6

To strengthen CSO engagement and coordination and accelerate the delivery of zero-dose objectives, the MoH/NIP should:

- Establish a CSO coordination mechanism within NIP, with clearly defined responsibilities for planning, oversight, and reporting to a national-level strategic committee with appropriate reporting to the TWGH.
- Streamline approval processes and decision-making within NIP to avoid delays in activity implementation.
- Engage Gavi to review and adjust the current payment mechanism to ensure timely disbursement of funds and avoid disruptions in project delivery.

its kick-off meeting in the same month. Consequently, the effective implementation period was reduced to approximately 12 months.

***Delays in activity implementation*:** Implementation of activities across all three CSOs was affected by internal approval bottlenecks and competing priorities at NIP. For instance, several RHAC activities remained pending NIP approval between January and May 2025, and the Project Launch Workshop initially scheduled for August 2024 was postponed to October 2024 due to the unavailability of the Project Management Group (PMG). Development of training materials for Village Health Support Groups (VHSGs) was rescheduled for August 2025, while quarterly learning reports due in December 2024 and April 2025 had not been finalised at the time of the audit.
As a result of these cumulative delays, the audit found that the project scope was revised downwards. For example, the Rapid Capacity and Community Assessment (RCCA), originally planned at baseline, midline, and endline—was reduced to two rounds after the midline assessment was removed from the workplan.

Payment delays and cash flow constraints: Prolonged delays in milestone approvals and disbursements disrupted cash flow for all three CSOs. Advance payments for RHAC and KHANA were received several months after contract signing (November 2024 and May 2025 respectively). See Table 6. These delays jeopardised operational continuity, staff retention, and activity rollout, particularly for smaller organisations with limited reserves.

Table 6: CSO expenditure Vs received funds

CSO	Fees and expenses to date (June 2025) (USD)	Funds received by CSO to date (June 2025) (USD)
PLAN	*283,506*	*107,417*
RHAC	*130,243*	*21,176*
KHANA	*83,732*	*40,577*

Root Cause

- There was no dedicated NIP focal point or unit assigned to coordinate CSO engagement or ensure timely review and decision-making.
- Key programme staff were frequently unavailable due to concurrent immunisation campaigns and other high-level commitments, delaying consultations and approvals.
- The current payment modality, reliant on milestone-based approvals, has created cash-flow pressures for CSOs, limiting their ability to deliver outputs within shortened timelines.

Management comments

See detailed management responses - Annex 10

Risk / Impact / Implications

- Condensed implementation timelines limit CSOs' ability to deliver comprehensive and sustainable interventions.
- Recurrent payment delays undermine CSO sustainability, affecting staff retention and timely delivery of activities.
- Absence of a structured mechanism within NIP reduces oversight, follow-up, and performance tracking of CSO-led activities.

Responsibility

See detailed management responses - Annex 10

Deadline / Timetable

See detailed management responses - Annex 10

4.2.5 The design, coordination and monitoring of technical assistance needs to be improved

Context and Criteria

The PEF TCA guidance (2019–2020) defines the roles and responsibilities of key stakeholders in planning, monitoring, and reporting on technical assistance. These responsibilities are designed to ensure that TCA contributes to measurable, sustainable improvements in national immunisation programme performance.

Under this framework, the National Immunisation Programme (NIP) is responsible for leading the development of the OneTA Plan, coordinating the identification of TCA needs, assigning implementation responsibilities among core and expanded partners, and convening quarterly meetings to review progress. The guidance emphasises country ownership and mutual accountability, requiring that partners report regularly on programmatic and financial progress, and that NIP validate the accuracy and consistency of reported results.

TCA performance should be reviewed jointly by NIP, implementing partners, and other stakeholders, with clear evidence of:

- Alignment of TCA activities with programme priorities;
- Defined deliverables and performance indicators;
- Capacity transfer and sustainability plans; and
- Verification of results through evidence-based assessments demonstrating improvements in coverage, data quality, supply chain, and financial management.

Condition

PEF TCA activities are not designed for transition to government ownership: Between 2022 and 2025, Cambodia received more than USD 4.7 million in TCA funding through core and expanded partners, of which approximately 72% was earmarked for staffing. The audit found that many positions filled through TCA primarily addressed short-term gaps rather than sustainable capacity building. TA was often used for direct implementation or operational support rather than skills transfer to NIP staff.

Furthermore, the audit noted the absence of structured exit strategies or transition plans. For example, the dashboards developed by CHAI continued to be maintained and updated by CHAI staff instead of being handed over to national personnel. Similarly, the training database created in 2022 remained unpopulated, and tools such as the EPI staff capacity assessment report and supportive supervision guidelines had not been operationalised by NIP.

Tracking of capacity building initiatives and contribution is not clear: Despite capacity strengthening being a stated objective of TCA, there was no mechanism to systematically track progress or measure the impact of capacity-building interventions. The country lacked baseline capacity assessments, mutually agreed training or mentorship plans, and a documented skills transfer framework. Consequently, it was not possible to assess whether TA inputs were improving institutional performance or staff competencies.

Delays in reporting milestones**: T**he strategic period for the ongoing PEF-TCA ends in December 2025.Analysis of milestone submissions between 2020 and 2024 as at 17 March 2025 showed that 37% of milestones for CHAI, 23% for UNICEF, and 32% for WHO had not been reported by the time of the audit. See Table 7 below. The absence of structured milestone validation and reporting reviews limited the NIP's visibility on implementation progress and overall value for money.

Table 7: Status of milestone reporting

Partner	Milestones completed and milestones on track	Milestones not reported
Clinton Health Access Initiative (CHAI)	61%	37%
UNICEF	47%	23%
WHO	52%	32%

Recommendation 7

To improve the design, coordination, and monitoring of technical assistance and ensure sustainability and impact, the MoH/NMCHC/NIP should:

- Develop a comprehensive transition plan that embeds capacity-building and structured skills transfer into all TA engagements, ensuring eventual handover of TA-supported functions to national staff.
- Collaborate with TA partners to ensure that all progress reports and milestone achievements are reviewed, validated, and formally endorsed by NIP prior to submission to Gavi.
- Strengthen the design of TA contracts by including clearly defined deliverables, milestones, and timelines, and by establishing a performance review process that directly links staff appraisals to agreed outputs.
- Institutionalise a TCA monitoring framework within NIP to track capacity-building progress, validate deliverables, and measure the long-term impact of technical assistance on programme performance.

Gaps in design of TA contracts and monitoring at NIP*:** Review of TA contracts managed by NIP revealed inconsistencies in design and oversight. Some contracts lacked defined deliverables, while others listed deliverables unrelated to job descriptions. In certain instances, roles combined distinct skill areas (e.g. communication and monitoring and evaluation), which may have compromised performance. Although a few contracts included deliverables and timelines, there was no evidence that outputs were monitored, validated, or retained. Requested deliverable samples were unavailable, and only generic progress reports were found across multiple contracts. In some cases, TA contracts (such as those related to cold chain and logistics management) were issued without any stated deliverables. ***Gaps in performance appraisal process for TAs hired at NIP: Performance appraisals for TA staff were largely generic and lacked objective, evidence-based evaluation. Assessments did not reference contractual deliverables or measurable outputs such as training sessions conducted, reconciliations completed, or reports submitted. There was minimal qualitative feedback or identification of areas for improvement. Appraisal comments were general and not linked to organisational objectives. (See Annex 7e).		
Root Cause • There is no defined roadmap for transferring responsibilities currently managed by partners to government staff, resulting in prolonged dependence on external TA. • Partners currently rely on the generic Gavi portal to report on implementation progress, but this system has several limitations, particularly concerning the quality and relevance of milestone data. The current approach to measuring results tends to focus either on activities, short-term outputs, and planning processes, or on end outcomes such as coverage, with limited emphasis on intermediate results and the actual impact of TA. • Inadequate visibility by NIP on the implementation progress with no formalised process to validate the achievement of PEF TCA milestones. There was no evidence of review, monitoring and validation of TCA activity milestones and deliverables by NIP. Reports on TCA activity milestones and deliverables were not shared with and/or reviewed by the NIP before reporting in the Gavi portal. • There is no dedicated unit or clearly defined structure to coordinate, supervise, and evaluate TA functions.	Management comments See detailed management responses - Annex 10	
Risk / Impact / Implications • Lack of accountability and structured capacity transfer may prevent the OneTA Plan from achieving its intended outcomes. • Continued reliance on partner-implemented TA risks creating parallel systems rather than building lasting national capacity. • Weak monitoring of TA contracts and milestones diminishes transparency, value for money, and sustainability of programme results.	Responsibility See detailed management responses - Annex 10	Deadline / Timetable See detailed management responses - Annex 10

4.3 Data reporting and assurance processes

4.3.1 Accuracy of immunisation coverage data requires strengthening to support data driven decision making

Context and Criteria

Gavi's grant application guidelines require all supported countries to strengthen data availability, quality, and use in immunisation planning, programme management, and performance monitoring. Countries are encouraged to institutionalise the use of immunisation coverage data to inform decision-making, resource allocation, and progress tracking toward national and global targets.

Specifically, the guidelines call for:

- Annual desk reviews to monitor coverage data and identify discrepancies;
- Independent mechanisms to assess the quality of administrative data and plans to address data weaknesses following annual Joint Appraisals; and
- Regular population-based surveys to verify immunisation coverage and assess the accuracy of administrative reports.

Furthermore, under the PFA, all information submitted to Gavi (including applications, progress reports, and supporting documentation) must be accurate and correct as of the date of provision. During the Independent Review Committee's (IRC) review of Cambodia's Full Portfolio Planning (FPP) application, the NIP was advised to strengthen data culture through incentives for timely, high-quality data reporting, improved analysis, and active use of data for performance management.

Condition

The audit identified significant disparities between administrative and WHO/UNICEF Estimates of National Immunisation Coverage (WUENIC) data for key antigens, notably Pentavalent 1 and MR1. The largest variance for Pentavalent 1 exceeded ten percentage points in 2023, while discrepancies of over ten percentage points for MR1 were observed in four of the five years reviewed. Refer to the Table 8 below for details:

Table 8: Immunisation coverage for Pentavalent 1 and MR 1

	Penta1		MR1	
	Administrative coverage (*HMIS*)	Estimated coverage (*WEUNIC*)	Administrative coverage (*HMIS*)	Estimated coverage (*WEUNIC*)
2020	95%	92%	107%	83%
2021	98%	92%	103%	83%
2022	97%	92%	102%	83%
2023	108%	93%	96%	79%
2024	95%	90%	108%	83%

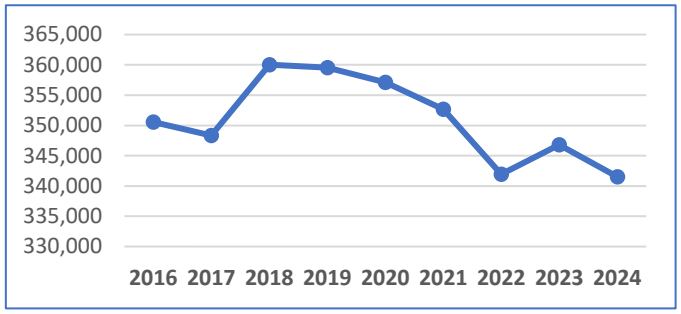
Further analysis revealed that the denominator assumptions used by NIP and WUENIC differ substantially. WUENIC's population denominator has shown a declining trend, whereas NIP continues to apply a 1.49% annual growth rate to the 2019 census data within the Health Management Information System (HMIS). These methodological differences have widened the coverage gap between administrative and WUENIC estimates. Refer to Figure 3 below to see the trend of denominator for WEUNIC computation.

Recommendation 8

To improve accuracy of immunisation coverage data and strengthen evidence-based decision making, the NIP should:

- Institutionalise regular data quality assessments, including detailed desk reviews and field verification of administrative data.
- Develop and implement a Data Quality Improvement Plan that defines timelines, responsibilities, and tools for validating data at all reporting levels.
- Establish a formal mechanism for systematic validation of administrative coverage figures before national reporting and submission to Gavi or WHO/UNICEF.

Figure 3:Denominator trend used for WUNEIC data computation



Root Cause

- The NIP has not conducted national Data Quality Assessments (DQA) or coverage evaluation surveys in the past ten years, nor developed a Data Quality Improvement Plan, as recommended in the previous programme audit.
- There is no established mechanism or standard process for validating administrative data before consolidation and reporting.

Management comments

See detailed management responses - Annex 10

Risk / Impact / Implications

- Over- or underestimation of immunisation coverage may distort resource allocation, masking areas with low performance or creating inefficiencies in vaccine distribution.
- Persistent data discrepancies may erode confidence in reported results.

Responsibility

See detailed management responses - Annex 10

Deadline / Timetable

See detailed management responses - Annex 10

4.4 Digital Immunisation Information Systems

4.4.1 There are opportunities exist to enhance the design and interoperability of the EIR

Context and Criteria

In Cambodia's Electronic Immunisation Registry (EIR) is a national digital initiative led by the National Immunisation Programme (NIP) under the National Maternal and Child Health Centre (NMCHC), in collaboration with the General Secretariat of the National Digital Government Committee (NDGC) within the Ministry of Post and Telecommunications. The system is intended to record individual-level vaccination data in real time, enabling health workers to monitor immunisation coverage, follow up on defaulters, and generate accurate data for decision-making across all administrative levels. Development of the EIR commenced in July 2024, aligned with Cambodia's draft National Digital Health Strategy (2021–2030), and followed a phased roadmap encompassing system design, configuration, testing, and a pilot phase. The pilot was conducted between October 2024 and May 2025 across four Operational Districts (ODs)—Porsenchey, Mekong, Siem Reap, and Kampong Cham–Kampong Siem—and at the NMCHC national hospital, involving 65 health facilities and 119 users.

At the time of the audit, two primary EIR functions were operational: 1). Child registration, enabling creation of individual electronic profiles prior to vaccination; and 2)Vaccination scheduling and tracking, allowing users to record administered doses and retrieve vaccination histories.

The National Digital Health Information for Immunisation Roadmap envisions the EIR as an integrated digital platform linked to national dashboards, master lists, and population registries. According to WHO and UNICEF guidance, effective EIRs should adhere to global design standards, exhibit interoperability with national health information systems, and include private-sector reporting mechanisms to ensure completeness of data.

Condition

***No alignment with standards for EIR implementation*:** The current EIR does not meet internationally recognised functional standards for immunisation registries. Of the seven core functions expected of a robust EIR (such as interoperability, data quality assurance, reporting, and user management) only two were partially operational. This limits the system's ability to reliably capture, analyse, and share data at scale. See table below for details

Table 9:EIR features

#	EIR Feature	Description	Status of completion	Cambodia EIR status
1	Child registration	Unique ID linked to national registry	Partially	System generated IDs not linked to national/ citizen registry
2	Vaccine schedule & tracking	Auto scheduling, alerts and vaccine history	Partially	Basic tracking and history available, no alerts or auto scheduling
3	Offline functionality	Full offline feature with sync option	No	Not supported
4	User management	Role based access and audit trails	No	No user management module
5	System integration	Interoperable with HMIS, eLMIS	No	Not integrated with any system
6	Dashboards & analytics	Subnational dashboards for decision support	No	Not yet integrated
7	Campaign monitoring	Realtime campaign module with data capture	No	Not supported

Recommendation 9

To improve the design, interoperability, and scalability of the EIR, the MoH/NIP, in collaboration with relevant stakeholders, should:

- Expedite endorsement of the National Digital Health Strategy (2021–2030) to establish a clear governance mandate and empower oversight structures for digital health.
- Operationalise the Digital Health Steering Committee and Technical Working Group, with defined terms of reference, regular meetings, and clear accountability for guiding EIR development and implementation.
- Recruit a dedicated digital health expert within the MoH to oversee EIR project management, coordination, and reporting.
- Ensure system design and evaluation include:
  - Alignment with national and international EIR standards;

EIR is not interoperable with existing health information systems: The EIR operates as a stand-alone platform, without integration with the Health Management Information System (HMIS) used to capture aggregated vaccination data. This siloed structure prevents synchronisation of vaccination data, leading to fragmented reporting and delayed analysis for programme management. ***No provision for private sector reporting:*** The EIR does not capture immunisation data from private health facilities, which represent a significant proportion of national service delivery, over 80% of outpatient visits in 2022 across 16,000 registered facilities. This omission risks producing incomplete and potentially misleading coverage data at national level. ***Absence of dedicated project oversight:*** There was no designated project manager within NIP to oversee EIR design and implementation. Although the Ministry of Health had attempted to recruit a digital health resource, the position remained vacant during the audit. The lack of dedicated leadership has contributed to slow progress, weak coordination, and unclear accountability for system implementation.	• Structured end-user feedback during design and testing; • Provisions for interoperability with HMIS and other national systems; • Inclusion of private-sector reporting; and • Comprehensive data management and security features, including audit trails, encryption, and role-based access controls.
Root Cause • The National Digital Health Strategy (2021–2030) and Digital Health Information for Immunisation Roadmap remain in draft form and lack formal endorsement, resulting in weak institutional authority for digital health initiatives. • The Digital Health Technical Working Group (TWG), established in August 2022 and intended to be co-led by WHO and UNICEF, was never operationalised, leaving no functional platform to guide and coordinate EIR development. • The Ministry of Health does not yet have a dedicated Digital Health Department or project management capacity to oversee digital health initiatives. Absence of an appointed technical project manager has constrained strategic and operational oversight	Management comments See detailed management responses - Annex 10
Risk / Impact / Implications • Delays in EIR system development and national scale-up may limit the availability of reliable, real-time immunisation data for evidence-based decision-making. • Lack of interoperability and private-sector integration increases the risk of incomplete data, undermining national coverage estimates and performance monitoring. • Absence of a coordinated governance framework reduces accountability and may result in fragmented, duplicative digital health investments.	Responsibility See detailed management responses - Annex 10 Deadline / Timetable See detailed management responses - Annex 10

4.5 Vaccine Supply Chain Management

4.5.1 The vaccine forecasting processes should be enhanced

Context and Criteria

Vaccine forecasting is a core supply chain function that ensures vaccines are available where and when they are needed by integrating programme data, consumption trends, and demographic information to estimate national and subnational requirements. Effective forecasting involves analysing epidemiological and population data, reviewing historical consumption and wastage rates, and maintaining sufficient buffer stocks to mitigate supply risks.

Accurate forecasting requires an evidence-based, participatory process involving national authorities, Gavi partners such as WHO and UNICEF, and other key stakeholders. Forecasts should be reviewed regularly to reflect new vaccine introductions, coverage targets, and system changes. This process directly informs budgeting, procurement, and distribution planning, ensuring efficient resource use, minimising stock-outs and wastage, and supporting equitable access to immunisation services.

In Cambodia, vaccine forecasting and related budgeting are typically conducted in April for the following year. The Ministry of Health (MoH)/National Immunisation Programme (NIP) prepares the forecasts using Excel-based tools that apply assumptions on surviving infants, coverage targets, wastage rates, and a 25% buffer stock during new vaccine introductions. The budget proposal is submitted to the Ministry of Planning and Economic Development for review and, after inputs from partners such as UNICEF, forwarded to the National Assembly for approval, usually by November or December.

Condition

***Partner-led forecasting process limits national ownership and sustainability*:** The forecasting process in Cambodia remains heavily dependent on partner support. Since the retirement of the former logistics officer in 2020, forecasting has been led primarily by UNICEF, with limited leadership from NIP staff. Attempts to fill the logistics officer position have been temporary, and the Gavi-funded Technical Assistance for logistics management has not been integrated into the forecasting function. At the time of the audit, the NIP Senior Programme Officer for Logistics and Inventory was not leading the process, and there was no clear succession plan to sustain forecasting capacity internally.

***Variances between forecasted and received vaccine quantities*:** Analysis of vaccine forecasts from 2020–2025 revealed notable discrepancies between forecasted quantities and actual vaccine receipts recorded in the National Drug and Inventory Database (NATDID). Variances included a 13% difference for Pentavalent vaccine and 17% for BCG, while IPV and MR vaccines were received in excess of forecasted amounts. The lack of systematic post-forecast reviews meant that these variances were not used to refine assumptions for subsequent years, reducing accuracy and predictability in procurement planning.

Recommendation 10

To strengthen ownership and improve forecasting processes, the MoH/NIP should:

- Designate dedicated personnel within NIP to lead the forecasting process, update their job descriptions to include this responsibility, and ensure clear accountability.
- Build forecasting capacity through structured mentoring, peer learning, and skills transfer initiatives from partners and technical assistance providers.
- Develop and institutionalise SOPs and work instructions that document data sources, parameters, and review protocols for forecasting accuracy.
- Establish an annual post-forecast review mechanism to compare forecasted versus actual vaccine usage and incorporate lessons into subsequent planning cycles.

Table 10: Forecasted Vs Received Vaccines at CMS

Vaccine		2020	2021	2022	2023	2024	Total	% Difference (# forecasted Vs # of doses received
Pentavalent	# of vaccine doses forecasted	1,067,455	1,051,180	1,076,374	1,059,978	1,075,440	**5,330,427**	**13%**
	# of vaccine doses received at CMS	977,000	791,800	1,043,650	1,279,940	540,210	**4,632,600**	
Measles & Rubella	# of vaccine doses forecasted	1,638,399	1,613,418	1,652,088	1,626,923	1,650,654	**8,181,481**	**(13%)**
	# of vaccine doses received at CMS	1,601,000	850,000	2,160,000	1,825,000	2,809,250	**9,245,250**	
IPV	# of vaccine doses forecasted	409,600	403,355	413,022	406,731	412,663	**2,045,370**	**(7%)**
	# of vaccine doses received at CMS	421,400	429,800	441,680	729,400	166,600	**2,188,880**	
PCV	# of vaccine doses forecasted	1,034,778	1,019,001	1,043,424	1,027,530	1,042,518	**5,167,251**	**6%**
	# of vaccine doses received at CMS	1,201,600	741,000	963,700	1,033,250	902,600	**4,842,150**	
BCG	# of vaccine doses forecasted	3,449,260	3,396,670	3,478,080	3,425,100	3,475,060	**17,224,170**	**17%**
	# of vaccine doses received at CMS	2,462,000	1,462,000	4,944,000	2,300,000	3,046,000	**14,214,000**	

Root Cause

- Absence of a designated forecasting lead within NIP and weak succession planning following staff turnover.
- No formal SOPs or forecasting manuals outlining key parameters, data sources, validation methods, or responsibilities of involved stakeholders.
- Forecasts are revised by Gavi and partners prior to approval without a structured national process for incorporating feedback into future iterations.
- Minimal skills transfer from partners and technical assistance providers has restricted NIP's ability to independently manage the forecasting process.

Management comments

See detailed management responses - Annex 10

Risk / Impact / Implications

- Without institutional ownership and designated forecasting champions, reliance on partners will continue, limiting long-term programme self-sufficiency.
- Forecasting methodological inconsistencies and absence of periodic validation may result in under- or overestimation of vaccine needs, leading to overstocking and wastage or stock-outs and missed immunisation opportunities.
- Inaccurate forecasts may distort vaccine distribution, leaving underserved areas under-supplied and undermining progress toward universal immunisation coverage.

Responsibility

See detailed management responses - Annex 10

Deadline / Timetable

See detailed management responses - Annex 10

4.5.2 Vaccine inventory management and stock visibility challenges should be addressed

Context and Criteria

Effective vaccine inventory management is critical to maintaining an uninterrupted supply of potent vaccines and preventing both shortages and wastage. A well-functioning inventory system enables accurate demand forecasting, timely order adjustments, and efficient distribution, thereby reducing the risk of stock-outs or overstocking.

An optimal inventory management framework should ensure end-to-end visibility of vaccine stocks across all levels of the supply chain, support accurate record keeping, and facilitate data-driven decisions for procurement and replenishment. In Cambodia, vaccine supplies from the Central Medical Store (CMS) typically pass through Provincial Health Departments (PHDs) and Operational Districts (ODs) before reaching health centres (HCs).

According to Gavi's Immunisation Supply Chain Strategy (2021–2025), countries are expected to strengthen vaccine inventory management by:

- Implementing electronic logistics management information systems (eLMIS) for real-time data visibility;
- Maintaining complete, accurate, and timely stock records;
- Regularly reviewing performance and stock accuracy; and
- Building the capacity of vaccine handlers to ensure accountability and efficiency.

Inventory management must also be integrated into national supply chain strategies, supported by cold chain infrastructure, clear partner roles, and robust monitoring mechanisms to ensure vaccines always remain available and potent.

Condition

***Absence of an operational eLMIS*:** At the time of the audit, Cambodia had not yet implemented a functioning electronic Logistics Management Information System (eLMIS). As an interim measure, UNICEF supported the development of a simplified tool on the Organisational Network Analysis (ONA) platform to help PHDs aggregate and report vaccine logistics data. However, ODs and health centres continued to rely on paper-based tools and Excel templates, limiting real-time visibility. The ONA system does not offer the functionality or analytical capability of a comprehensive eLMIS, constraining national oversight of vaccine flow and stock accuracy.

Unreconciled stock in National Drug and Inventory Database (NATDID) system - Annual stock reconciliations for five sampled antigens (Pentavalent, IPV, MR, PCV, and BCG) at the CMS for the period 1 January 2020 – 31 December 2024 revealed variances in three of the five vaccines. See Table 11 below. Similar discrepancies were found at sub-national level: two of five PHD vaccine stores had unreconciled stock balances over the same period (Annex 8a). These differences indicate incomplete or inconsistent updating of stock records in NATDID.

Recommendation 11

To enhance vaccine inventory management and stock visibility at National and sub national level, MoH/NIP:

- In collaboration with other donor partners should expedite the development and implementation of the mSupply eLMIS
- Should periodically conduct data checks in NATDID and reconcile the data after obtaining the necessary approvals
- In collaboration with PHDs and ODs should standardise and enforce comprehensive record keeping practices, ensuring that all inventory transactions are consistently and promptly documented on stock cards. Staff should receive focused training on proper stock card completion, regular updates, and reconciliation procedures, supported by supervisory reviews and periodic checks to verify compliance and accuracy

Table 11: Stock reconciliation at CMS between January 2020 and December 2024

Vaccines	Closing Balance as of 31 Dec 2019 (A)	Opening Balance as of 1 Jan 2020 (B)	Total Receipts [Jan '20 - Dec '24]	Total Issues [Jan '20 - Dec '24]	Calculated Balance (C)	Stock Balance as of 1 Jan 2025 (D)	VAR 2(C-D)
Pentavalent vaccine	451,645	451,645	4,632,600	4,979,739	104,506	180,806	(76,300)
Inactivated Polio vaccine (IPV)	144,350	144,350	2,188,880	1,903,325	429,905	429,905	-
Pneumococcal Conjugate Vaccine (PCV)	387,850	387,850	4,842,150	5,006,545	223,455	324,655	(101,200)
Measles and Rubella	922,300	922,300	9,245,250	9,179,535	988,015	656,015	332,000
BCG	1,259,500	1,259,500	14,214,000	12,506,900	2,966,600	2,966,600	-

Inconsistent traceability of vaccine stocks between distribution points: During field visits, the audit team compared vaccines issued by supplier stores with quantities received at downstream facilities. In two of five PHD stores, not all vaccines issued by CMS could be traced in stock cards. At three of eight OD vaccine stores, vaccines issued by PHDs were missing in OD records, and in 15 of 31 health centres, vaccines issued by ODs were not fully traceable (Annex 8b, Annex 8c and Annex 8d). In one case, a PHD recorded receiving more stock than was issued by CMS, reflecting data entry and reconciliation weaknesses).

Variances in stock counts and current balances - A physical stock count of six selected vaccines including one Covid'19 vaccine was conducted and compared against the running balances recorded in the stock cards at the various vaccine storage points. Discrepancies between physical stock and recorded balances of at least one of the sampled vaccines were found in: 3 out of 5 PHD vaccine stores, 2 out of 8 ODVS and 23 out of 31 health centres (See Annex 8e, Annex 8f, Annex 8g).

Vaccine stock outs during review period: Between 1 January 2020 and the audit date, stockouts of at least one of the sampled vaccines (Pentavalent, IPV, PCV, MR, BCG) were observed at the CMS during the period with the last stock out occurring for IPV on 13 December 2022. No stock outs of the sampled vaccines have been registered since that date at the CMS (See Annex 8h for details). At sub national level 2 out of 5 PHDs registered stock outs of at least one of the indicator vaccines. IPV registered the greatest number of consecutive stocked out days at 62 followed by MR (50 days) (See Annex 8i for details). 6 out of 8 ODVS recorded a stock out of at least one of the sampled vaccines. BCG vaccines registered the greatest number of consecutive stock out days at 69, the same vaccine was stocked out at for 61 days at another ODVS followed by MR vaccine (59 days) (See` Annex 8j for details). At the service delivery point, 26 out of 31 HCs registered a stock out of at least one of sampled vaccines (See Annex 8k for details).

<table>
<tr><td>Root Cause
Cambodia’s delay in developing an eLMIS has been primarily attributed to limited IT human resources, skills and technical capacity for managing digital supply chain systems.
There is no defined procedure for recording and passing stock adjustments, either within NATDID or on manual stock cards.
Record keeping deficiencies were observed, including newly created stock cards, missing stock cards, unrecorded transactions, and delays in updating stock cards
Inconsistent physical stock counts and documentation - Physical stock counts were either inconsistently performed or poorly documented.</td><td colspan="2">Management comments
See detailed management responses - Annex 10</td></tr>
<tr><td>Risk / Impact / Implications
Absence of an integrated eLMIS limits access to real-time inventory data, constraining evidence-based decisions for stock redistribution and replenishment.
The absence of standardised guidance for passing stock adjustments increases the risk of inconsistent or inaccurate stock records, weakens accountability, and undermines the reliability of inventory data for decision-making and reporting.
Risk of undetected vaccine losses and accountability gaps in NATDID: Weak system controls and data inconsistencies in NATDID create the potential for undetected vaccine losses and raise accountability concerns.
Poor records management at vaccine handling points increases the risk of stock discrepancies, prevents timely identification of inventory needs, resulting in disruptions to vaccine availability and undermining the reliability of service delivery.</td><td>Responsibility
See detailed management responses - Annex 10</td><td>Deadline / Timetable
See detailed management responses - Annex 10</td></tr>
</table>

[1] Designing a Repair and Maintenance System for CCE

4.5.3 Cold chain management practices need to be improved

Context and Criteria

Gavi's CCEOP requires countries to conduct a structured gap analysis before procuring new equipment. This analysis involves reviewing facility-level data to identify where capacity is lacking or equipment is outdated, ensuring investments are targeted to maximise performance and coverage. Gavi supplies multiple tools and templates, such as the Total Cost of Ownership tool and CCEOP Application guidelines, to support countries in inventory assessment and defining CCE requirements.

To ensure that the CCE continue to function reliably, protect vaccine potency, and minimise equipment failures that can lead to vaccine losses, the CCE should be subjected to regular preventive maintenance. Preventive maintenance of vaccines and freezers is essential to ensure that vaccines are stored at the correct temperature according to the guidelines. Sections 4.1, 4.2, 4.3 and 4.4 of the SOP-NIP-08 for preventive maintenance of vaccine refrigerators and freezers lists the regular, daily, monthly annual tasks that must be performed on each CCE. Implementing systematic maintenance for cold chain equipment is essential, as it extends the lifespan of devices, reducing costs tied to replacement and emergency repairs. This proactive approach supports health workers by minimising downtime and alleviating the stress caused by equipment failures, thereby fostering smoother immunisation operations. Moreover, it helps ensure compliance with national and international standards for immunisation logistics[9].

In compliance with WHO standards, warehouses responsible for vaccine storage must conduct thorough temperature mapping to identify any cold or hot spots within storage areas, ensuring all vaccines are maintained strictly within the recommended temperature range of +2°C to +8°C. Temperature mapping is not only essential for optimal vaccine preservation but is also a mandatory procedure before using any new cold or freezer rooms for vaccine storage. For established facilities, WHO's 2024 guidelines specify that temperature mapping should be performed at a minimum every two years; this systematic approach reduces the risk of unnoticed temperature excursions that could compromise vaccine potency.

The Effective Vaccine Management Improvement Plan (2021–2025) identified the establishment of a national cold chain equipment maintenance and repair plan with clearly defined roles, responsibilities, and dedicated funding for both preventive and corrective maintenance as a key intervention area for the country to address.

Condition

There is excess cold chain storage capacity at both national and subnational levels, which necessitates a comprehensive CCE assessment to optimise distribution, utilisation, and ensure long-term sustainability – The audit team observed redundant cold chain storage capacity across multiple levels. For example, at the Central Medical Store (CMS), the facility has a storage capacity of 30 WICRs, 4 WIFRs, and 16 UCC units. However, 7 out of the 30 WICRs were empty (see Annex 8l) in spite of the fact that CMS has been well stocked over with vaccines with no stock outs since 2022.

At sub national level, the story was not different. At the PHDVS, ODVS and health centres visited, whereas the audit team found all vaccines stored in functional refrigerators, there were incidences where refrigerators were found uninstalled and unused at 4/5 PHD vaccine stores and 3 out of 8 ODVS implying that the storage facilities had excess cold chain storage facilities more than what they could utilise(Annex 8m). In Pursat PHDVS, 10 brand new GAVI-funded CCE units were found uninstalled.

Recommendation 12

To improve the cold chain operations. MoH/NIP with support from partners should

- Conduct a comprehensive CCE assessment that includes quantifying the aging of existing equipment and identifying units due for replacement. The assessment should also evaluate electricity access at various locations to guide appropriate CCE procurement decisions
- Build capacity of cold chain officers and NIP officers at sub national level in cold chain management through on-the-job training and mentorship programmes

[9] Supply Chain Strengthening for Immunisation Programs. New York: UNICEF, 2021

Temperature mapping not done - The audit found that routine temperature mapping had not been conducted for the WICRs and WIFRs at the CMS. This is concerning especially for equipment over 5 years of age. Similarly, temperature mapping was not conducted at any of the sub-national vaccine stores equipped with WICRs and WIFRs. **Inadequate archival data from cold chain temperature monitoring devices -** The cold rooms in CMS are fitted with a Beyond Wireless Remote Temperature Monitoring System for temperature monitoring. While the system captured data and sent updates via email, there was no evidence that this data was routinely downloaded, reviewed, or used for decision-making. At sub-national stores, temperature data was not downloaded at 1 out of 5 PHDs and 2 out of 8 ODVS. **Preventive maintenance schedules and checklists were largely absent at sub-national vaccine handling points** - The audit team found that structured preventive maintenance plans detailing daily, weekly, monthly, and quarterly maintenance requirements for CCE were missing in most facilities visited. Specifically, such plans were not available in 4 out of 5 PHDVS, all 8 ODVS, and 31 HCs. **Equipment maintenance logs not available** - A walkthrough at the respective sub-national vaccine handling points revealed that maintenance logs documenting preventive and corrective activities, including parts replacement conducted on CCE were not maintained. This gap was observed consistently across all 5 PHDVS, all 8 ODVS, and all 31 HCs. The absence of these records limits the ability to track maintenance history, monitor performance, and ensure accountability in CCE management. **Uncalibrated cold chain trucks** - The CMS warehouse operated refrigerated trucks to transport vaccines from the store to the PHDVs and some hospitals, but none of these trucks had been calibrated to verify whether the temperature readings on their dashboards accurately reflected the actual temperatures inside the cold chain cabins. Key to note is that there were 6 brand new unused cold chain trucks at CMS (See Annex 8n) which will require regular calibration to prevent deterioration of the temperature settings from the factory settings. **Absence of power backup systems at some locations** - Most vaccine handling points relied on electricity and generators for backup during power outages. The audit revealed that some facilities lacked power backup systems and CCE had to go unpowered where there were power outages. This included 2 out of 5 PHDVS, 4 out of 8 ODVS and 19 out of 31 HCs. **Obsolete cold chain equipment without decommissioning plans -** The audit identified that at some locations there were CCE that were obsolete and therefore it was not possible for them to function again. Obsolete CCE we found at 1 out of 5 PHDs and 1 out of 8 ODVS.	• Develop detailed preventive maintenance plans that outline daily, weekly, and monthly activities, along with comprehensive checklists to support and document these tasks. Ensure that the checklists are used consistently at all levels. • Include calibration of cold chain trucks as part of the preventive activities of the 3PL provider • Install power backup systems at PHD and OD vaccine stores that keep significant quantities of vaccines as other cold chain contingency plan like use of cooler boxes may not be applicable to them. • Expand the scope of support supervision to comprehensively cover key elements of cold chain management, including oversight of preventive and corrective maintenance activities, systematic archiving and utilisation of temperature monitoring data, and other critical areas.
Root Cause • There were significant CCE donations from multiple donors during the COVID-19 outbreak. • There were knowledge gaps in cold chain management at sub-national stores, resulting in the omission of best practices in the handling, storage, and monitoring of vaccines. These gaps hinder the effective management of cold chain equipment and can contribute to temperature excursions and other risks to vaccine integrity.	Management comments See detailed management responses - Annex 10

<table>
<tr><td colspan="2">

- Significant human resource gaps are hampering the ability to establish and maintain a fully functional cold chain operation. Specifically, only 2 out of PHDVS and 6 out of 8 ODVS lacked dedicated cold chain officers and relied on other PHD NIP and OD NIP staff to temporarily cover essential cold chain management duties, rather than having specialised staff in place for these critical roles.
- Non-adherence to CCEOP grant application requirements specifically the obligation for the Country to follow its preventive maintenance SOP, jeopardising the validity of their warranties. Regular preventive maintenance is essential for maintaining cold chain equipment functionality and ensuring compliance with the terms of the agreement. Relatedly, the recommendation of the EVM 2000 of establishment of a national cold chain equipment maintenance and repair plan was not implemented.
- Calibration of cold chain trucks at CMS is not part of the activities conducted by the 3PL cold chain service provider hence temperature control and monitoring devices on these vehicles have not been calibrated.
- Current support supervision systems primarily assess the functionality of cold chain equipment at the time of visit. However, critical aspects of cold chain management such as preventive maintenance, temperature monitoring, and documentation practices are not sufficiently addressed, increasing the risk that underlying issues remain undetected.

</td><td></td></tr>
<tr><td>

Risk / Impact / Implications

- Excess CCE requires regular servicing, temperature monitoring, spare parts and electrical power resulting in increased maintenance and operational costs.
- Risk of uninstalled CCE losing their warranties as the warranty period passes while they are still in their boxes. Relatedly, some facilities may be over-equipped while others remain underserved, resulting in inequitable distribution of cold chain capacity.
- Knowledge gaps in cold chain management increase the risk of increased likelihood of vaccine temperature excursions due to poor handling, storage, or monitoring practices, reduced potency and effectiveness of vaccines, jeopardising immunisation program outcomes.
- Human resource gaps will cause inadequate oversight and supervision, resulting in unstable cold chain operations, critical tasks may be performed inconsistently or incorrectly by non-specialised staff increasing the risk of service interruptions and prolonged downtime during breakdowns.
- Nonadherence to preventive maintenance requirements may result in voided warranties, leaving equipment without manufacturer support for repairs or replacement.
- Non calibration of cold chain trucks increases the risk of undetected calibration errors, leading to inaccurate temperature monitoring during vaccine transportation.

</td><td>

Responsibility

See detailed management responses - Annex 10

</td><td>

Deadline / Timetable

See detailed management responses - Annex 10

</td></tr>
</table>

4.6 Fixed Asset Management

4.6.1 Fixed asset management controls need to be improved

Context and Criteria

Gavi's Grant Management Requirements (GMRs), embedded in Annex 6 of the PFA state that, *"NMCHC will ensure that the fixed assets policy is applied and will maintain a comprehensive Fixed Asset Register (FAR) for all assets procured through Gavi grants to Cambodia. NMCHC in close coordination with the NIP will ensure tagging of all assets procured with Gavi funds with unique identifiers and will carry out asset verifications at least annually, reconciling the physical assets to the FAR at all levels".*

Condition

The audit team reviewed the fixed asset management practices for the GAVI grant and have noted following gaps:

***Documentation of fixed asset physical verification not maintained*:** There was no evidence of physical verification for Gavi-funded assets at the sub-national level. Specifically, one of five PHDs and five of eight ODs visited had not maintained any records or documentation confirming that annual physical verification exercises had been conducted. Where verbal confirmation was provided, the verifications were reportedly recorded informally and not retained.

Missing asset tagging and inconsistent donor identification: Several assets procured with Gavi funds were either not tagged or did not display the Gavi logo as required. In some instances, the logos were affixed only during audit fieldwork, indicating delayed compliance. The audit also noted cases where single assets bore multiple donor logos, suggesting poor asset control and lack of clear ownership (See Annex 9).

***Assets unavailable for verification*:** During field visits, several Gavi-funded assets (including smart TVs, tablets, and motorbikes) could not be physically verified.

- Some assets were reportedly kept at staff residences or relocated without supporting transfer documentation. For example, at Koh Kong PHD, a smart TV (Asset ID: Gavi-CDS-2023-KHK-TV-0645) was not found at its recorded location in the FAR. (Refer to Annex 9 for details.)
- In other cases, assets were not available on the day of the visit but were later presented, such as at Soung OD, where a tablet and motorbike were produced the following day. These instances raise concerns regarding asset custodianship and whether the assets were consistently used for intended programme purposes.

***Discrepancies between fixed asset register (FAR) and physical condition*:** The audit identified several inconsistencies between the FAR and the observed asset status:

Recommendation 13

To strengthen fixed asset management controls at national and sub national level, NIP in collaboration with PHDs and ODs should:

- Enforce management oversight by instituting regular spot checks and annual physical verification exercises, ensuring results are documented and reconciled with the FAR.
- Implement a robust asset tagging and labelling process to ensure all Gavi-funded assets are promptly and consistently tagged and display donor identification logos.
- Ensure continuous updating of the Fixed Asset Register, capturing new procurements, changes in condition or location, and disposals, with supporting documentation.
- Establish formal procedures for asset transfers, ensuring all relocations are properly approved and recorded.
- Provide training and supervision for staff responsible for asset management to promote compliance with fixed asset control procedures and strengthen accountability.

<table>
<tr><td colspan="2">

- Misclassification of asset condition: Damaged or non-functional items were recorded as “good.” For example, a tablet at Kilo 6 Health Centre and a smart TV at Prey Nhy Health Centre were found broken but still listed as functional. Refer to Annex 10 for details
- Unrecorded assets: Some items found in the field such as a motorbike (MB-2020-GAVI-MDK-11), a tablet (Gavi-2025-MOD-Tablet-2321), and a smart TV (Gavi-CDS-2023-PUS-TV-0705)—were not included in the FAR, indicating incomplete asset registration. (Refer to the table “Fixed Assets Not Listed in FAR” in Annex 10)
- Non-functional assets present: Certain items were found but were no longer operational, demonstrating weak maintenance tracking and reporting.

</td><td></td></tr>
<tr><td>

Root Cause

- Oversight at national, provincial, and district levels is weak, resulting in poor adherence to fixed asset management procedures. Routine checks and verifications are not institutionalised.
- Absence of formal procedures for recording transfers, tagging new assets, and updating the FAR in real time contributes to data inaccuracies and incomplete records.

</td><td colspan="2">

Management comments

See detailed management responses - Annex 10

</td></tr>
<tr><td>

Risk / Impact / Implications

- Non-compliance with the GAVI grant's asset management requirements as mentioned in the GMRs
- Weak tagging, tracking, and verification increase the risk of asset misappropriation, underutilisation, or use for non-programme purposes.
- Incomplete and outdated FAR data impede effective management, maintenance, and replacement planning.

</td><td>

Responsibility

See detailed management responses - Annex 10

</td><td>

Deadline / Timetable

See detailed management responses - Annex 10

</td></tr>
</table>

5. Annexes

Annex 1 : Acronyms

AOP	Annual Operational Plan
AP	Assurance Provider
AWPB	Annual Work Plan and Budget
BCG	Bacillus Calmette–Guérin vaccine
CCE/CCEOP	Cold Chain Equipment/Cold Chain Equipment Optimisation Platform
CHAI	Clinton Health Access Initiative
CMS	Central Medical Store
CPD	Country Programme Delivery
CSO	Civil Society Organisation
DG	Demand Generation
EAF	Equity Accelerator Funding
eLMIS	Electronic Logistics Management Information System
FPP	Full Portfolio Planning
HC	Health Center
HSS	Health System Strengthening
ICC	Interagency Coordination Committee
IPV	Inactivated Polio Vaccine
IAD	Internal Audit Department
M&E	Monitoring and Evaluation
MR	Measles-Rubella
MR-SIA	Measles-Rubella Supplementary Immunisation Activities
NATDID	National Drug and Inventory Database
NIP	National Immunisation Program
NIPHL	National Institute of Public Health Laboratory
NIS	National Immunisation Strategy
NITAG	National Immunisation Technical Advisory Group
NMCHC	National Maternal and Child Health Center
OD	Operational District
ODVS	Operational District Vaccine Store
ONA	Organisational Network Analysis (platform)
PCV	Pneumococcal Conjugate Vaccine
PEF	Partners' Engagement Framework

PHD	Provincial Health Directorate/Department
PLAN	PLAN International
PwC	PricewaterhouseCoopers
RHAC	Reproductive Health Association of Cambodia
ROTA	Rotavirus vaccine
SIA	Supplementary Immunisation Activities
SOP	Standard Operating Procedure
TCA	Targeted Country Assistance
TWGH	Technical Working Group on Health
UCC	Ultra Cold Chain
UNICEF	United Nations International Children's Fund
VPD	Vaccine Preventable Disease
WUENIC	WHO/UNICEF Estimates of National Immunisation Coverage
WHO	World Health Organisation
WICR	Walk-in Cold Room
WIFR	Walk-in Freezer Room
VHSG	Village Health Support Group

Annex 2 : Methodology

Gavi's Audit and Investigations (A&I) audits are conducted in conformance with the Global Internal Audit Standards of the Institute of Internal Auditors. These Standards constitute the fundamental requirements for the professional practice of internal auditing and for evaluating the effectiveness of the audit activity's performance. The Institute of Internal Auditors' Global Guidance is also adhered to as applicable to guide operations. In addition, A&I staff adhere to A&I's Audit Manual.

The principles and details of the A&I's audit approach are described in its Board-approved Terms of Reference and Audit Manual and specific terms of reference for each engagement. These documents help our auditors to provide high quality professional work, and to operate efficiently and effectively. They help safeguard the independence of the A&I's auditors and the integrity of their work. The A&I's Audit Manual contains detailed instructions for carrying out its audits, in line with the appropriate standards and expected quality.

In general, the scope of A&I's work extends not only to the Gavi Secretariat but also to the programmes and activities carried out by Gavi's grant recipients and partners. More specifically, its scope encompasses the examination and evaluation of the adequacy and effectiveness of Gavi's governance, risk management processes, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve Stated goals and objectives.

Annex 3 : Definitions – audit opinion, audit rating and prioritisation

A. Overall Audit Opinion

The audit team ascribes an audit rating for each area/section reviewed, and the summation of these audit ratings underpins the overall audit opinion. The audit ratings and overall opinion are ranked according to the following scale:

Effective	**No issues or few minor issues noted**. Internal controls, governance and risk management processes are adequately designed, consistently well implemented, and effective to provide reasonable assurance that the objectives will be met.
Partially Effective	**Moderate issues noted.** Internal controls, governance and risk management practices are adequately designed, generally well implemented, but one or a limited number of issues were identified that may present a moderate risk to the achievement of the objectives.
Needs significant improvement	**One or few significant issues noted.** Internal controls, governance and risk management practices have some weaknesses in design or operating effectiveness such that, until they are addressed, there is not yet reasonable assurance that the objectives are likely to be met.
Ineffective	**Multiple significant and/or (a) material issue(s) noted.** Internal controls, governance and risk management processes are not adequately designed and/or are not generally effective. The nature of these issues is such that the achievement of objectives is seriously compromised**.**

B. Issue Rating

For ease of follow up and to enable management to focus effectively in addressing the issues in our report, we have classified the issues arising from our review in order of significance: High, Medium and Low. In ranking the issues between 'High,' 'Medium' and 'Low,' we have considered the relative importance of each matter, taken in the context of both quantitative and qualitative factors, such as the relative magnitude and the nature and effect on the subject matter. This is in accordance with the Committee of Sponsoring Organisations of the Treadway Committee (COSO) guidance and the Institute of Internal Auditors standards.

Rating	Implication
High	At least one instance of the criteria described below is applicable to the finding raised: • Controls mitigating high inherent risks or strategic business risks are either inadequate or ineffective. • The issues identified may result in a risk materialising that could either have: a major impact on delivery of organisational objectives; major reputation damage; or major financial consequences. • The risk has either materialised or the probability of it occurring is very likely and the mitigations put in place do not mitigate the risk. • Fraud and unethical behaviour including management override of key controls. Management attention is required as a matter of priority.
Medium	At least one instance of the criteria described below is applicable to the finding raised: • Controls mitigating medium inherent risks are either inadequate or ineffective. • The issues identified may result in a risk materialising that could either have: a moderate impact on delivery of organisational objectives; moderate reputation damage; or moderate financial consequences. • The probability of the risk occurring is possible and the mitigations put in place moderately reduce the risk. Management action is required within a reasonable time period.
Low	At least one instance of the criteria described below is applicable to the finding raised: • Controls mitigating low inherent risks are either inadequate or ineffective. • The Issues identified could have a minor negative impact on the risk and control environment. • The probability of the risk occurring is unlikely to happen. Corrective action is required as appropriate.

Annex 4 : List of Facilities Visited

Provinces & Municipality (5)	Operational Districts (8)	Health Centers (31)
Phnom Penh	Mekong/Chaktomouk	1. Kilo 6 HC 2. kilo 9 HC 3. Chroy Changva HC
Mondul kiri	Senmonorom	1. Sen Monorom HC 2. Ou Raeng HC
Koh Kong	Smach Mean Chey	1. Smach Mean Chey HC 2. Steung Veng HC 3. Neang Kok HC 4. Bak Klong HC
	Sre Ambel	1. Beung Preav HC 2. Sre Ambel HC 3. Andong Teuk HC 4. Chi Pat HC 5. Thmar Sor HC
Pursat	Sampov Meas	1. Prey Nhi HC 2. Koh Chum HC 3. Voat Po HC 4. Prek Tnoat HC
	Bakan	1. Beung Khnar HC 2. Ou Ta Poang HC 3. Rumlech HC 4. Khnar Totoeng HC 5. Trapeang Chong HC
Thoung Khmom	Suong	1. Vihear Loung HC 2. Soung 1 HC 3. Soung 2 HC
	Krouch Chhmar/ Ou Reang Ov	1. Peus Pi HC 2. Peus Mouy HC 3. Svay Khlaing HC 4. Proches Kandal HC 5. Trea HC

Annex 5a: The Kingdom of Cambodia immunisation schedule

Vaccine	Age					
	Birth	6 weeks	10 weeks	14 weeks	9 months	18 months
BCG	√					
Hepatitis B	√					
OPV		√	√	√		
DTP-HepB-Hib		√	√	√		
PCV13		√	√	√		
IPV				√		
MR					√	√
JE					√	

Annex 6b: Disbursement of funds to Partners (2020 – 2024)

Partners	Grant	2020	2021	2022	2023	2024	Total
CARDNO	Cash		52,569	63,735	114,422	43,707	274,433
CHAI	Cash		27,155	27,155	33,681		87,991
	TCA	84,068	200,859	139,847	442,950	454,449	1,322,172
MOH	Cash	2,915,381	1,211,800	1,219,247	3,853,378	1,911,651	11,111,457
PLAN	Cash					224,121	224,121
PWC	Cash					160,232	160,232
RHAC	Cash					21,176	21,176
UNICEF	Cash				4,269,170	1,379,345	5,648,515
	TCA	374,702	251,285	503,082	931,004	280,953	2,341,026
UNICEF SD	Cash			663,117		505,577	1,168,694
WHO	TCA	457,826	326,350	481,951	380,253	501,615	2,147,994
Total		**3,831,976**	**2,070,017**	**3,098,134**	**10,024,858**	**5,482,826**	**24,507,812**

Annex 6: Governance and oversight

Annex 6a: Composition of NITAG

#	Designation	Position held
1	Chairperson	Secretary of State, MoH
2	Vice Chairperson -1	Secretary of State, MoH
3	Vice Chairperson -2	Secretary of State, MoH
4	Members	Undersecretary of State, MoH
5		Director General for Health
6		Director General for Administration and Finance
7		Advisor and Director of the Department of Communicable Disease Control
8		Head of the National Reference Medical Laboratory
9		Advisor and Deputy Director of the National Institute of Public Health
10		Director of Kantha Bopha Hospital
11		Deputy Director of the National Institute of Public Health
12		Deputy Director of the National Pediatric Hospital
13		Head of the National Reference Medical Laboratory,

Annex 6b: TWGH meetings minutes provided

Date of meeting	Focus of discussion in relation to immunisation
Feb'20	C-19 and upcoming joint appraisal
May'22	Endorsement of Gavi FPP application
Apr'24	proposed MR campaign plan
Jan'25	HPV proposal approval

Annex 6c: Status of previous audit and review recommendations

Status of Programme Audit Recommendations

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
Weaknesses in oversight mechanism	We recommend that MoH strengthen the oversight mechanism to provide effective oversight over the immunisation programme by ensuring that the: • Technical Working Group on Health include NIP activities as a standing agenda item once a quarter to ensure that critical issues are escalated and addressed in a timely manner. • The TWGH sub committees have the responsibility for follow up of recommendations from the various NIP reviews for example EVM, Data quality and NIP programme review; • Sub-Technical working group for MCH, the selected oversight body for the NIP programme include EPI operational activities as a standing agenda during its meetings. • NIP working group terms of reference are finalised to include reporting responsibilities to the Sub TWG for MCH.	The Technical Working Group for Health (TWGH) is the ICC and NITAG for immunisation program. But, TWGH covers all health related matters with the clear TORs. The review and endorsement of some NIP plans and activities happen at any time as needed. Thus, the NIP activities didn't specifically include into TWGH's agenda as once in a quarter. Sometimes, NIP included as the agenda for more than one time in one quarter. Sub-Technical working group for MCH also review (technical areas) the NIP plans and activities regularly. Sub-Technical working group for MCH also report to Technical Working Group for Health (TWGH) twice a year.	MoH/MCH	31 March 2020	Not Started Issues around documentation of minutes still persist See new recommendation 1 included in this report.
Effectiveness of the internal audit assurance mechanism	We recommend that the MoH ensure that: • The annual internal audit plan is shared with Gavi as required by the GMRs. • Scope of internal audit review includes expenditure at the central level, scope areas like fixed assets (including verification); and • Completed internal audit reports are formally shared with the respective PHDs and the NIP programme to ensure that findings are adequately followed up and addressed. • Internal audit reports are formally translated into English and shared with Gavi annually.	The MoH agrees with recommendation of Gavi Audit.	MoH/NIP	31 March 2020	In Progress '- No internal audits were conducted for financial years 2020, 2022, and 2023. The only available audit covers FY2021, conducted in 2022. The MoU signed for 20205 & 2025 and accordingly, the plan was prepared by Internal Audit Department within MoH, however that was not shared with GAVI. The GAVI assurance provider not involved in planning. - The internal audit conducted in 2022 only covered 14 PHDs with no central-level expenditure or fixed asset verification included. Audit visits did not extend to ODs or HCs, despite significant programmatic activities at these levels. The Audit for 2024

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
					is in progress and so far only completed 4 PHDs out of 14 PHDs. - The 2022 audit report presents aggregated findings without disaggregation by PHD, limiting its usefulness for targeted follow-up by PHDs or the NIP. The IA report was not shared with PHDs. - The internal audit report for FY2021 (conducted in 2022) has not been translated into English or formally shared with Gavi. No subsequent reports are available for sharing. Further, as per MoU between IAD and NMCHC, the IAD shall prepare the report in Khamer only. See new recommendation 2 included in this report.
Sustainability of incentive payments to staff	We recommend that the MoH: • Ensure that the approved appraisal process is implemented consistently. Evaluation forms should be completed to indicate date of completion, staff performance ratings and areas for development. • Evidence of the appraisals, held every semester, should be filed and used for the next semester's incentive payments; and • Review the current Gavi funding and ensure that a clear exit plan for such recurrent costs is established as required by Gavi's guidelines on detailed budgeting.	Incentives and appraisal issues have been in discussion several times in 2015 within country team, Gavi Secretariat staff and TWGH (ICC). Ministry of Health also closely worked with the Ministry of Economy and Finance for developing the incentive guidelines and approved in May 2015. Then, the incentive guidelines have been updated on 04 January 2016 by the MoH for implementing of Gavi-HSS2 project from 2016 to end of 2020. In 2019, the incentive payment scheme have been discussed again and agreed by Gavi project country team and Gavi Secretariat staff to continue incentive and appraisal process until the end of the grant (Gavi-HSS2). Therefore exit plan of this recurrent cost will be taking care in new project. **Audit Team's additional comments** While some of the issues noted in our review of the incentives programme will be addressed in the new grant for 2022, there is still a need for MCH/NIP management to ensure that the performance reviews conducted	MoH/NIP	New grant (2022)	Not Applicable This recommendation has now become not applicable, considering there was no budget for incentive. The incentive budgeted in 2020 HSS was USD 381,604 and actual expense incurred was USD 351,654.

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
		for 2020 and 2021 align with the incentive guidelines. As noted in the evidence reviewed, the evaluation forms completed were not indicative of the individual's performance and therefore not in compliance with the incentive scheme.			
Inadequate data management and oversight	We recommend that the MoH: • Routinely triangulates available immunisation data, including an assessment of administrative coverage data and vaccine availability / utilisation as a check for accuracy of data reported. Data anomalies noted should be included in the review of accuracy of vaccine stock and utilisation data and coverage data; • Build data management capacity at the sub-national and conduct relevant staff training on the Guidelines and SOPs at the Central and sub-national levels; • Develop / improve and implement suitable job aids for managing immunisation data including roles and responsibilities for staff. These guidelines should be distributed at all levels to promote uniformity in data collection, collation and reporting and be used as tool in the monitoring and supervision visits; • Ensure that the Sub-Technical Working Group for MCH reviews immunisation data periodically and follows up on the timely implementation of the data quality assessments; • Develop and implement a data supportive supervision plan to address data issues noted including data availability, inaccuracies and timely reporting; • Consider adjusting the denominator data in HMIS, based on the results of the 2019 population census as necessary; • Update data in HMIS to ensure accuracy and completeness of historical data for IPV and PCV	Triangulation of the immunisation data is a new concept at global level and also to NIP/MoH, Cambodia. WHO Country Office shared the summary concept note in 2018. At this point of time, the Ministry of Health emphasized to use one source of data for all programs and activities under Ministry of Health. The Ministry of Health welcome the idea for triangulation, however, Ministry also likes to see the maturity of this triangulation, example of other countries, therefore, would like to wait and plan for the next grant (Gavi-HSS3). In the meantime, after following pilot study on data accuracy/audit in 2018, with the support from WHO, NIP started implementing data accuracy/audit at OD and HC in four provinces from June 2019. It will be implemented in remaining provinces in 2020.	MoH/NIP	31 December 2021	In Progress NIP did not perform any data triangulation exercise in the period under audit, however some trainings were conducted for staff at sub national level on data management under the Immunisation in Practice training in 2024. This recommendation will be retained for follow up.
Inefficient stock management at national level	We recommend that MoH; • Work with the relevant development partners, with the objective of ensuring that the mSupply eLMIS system includes an activated vaccine module within its design for use at CMS; • Ensure that the vaccines stores at CMS are adequately staffed;	• MoH will work with the relevant development partners on the mSupply eLMIS system. • The MoH agrees with these recommendations	MoH/NIP	31 December 2020	Only 2 out of 7 activities were done - There was no evidence of any discussion in any fora about the mSupply eLMIS system - Additional staff was recruited at CMS to support management of vaccines. However, this doesn't tantamount to adequacy of staff at CMS

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
	• Finalise the SOPs and develop job aids for Vaccine and Cold Chain management or adopt the recommended WHO Vaccine and Cold Chain Management procedures and Stock Management guidelines; • Finalise the cold chain equipment maintenance contract, develop and operationalise a maintenance plan including specific guidelines on preventative and curative maintenance processes with defined roles and responsibilities at national and subnational levels; • Review CMS' process inefficiencies as noted by the Audit Team and ensure that the respective weaknesses are addressed; • Link identified capacity gaps at national and subnational levels to ensure that practical hands on training is delivered to the appropriate levels within the supply chain; • Insure vaccines at CMS and regional levels as required by the GMRs.				- SOPs for vaccine and cold chain management were finalised. However, there were no job aids for vaccine and cold chain management - At the time of the audit there was a contract with a firm, Dynamic health Care Co. Ltd for preventive maintenance of cold chain equipment at CMS - Review of CMS's process inefficiencies was never done - There was no initiative of identifying capacity gaps at national and sub national levels - Vaccines at CMS were reported insured, however, the insurance certificate was not seen by the auditors See new recommendation 11 included in this report.
Inadequate stock management at subnational levels	It is recommended that the MoH ensure that: • Physical stock counts are conducted periodically at subnational level (at least quarterly) • All vaccine stores must comply with the "Earliest Expiry, First Out (EEFO)" principle and evidence their stock movements. • Ensure that stock records and supporting documents are complete and systematically filed. • Ensure that supportive supervision at subnational levels monitors compliance with SOPs	The MoH agrees with these recommendations	MoH/NIP	31 December 2020	Not Started The Audit noted the following: - Physical counts, even when conducted, not properly documented. - Batch numbers, expiry dates, and VVM status inconsistently recorded across all levels. - The current support supervision tool doesn't check for compliance with SOPs See new recommendation 11 included in this report.
Inefficient budget preparation and management processes	The MOH, in collaboration with the NIP should: • Ensure that a consolidated NIP budget is completed every year, which details all funding sources including national contributions; • Ensure that budget preparations are completed and submitted to Gavi on time; • Ensure that disbursements to subnational levels are done on time to support timely implementation of activities; and	Based on the many years' experience, the partner's fund usually committed at the end of the year for next implementing year or beginning of the implementing year. At the same time, the financial/fiscal year of different organisations is different. Therefore, MoH will consolidate the national budget into the NIP budget and the other funding source will be updated, if available. On time budget disbursement to sub-national levels depends on many factors which include the agreement	MoH/NIP	31 December 2021	In Progress '- Currently, the NIP does not have a fully consolidated budget capturing all funding sources, including national contributions. While MoH consolidates the national budget into the NIP budget, external partner funding is updated only when confirmed generally at the end or start of

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
	• Ensure that the TWGH, (as an equivalent of the ICC) monitor and report on the use of Gavi-provided funding on a quarterly basis, so as to maximise the level of funds available	of amount allocation for the year from Gavi secretariat, time of disbursement of the amount by Gavi secretariat and receiving the decision letter from the Gavi secretariat.			the implementing year due to differing fiscal calendars of funding partners. - There have been consistent delays in budget preparation and submission. For instance, the 2024 AOPs for both HSS3 and EAF were submitted and approved on 20 February 2024. Similarly, the 2022 budget was approved late, on 11 June 2022, leaving only seven months for activity implementation. The 2023 cycle also experienced delays, with the budget approved on 8 May, funds disbursed on 12 July, and the AOP finalised on 31 August. - Timely disbursement to subnational levels depends on multiple external factors, including finalisation of AOP, timing of fund disbursement by the Gavi , and the issuance of the decision letter. These dependencies often result in delays. See new recommendation 3 included in this report.
Improvements needed in accounting systems and records	It is recommended that the MOH: • Ensure that central-level budgets are uploaded and monitored using the accounting software to ensure timely review and analysis of expenditure vs budget. This will ensure that budgets are monitored periodically; • Consider using suitable accounting software at provincial levels so that the primary accounting records are maintained in a more robust format. • Review the Financial Management manuals to provide appropriate guidance on supporting documents required. • See recommendation 3 on recurrent costs	• MoH will upload and monitor using the accounting software from 2019. • MoH will discuss with relevant partners and align with MEF accounting software to consider using suitable accounting software at provincial levels in the appropriate time.	MoH/NIP	31 December 2021	Implemented '- NIP has been using QuickBooks at the central level since 2019 to record expenditures and monitor budgets under NIP. Central-level expenditures, as well as those reported by PHDs, are recorded in QuickBooks to support regular review and analysis. PHDs do not use accounting software directly. Expenditures incurred at the PHD and subnational levels are documented in SoEs, which are submitted to the central level for entry into QuickBooks. NIP plans to coordinate with relevant partners and the Ministry of Economy and Finance to

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
					explore the feasibility of rolling out appropriate accounting software at the provincial level in due course. - The Financial Management Manual provides guidance on the supporting documentation required for expenditure. During expenditure verification exercises, sufficient supporting documents were made available for review, indicating adherence to the guidance.
Questioned expenditure	It is recommended that the MoH ensure that: • All expenditures are adequately supported with the necessary documents included: signed and dated minutes of meetings; attendance sheets; payment schedules for allowances and per diems; third party receipts and invoices; acknowledgement forms; and/or activity reports • The Government uses reasonable efforts to not charge duties or taxes or any other supplemental charges on Gavi funded expenditures, in accordance with the PFA.	The Gavi project will strengthen the capacity of implementing units to follow to financial management manual. • Gavi project was managed by Health Sector Support Program (HSSP2) which financed by pool funded and discrete funded projects (AFD, BTC, UNFPA, UNICEF) and used to pay taxes from the development partners fund. After the HSSP2 closed in October 2016, the Ministry of Economy and Finance issued a letter on tax exemption dated 06 September 2017 for Gavi funded project.	MoH/NIP	31 December 2021	In Progress '- During sample expenditure verification, we didn't observed tax being charged to the GAVI Project. - There were issues noted and reported in inappropriate documentations like similar signatures, unsupported documentation, etc. See new recommendation 13 included in this report.
Non-compliance with the national procurement manual	It is recommended that the MoH: • Ensures compliance with the National Procurement Manual so that all goods, works and services are procured in a transparent and competitive manner; • Utilise the annual procurement plan as an opportunity to negotiate tenders for bulk purchasing of goods and services; • Formally record the involvement of the Procurement Committee decisions and the review of work done by procurement specialist; • Formally record delegations of authority to the procurement specialist for performing various procurement functions • Ensure to separate the Bid Evaluation committee from the procurement committee for independent evaluation and awarding of contracts; and	The Ministry of Health will add the representative from Ministry of Economy and Finance in the procurement committees as audit recommendation. • The Ministry of Health will separate the procurement committees as auditor recommendation. • The Gavi project will update the procurement plan regularly in order to ensure the value for money.	MoH/NIP	31 December 2021	Implemented Complied with the National Procurement Manual.

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
	• Mandates that the NIP should maintain an annual procurement plan for the assets it plans to acquire, including details such as the funding source; • Pools procurement activities wherever possible in accordance with the Supporting Procurement Acquisition Concepts outlined in section 3.7 of the National Proc				
Ineffective controls over Fixed Assets	It is recommended that the MoH: • Maintain updated Fixed Assets Registers are maintained at both the central and sub-national levels. These registers should include pertinent information, such as: each item's purchase cost including a benchmark currency valuation; date of purchase; serial numbers; unique identifiers; location and condition. This will help to ensure that assets are tracked, used for their designated purpose. • Conduct and document annual physical asset verifications at national and subnational levels. • Ensure that where non-insured fixed assets are lost or damaged during their useful life, they are replaced using government funds.	MoH does with agree all of three recommendations such as update fixed assets register, conduct and document annual physical asset verifications and replace of lost or damaged fixed assets by using other sources.	MoH/NIP	31 December 2021	In Progress Still issues around discrepancies in FA and FAR are noted. See new recommendation 14 included in this report.

Status of Previous External Audits Recommendations

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
Underutilisation of the budget	• NMCHC should ensure to improve the budget utilization for timely achievement of project objective. • NMCHC should ensure that activities are implemented in accordance with the approved work plan in order to achieve the overall targets of the project.	There's been improvement on the utilisation of budget (approximately 80%) and most activities have been carried out according to plan. There's no delay in AOP approval compared to past years. The team will continue to monitor the budget utilisation closely and ensure activities are carried out according to plan.	Programme team	Q1 2025	In Progress
Delay in submission of request for advance	• NMCHC and PHDs should ensure that advance requests are submitted as per the agreed timeframe set out in the Financial Management Manual for timely disbursement of advance to achieve the milestone.	The implementation of this point has improved the management of advance requests. NMCHC and PHDs will continue monitoring to prevent request submission delays.	Programme and Finance teams	Within 2024	Implemented
Delay in liquidation of advances	• PHDs should ensure the liquidation of advances promptly. It should make more attention and rigorously follow up with the custodians for the settlement.	The implementation of this point has improved the management of advance liquidation. NMCHC and PHDs will continue monitoring to prevent liquidation delays.	Finance team	Within 2024	Implemented

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
Weakness in DSA payment sheet (PHD-Prey Veng)	• PHD Prey Veng should ensure that DSA payment sheets are signed by all the participants and approved by the supervisors.	The NMCHC finance team confirmed that this observation has been implemented and will continue monitoring it as part of their supervisory duties.	PHD Prey Veng - Finance	NA	Implemented
Delay in filling vacancy	• NMCHC should ensure that project personnel are appointed as per the approved work plan to attain the targets set for the projects.	To revise job description so that more candidates are eligible for application.	Programme team	Within 2025	In Progress
Discrepancies noted during the physical verification	• NMCHC and PHDs should ensure that proper inventory records are maintained for the equipment purchased using project funds. • NMCHC and PHDs should ensure that all the project assets are tagged with asset ID assigned to them.	Supervision team conduct fixed asset check, reconciled records and putting tags on assets at selected PHDs. In addition, informed all PHDs to conduct regular count with proper evidence and ensure records are reconciled.	Programme and Finance teams	Q3 2025	In Progress
Non submission of Assets Register to the Gavi	• NMCHC should ensure to submit the assets register with Gavi along with submission of periodical financial report.	This observation has been implemented by submitting the asset register to Gavi along with the quarterly financial reports.	Finance team	Within 2024	Implemented
Improvement needed for the payment of activities related cost	• NMCHC to introduce the system of payment of per diem and travel cost to participants and vaccinators using banking channel or mobile money. • If this is not possible then measures should be implemented to verify the identity of the people receiving cash payments such as preparing the database of the participants / vaccinators. • NMCHC to update the "Annex 4 Procedures for daily allowances and operations" to include additional supporting document such as ID card of vaccinators and participants to whom cash payments were made and patient card etc. • NMCHC to consider transferring the advances to OD bank account for activities to be implemented by the ODs. • NMCHC and PHDs to consider using banking channel for directly paying to the suppliers for high value expenditures instead of staff making the payment in cash using advances.	Currently, the team is updating the finance manual to incorporate the recommendations.	Programme and Finance teams	Within 2025	In Progress
Lack of computerized accounting system at the PHDs	• The Project management should consider introducing the accounting systems at the PHDs so that consolidated books of account can be maintained. • PHDs should ensure to extract the quarterly and annual report from accounting software and submit the report to NMCHC on timely basis or update reporting requirement in the financial management manual.	The introduction of an accounting system at PHDs is subject to further internal discussion at NMCHC. Despite the current manual processes, the NMCHC finance team continues to monitor PHDs' financial reports by closely following up and cross-checking data for accuracy.	Finance team	To be determined	In Progress

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
Shortcoming in the supporting documents	• PHDs should ensure to correctly record the description and activity code in the books of account. • PHDs should ensure that DSA payment sheets are signed by all the participants and date of approver of sheets to be stated. • PHDs should ensure that the all the supporting documents are properly maintained and made available to the auditors for verification at the time of field visit. • NMCHC to ensure that field visits to PHDs are made on timely basis so that shortcomings in the supporting documents are identified and corrected.	This observation has already been implemented. The PHD ensures that supporting documents are sufficient and properly maintained, while the NMCHC finance team has established a proper schedule for their document review visits to the PHDs.	PHDs - Finance	Q2 2025	Implemented
Insufficient internal audit and monitoring visit done at PHD level	• NMCHC to ensure that the annual internal audit plan is shared with Gavi as required by the GMRs. • NMCHC to ensure that the annual internal audit and monitoring visit should be conducted as per agreed plan and reports are formally shared with the respective PHDs and the NIP programme to ensure that findings are adequately followed up and addressed. • NMCHC to ensure that internal audit reports are formally shared with Gavi annually.	Monitoring visits were conducted at 16 PHDs in 2024. The internal audit is still in progress; Refer to item 1.1 for further details.	Internal Audit Department	Within 2025	In Progress
Safe box not maintained for holding petty cash by PHDs	• All the PHDs should ensure to maintain the safe box for proper safeguard of the cash.	This observation has already been implemented. NMCHC finance team continues to check during their supervision.	PHDs - Finance	Q2 2025	Implemented
Unavailability of theft insurance for vaccine inventory and cold chain equipment's held at the warehouse	• The NMCHC should ensure to follow the Grant Management Requirements and obtain the theft insurance cover for the vaccine inventory and cold chain equipment held at the warehouse.	Fire insurance has been obtained. For theft insurance, it needs approval from the MoH. NMCHC programme team can only follow up with MoH but does not have the authority.	Programme team	To be determined	In Progress
Shortcoming noted in assets management	• The NMCHC and PHDs should ensure that proper records are maintained for the assets purchased using project funds. All the assets procured should be provided with serial number in the assets list. • PHDs should ensure to perform periodical physical verification as per the frequency stated in the internal policy and assets register should be updated with the information identified during the physical verification. • The report for such physical verification should be documented and retained for future reference.	Supervision team conduct fixed asset check, reconciled records and putting tags on assets at selected PHDs. In addition, informed all PHDs to conduct regular count with proper evidence and ensure records are reconciled.	PHDs - Programme	Q3 2025	Implemented

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
	• PHDs should ensure that all the project assets are tagged with asset ID assigned to them.				
No formal mechanism to follow up on the recommendations of internal audit and Gavi programme audit	• NMCHC to maintain a comprehensive database for tracking progress on all recommendation provided in previous project audit, Gavi programme audit and internal audit report. • NMCHC to nominate a focal person to conduct periodic follow ups and provide status update to Gavi and other stakeholders.	The NMCHC finance team maintains an observation tracker to monitor all raised observations. They frequently review the tracker to ensure all observations are implemented.	Programme and Finance teams	N/A	Not Started
Late submissions of Financial Report and Annual Operation Plan (AOP)	• NMCHC should strengthen its internal planning and coordination processes to ensure timely preparation, review, and submission of financial reports in accordance with the timelines set out in the Financial Management Manual. • NMCHC should proactively engage with the Ministry of Health and relevant stakeholders to facilitate the timely review and approval of the Annual Operational Plan within the timeframe. Clear accountability, tracking mechanisms, and escalation procedures should be implemented to monitor and address any potential delays in the reporting and approval process.	N/A	Finance team	TBD	Not Started

Status of Previous Internal Audit Recommendations

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
Health Department of Kampong Speu Provincial Administration	• Some Objectives did not follow the plan (Objective 3 did not act). • Documents supporting the payment of some budgets do not have the PAID Gavi-HSS stamp. • Documents supporting the payment of some budgets. There is no exchange rate attached. • Some travel expenses are calculated incorrectly. • Some mission orders are still issued incorrectly. A. No source of the budget usage. B. No Signature name. - Some of the travel visa information is incorrect. - Some of the travel documents are not correct.	Invited PHD accountant to attend workshop and shared observations and how to approve on financial management. The supervision team will conduct a field visit to Kampong Speu to review the supporting documents.	Finance team	Q3 2025	In Progress

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
	• Supporting document of DVCH/21-031 for immunisation of children and women are not yet sufficient and complete such as: A. Improper of expense usage: - No Names and signatures of service providers. - Inconsistence name of the same signature service provider. • B. Pre-report letter on mission issue. • Supporting documents for DVCH / 21-014 to provide immunisations to children and women are not yet sufficiently complete: - Mission order does not have the name of the mission. - The officer signs differently in the mission payment.				
Department of Health of Kampong Thom Provincial Administration	• Activity 62038-1-12: There is still a gap in the use of Village Volunteer Invitation (VHSG). • Activity 6112-4-10: There is still a gap in the activity report without specifying the location of the activity.	Conducted field visit to Kampong Thom in 2024.	Finance team	Q2 2025	Implemented
Department of Health of Takeo Provincial Administration	• Some forms of transportation are not yet correct. • Documents supporting the payment of some budget expenditures are not attached to the mission report. • Training activities on JE in preparing and managing supporting documents, expenses are not attached to training documents (lessons). • Some DVCH / 21s have missing supporting documents, such as: A. Some cost support documents have been scratched. B. Have not yet stamped PAID / GAVI.	Conducted field visit to Takeo in 2023.	Finance team	Q2 2025	Implemented
Department of Health of Kratie Provincial Administration	• DVCH / 21-035 Implementation of Vulnerable Villages or Communities Supporting VHSG and Visiting Vulnerable Villages or Communities in Kratie OD HCs with Total Amount $ 3,515, not linked to the bank's exchange rate. • DVCH / 21-029 Document supporting the expenses of the mission to vaccinate vulnerable villages of Chhlong OD Health Office is not correct: A. Date of report before the date of mission. B. Single travel visa form used for two missionaries. C. Unit Manager and Chief Accountant signed before the organiser.	Conducted field visit to Kratie in 2024.	Finance team	Q2 2025	Implemented

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
	• DVCH / 21-014 Document supporting budget payments for GAVI budget labor relations at the MoH, mission payments below the new rate. • DVCH / 21-031 Document Supporting Budget for Employment, Vaccination and Delivery: A. Signature of the Chief Accountant (Per diem Sheet).				
Department of Health of Kampot Provincial Administration	• Documents supporting the payment of some budget expenditures are not yet correct by: A. Some forms of transportation are not yet fully correct. B. Some mission reports are not accurate and clear. C. Some documents are not dated. • The issuance of some mission orders is still incorrect by: A. The source of the budget is not specified.	Conducted field visit to Kampot in 2025.	Finance team	Q2 2025	Implemented
Department of Health of Svay Rieng Provincial Administration	• Activity 6112-5-5 There are still gaps in the payment documents, such as: A. The problem letter of the mission of the Department of Health did not specify the source of the budget. B. The certificate to the health facility did not fill in the date. C. PAID Stamp • Activity 62038-1-2 There are still gaps in the payment documents, such as: A. Invitation of invitations for village volunteers to participate in activities. B. Transportation vouchers of some OD health offices Fill in the date, month, year. C. Not stamped PAID. • Activity 6112-1-7 There are still gaps without activity report attached.	Invited PHD accountant to attend workshop and shared observations and how to approve on financial management. The supervision team will conduct a field visit to Svay Rieng to review the supporting documents.	Finance team	Q3 2025	In Progress
Department of Health of Pursat Provincial Administration	• Supporting document of 9-19 DVCH / 21-017 Vaccine Preventable Disease Outbreak Response and Catch-up Activities Some incomplete mission reports did not specify the exact location and some mission reports did not have a signature and name. • Support Documents Support Quarterly Supervision Visit to High-Risk Communities is still lacking: A. Some invoices are not dated. B. Some mission reports do not have the signature and name of the reporter.	Conducted field visit to Pursat in 2024.	Finance team	Q2 2025	Implemented

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
	• Documents supporting the payment of some incomplete budget expenditures: A. Incomplete application for travel visa. B. Vulnerable areas.				
Department of Health of Preah Vihear Provincial Administration	• In the annual plan, there are 5 Objectives (Objective 1, 2, 3, 4 and 5), but according to the audit, it is found that: A. Objective 2 and 3 Acted on the basis of GAVI project accounting instructions to perform only 3 objectives. B. For the other three objectives, only 39% of the plan was implemented due to delays in implementing the GAVI project.	Invited PHD accountant to attend workshop and shared observations and how to approve on financial management. The supervision team will conduct a field visit to Preah Vihear to review the supporting documents.	Finance team	Q4 2025	In Progress
Department of Health of Rattanak Kiri Provincial Administration	• Some budget support documents do not have PAID GAVI-HSS stamp. • Some transportation licenses are not signed by the service provider. • A small number of mission vaccinations were not attached to the mission activities report.	Invited PHD accountant to attend workshop and shared observations and how to approve on financial management. The supervision team will conduct a field visit to Rattanak Kiri to review the supporting documents.	Finance team	Q3 2025	In Progress
Department of Health of Mondulkiri Provincial Administration:	• Some documents supporting the expenses for the registration of the governor are not yet correct, such as: A. Some transportation expenses are in the name of the same service provider. B. Some vouchers do not have the name of the service provider. • Some catch-up budget payment documents are not correct, such as some mission reports are incorrectly dated.	Conducted field visit to Mundulkiri in 2024.	Finance team	Q2 2025	Implemented
Department of Health of Battambang Provincial Administration:	• The issuance of some mission issue letters is still incorrect, without specifying the source of the budget. • Documents supporting the expenses for the registration of some governors are not sufficient and correct, such as: A. The mission report has not been submitted. B. Some travel expenses are incorrect. • Some quarterly outreach documents for the supply of vaccines to vulnerable areas (conduct quarterly outreach visits to high-risk communities to conduct immunisation) are not yet correct, such as: A. The budget request letter was signed without a date and without the name of the signer. B. Filling out vouchers for some means of transportation is not yet correct.	Conducted field visit to Battambang in 2024.	Finance team	Q2 2025	Implemented

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
Department of Health of Siem Reap Provincial Administration	• Activity 62038-1-2: There are still gaps in the payment documents such as: A. Not using invitations for village volunteers to participate in activities. B. Some OD health offices did not fill in the dates. • Activity 6112-1-7: There are still gaps due to no activity report.	Invited PHD accountant to attend workshop and shared observations and how to approve on financial management. The supervision team will conduct a field visit to Rattanak Kiri to review the supporting documents.	Finance team	Q4 2025	In Progress
Department of Health of Kampong Chhnang Provincial Administration:	• The issuance of some mission orders is still incorrect, without specifying the source of budget.	Invited PHD accountant to attend workshop and shared observations and how to approve on financial management. The supervision team will conduct a field visit to Kampong Chhnang to review the supporting documents.	Finance team	Q4 2025	In Progress
Department of Health of Preah Sihanouk Provincial Administration	• Some objectives did not follow the plan (Objective 2 is not implemented). • Documents supporting the payment of some budget expenditures are not linked to the exchange rate. • Completing the voucher for some means of transportation is not correct yet. • The entry information on some travel visas is not correct yet.	Conducted field visit to Battambang in 2025.	Finance team	Q2 2025	Implemented

Status of Previous Assurance Provider Recommendations

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
Budgeting	• Initiate the FY25 budget/rebudgeting and AOP approval in Quarter 4 of 2024. • Provide the budget summary and detailed assumptions including written explanation, distribution list, name of villages and detailed workplan.	Although the FY25 AOP has been approved, the request for budget reallocation from the 2024 savings is still pending. The request currently lacks a narrative that explains the rationale and details behind the proposed budget reallocation.	Finance team	Q1 2025	In Progress
Financial Management	• Prepare and execute the accounts closure checklist. • Set clear roles and responsibilities for the finance/accounting personnel. • Identify the training need assessment for accounting/finance personnel. • CAPEX investment from MoH/MEF and donors on a sustainable accounting system.	Overall, the finance manual is in the process of being updated with support from AP, ensuring roles and responsibilities are clearly stated. Additionally, the supervision team from the central level conducts fixed asset checks and oversees the	Finance team	Q4 2025	In Progress

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
	• Update and inspect 100% fixed assets listing.	subnational level to update and monitor the fixed asset register.			
Internal and external audit	• Early communicate with the internal auditors on TOR, budget, workplan, report submission. • Develop toolkits, work plan and resource assignment to improve the identified gaps and deficiencies.	The TOR of the internal audit is outlined in the MOU signed between the IAD and NMCHC. In addition, the AP has developed an "Actions and Recommendations Tracker" for the Implementer to monitor and track the implementation of recommendations from internal and external auditors, program audits, and other sources.	Finance team	N/A	In Progress
Procurement and supply chain	• Review of dashboard data and cross check with HMIS, match vaccine procurement data between supply and demand. • Strengthen the microplanning data for vaccine quantification/forecast. • Review of ONA data summarise to cross check with sample of HC-OD-PHD-Central consolidated logistics data. • Spot checks on staff at subnational level to prioritise training needs. • Fixed asset verification at national/subnational level, explore online tools to accelerate the process. • Review of progress and to strengthen cold chain monitoring.	The program team at the central level collaborates closely with the subnational level to ensure the accuracy of vaccination data. Additionally, the supervision team from the central level visits PHDs to monitor fixed asset management status, perform document reviews, and identify training needs.	NMCHC and relevant partners	To be determined	In Progress
Capacity building	• Identify and develop the capacity building requirement and plan.	NMCHC, with assistance from the AP, is aware of the areas in need of capacity building. The requirements for capacity building will be developed following internal discussions.	Finance team	Q4 2025	In Progress
Counter fraud	• Develop a fraud policy. • Identify fraud risks and mitigation action. • Evaluate the effectiveness of the current counter-fraud measures. • Identify gaps and weaknesses in the system.	The finance manual is currently undergoing revision, which will incorporate counter-fraud mechanisms.	Programme and Finance teams	Q4 2025	In Progress
System	• Conduct regular testing and review on their backup and audit trail respectively. • Install anti-virus and update QuickBooks and operating systems.	Regular testing and reviews are conducted, but the installation of antivirus software and updates to QuickBooks are subject to further internal discussion.	Finance team	Q3 2025	In Progress

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
Financial reporting	• Reconcile the figures between general ledger and financial report. • Fill in the fixed asset tab and provide explanation on variance between budget and actual expenditures per Gavi's guideline. • Explain the variance in financial reports. • Reconfirm the financial reporting template with Gavi to verify that the figures reported are on a quarterly basis.	NMCHC's finance team has enhanced its financial reporting practices by filling in the fixed asset tab and providing explanations for the variance between budgeted and actual expenditures, following feedback from the AP.	Finance team	N/A	Not Started
Financial Management	NMCHC should: • Implement more robust monitoring and verification processes to cross-check overtime work records against per diem and travel claims. • Ensure there's a signed attendance list specifying the time and date of the overtime work. • Ensure there's a report on the outcome of the overtime work for monitoring effectiveness. • Overtime payment should not be approved if there is no attendance record to support the claimed overtime.	NMCHC is collaborating closely with the PHD to address this issue. As part of their supervision activities, the NMCHC finance team will visit selected PHDs.	Finance team	Q2 2025	In Progress
Financial Management	NMCHC should: • Obtain the names of the volunteers and include them in the lists attached to the invitation letter for each event. This ensures accuracy and accountability by clearly identifying who is expected to attend and participate in the scheduled activities. • There should be an attached identification card. This attachment serves to verify and confirm the identity of each individual who attends the event or activities, ensuring that only legitimate participants are involved. • The field staff should take photos of the volunteer activity during the field trip and attach them to the activity report for the advance liquidation process. • Implement stricter record-keeping procedure, enhance verification process, and provide	NMCHC is collaborating closely with the PHD to address this issue. As prt of their supervision activities, the NMCHC finance team will visit selected PHDs. This process and the requirements will be updated in the finance manual to ensure compliance with MEF SOP.	Finance team	Q4 2025	In Progress

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
	comprehensive training to staff and volunteers on the importance of accurate documentation and ethical standards.				
Financial Management	NMCHC should: • Draft a memo outlining the correct procedure for issuing cheques, emphasizing that cheques must not be dated earlier than submission date of supporting documents, and address it to the authorized person(s) from finance manager.	The PHD's finance team agreed with the findings and committed to improving financial management by ensuring cheques are not pre-dated and their dates align with the submission of supporting documents. This process will be updated in the finance manual to ensure compliance with MEF SOP.	Finance team	Q4 2024	Implemented
Financial Management	NMCHC should: • Establish a clear guideline requiring that all must accurately reflect their preparation date and ensure any deviation from these protocols are flagged for proper investigation. • Create detailed procedures for verifying the authenticity of documents, including cross-checking with original sources and ensure that all documents are properly prepared. • Conduct regular training sessions for employees to ensure they understand the new policies and the importance of adhering to them.	NMCHC is working closely with PHD to address this issue, which will be reflected in updates to the finance manual.	Finance team	Q4 2025	In Progress
Financial Management	NMCHC should: • Develop a clear travel policy that ensure that they are applicable, the policies should outline defined rate and permissible expense. • Mandate detailed documents for all the expenses, including reference linked to the travel cost calculations, which should be based on established policies. Additionally, established an effective management system for overseeing the approval workflows.	NMCHC is working closely with PHD to address this issue, which will be reflected in updates to the finance manual.	Finance team	Q4 2025	In Progress
Budgeting	NMCHC should: • Start preparing the AOP as early as possible in the preceding year, which will lessen the need to adjust the plans.	NMCHC's finance team has prepared the FY25 AOP early enabling timely approval with the support of the AP.	Finance team	Q4 2024	Not Started

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
Fixed Asset Management	NMCHC should: • Have an SOP in place for staff to refer to when maintaining the fixed assets including tracking the movement of the assets. • After establishing the SOP, ensure staff are properly trained and understand the importance of it. Then carry out a spot check to strengthen their compliance.	NMCHC is working closely with PHD to address this issue, which will be reflected in updates to the finance manual.	Finance team	Q4 2025	In Progress
Fixed Asset Management	NMCHC should: • Relocate unused equipment to more secure, appropriate storage locations. • Revisit the demand planning requirements to ensure procured items are for necessary use.	NMCHC is working closely with PHD to address this issue, which will be reflected in updates to the finance manual.	Finance team	Q4 2025	In Progress
Fixed Asset Management	NMCHC should: • Establish a schedule for periodic fixed asset counts at both PHD and OD levels. • Train finance staff on the importance of asset counts and proper procedures for inspecting them.	NMCHC is working closely with PHD to address this issue, which will be reflected in updates to the finance manual.	Finance team	Q4 2025	In Progress
Fixed Asset Management	NMCHC should: • Conduct a formal assessment of the family's situation and explore alternative support mechanisms for their livelihood for the motorbike with the state 12 1-8657. If deemed necessary, officially document and approve the temporary use of the motorbike by the family with a clear timeline and conditions for return. • Ensure that the official documents the transfer of the motorbike under the state 2 1-2556 to the wife of the late responsible person, including her role in Gavi-funded activities, are properly documented. Then, ensure formal reallocation procedures are followed, including updating the asset register to reflect the new custodian.	NMCHC is working closely with PHD to address this issue.	Finance team	Q2 2025	In Progress
Financial Management	NMCHC should: • Adhere to the financial manual and prohibit the approval of new advances until the previous	NMCHC is working closely with PHD to address this issue, which will be reflected in updates to the finance manual.	Finance team	Q4 2025	In Progress

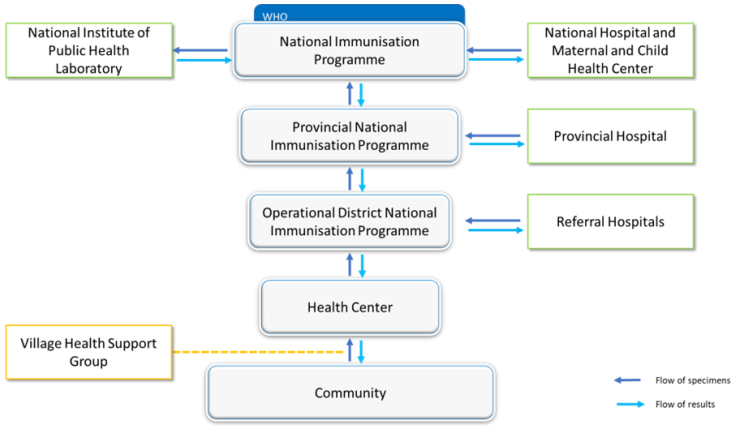
Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
	advances have been fully liquidated and accounted for. Or, revise the policy to follow the current practice. • Ensure there's proper segregation of duties where the approval of advance, processing of payments, and reconciliation of accounts are handled by the authorised individual to prevent fraud or errors. • Regularly report outstanding advances, the status of their liquidation and any discrepancies. The report will help in early detection and correction toward non-compliance.				
Procurement	NMCHC should: • Obtain the documents and information from the suppliers such as credentials and CVs of their teams by setting a clear deadline for submission to avoid the delay of the procurement process. • Make sure the proposal meets the technical needs. • Consider each supplier's past performance and reliability. • Make sure suppliers follow all relevant rules and assess any risks they might pose.	NMCHC and Sihanouk PHD has already submitted the relevant credential from the valid bidder.	Finance team and Sihanouk PHD	Q1 2025	Implemented
Financial Management	NMCHC should: • Implement more robust monitoring and verification processes to cross-check staff's assignments. • Ensure there's a signed attendance list specifying the time and date of the overtime work. • Ensure there's a report on the outcome of the overtime work for monitoring effectiveness. • Overtime payment should not be approved if there is no attendance record to support the claimed overtime.	NMCHC is working closely with the PHD to address this finding. PHD is committed to enhance the practice ensuring that there will be no overlapping payment.	Programme team and Finance team	Q2 2025	In Progress
Financial Management	NMCHC should: • Develop and enforce a comprehensive internal control framework that outlines specific procedures for reviewing and approving disbursements. This framework should include detailed checklists and	NMCHC is working closely with PHD to address this issue, which will be reflected in updates to the finance manual.	Finance team	Q4 2025	In Progress

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
	guidelines for ensuring compliance with the finance manual. • Establish a multi-tiered review process where disbursements are checked by multiple individuals to ensure accuracy and compliance. This can serve as a deterrent to fraudulent activities and reduce the risk of errors.				
Fixed Asset Management	NMCHC should: • Establish a clear roll-out plan to prioritise the installation of the EIR application to cover all relevant ODs and HCs. This should be conducted immediately to ensure that the tablets can be used effectively for their intended purpose. • Organise training sessions for HC staff on how to use the EIR application and the tablets efficiently. This will enhance their capability in utilising the technology for vaccination data entry. • Ensure that all tablets are set up and prepared for use as soon as possible. • Implement a monitoring system to track the usage of tablets and the EIR application, including screen time, data entry activities, and feedback from HC staff.	NMCHC's program team is working closely with the sub-national level to address this issue. A pilot test has already been rolled out in a few provinces, and a clear timeline for the EIR application's rollout will be scheduled as soon as possible.	Programme team	Q3 2025	In Progress
Fixed Asset Management	NMCHC should: • Establish clear policies and raise awareness among relevant personnel regarding the significance of maintaining clean and organised storage areas to prevent damage to the refrigerators. • Instruct the relevant personnel to clean and organise the messy warehouse to create a safe and accessible space for storing the unused refrigerators. • Conduct spot checks for regular inspections of storage areas to ensure that refrigerators and other fixed assets are stored properly and maintained in good condition.	NMCHC is working closely with PHD to address this issue.	Programme team	Q2 2025	In Progress

Issues	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 31 July 2025
Fixed Asset Management	NMCHC should: • Designate HC staff for maintaining and updating the fixed asset register. This individual should be accountable for ensuring accurate and timely records. • Implement a procedure for regularly updating the fixed asset register whenever new assets are received, disposed of or relocated. • Establish a timeline for reviewing and reconciling the register against physical assets.	NMCHC is working closely with PHD to address this issue.	Finance team	Q2 2025	In Progress
Fixed Asset Management	NMCHC/OD should: • Maintain records of the location and condition of refrigerators and other fixed assets, ensuring that any changes made, or relocation are documented properly. • Update the fixed asset register to accurately reflect the current locations of the refrigerators and other fixed assets. • Perform a thorough physical inventory check of the fixed assets to determine their current locations. • Require the movements of fixed assets be authorised by a designated individual to ensure accountability.	NMCHC is working closely with PHD to address this issue.	Finance team/ Programme team	Q2 2025	In Progress
Fixed Asset Management	NMCHC should: • Provide training for OD and HC staff on the importance of asset tagging including how to properly affix and maintain asset tags to prevent loss and damage. • Ensure that all missing or torn asset tags are promptly replaced with new tags. This should be completed as soon as possible for all levels to maintain an accurate inventory. • Schedule routine inspections of the fixed assets to verify the presence and condition of asset tags. This can ensure compliance with tagging procedures.	NMCHC is working closely with PHD to address this issue.	Finance team	Q2 2025	In Progress

Annex 7: Programme management

Annex 7a: MR specimen and results process flow



Annex 7b: Duration between onset of symptoms and specimen collection for positive cases

Table: Duration between onset of symptoms and specimen collection for positive cases

# of Days	2020	2021	2022	2023	2024	2025*
-17						1
-2						2
-1						1
0	34	1		1	666	495
1	122	2	6	4		1029
2	93	1	2	2		603
3	49	1	2	1		333
4	28		1	1		143
5	12		2	1		51
6	5					37
7	5					21
> 7	31			1		46
Grand Total	**379**	**5**	**13**	**11**	**666**	**2762**
% of +ve specimens drawn within 2 days	**66%**	**80%**	**62%**	**64%**	**100%**	**77%**

Annex 7c: Duration between date specimen is sent to the Lab and specimen collection for positive cases

Table: Duration between date specimen is sent to the Lab and specimen collection for positive cases

# of Days	2020	2021	2022	2023	2024	2025*
-25					1	
0					3	122
1					19	119
2					87	307
3	379	2	4	2	109	411
4		3	9	9	127	362
5					104	306
6					60	326
7					63	311
8					47	201
9					16	157
10					10	57
>10					20	83
Grand Total	**379**	**5**	**13**	**11**	**666**	**2762**
% of +ve specimens transported within 5 days	**100%**	**100%**	**100%**	**100%**	**68%**	**59%**

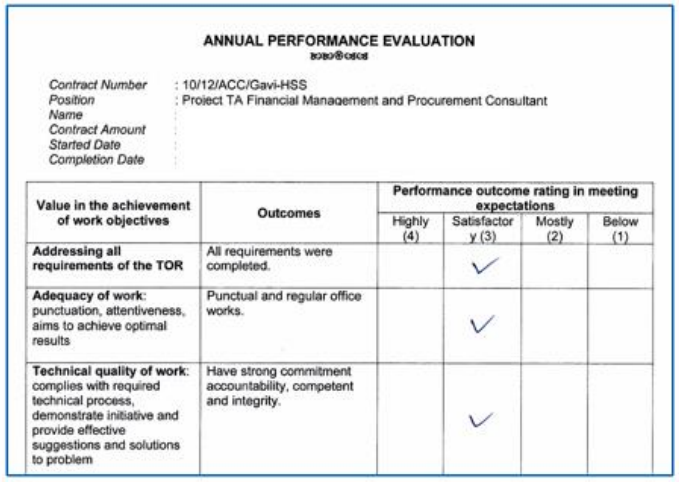
Annex 7d: Duration between date results are obtained and specimen received by Lab for positive cases

Table: Duration between date results are obtained and specimen received by Lab for positive cases

Days	2020	2021	2022	2023	2024	2025*
0	4				59	262
1	32				239	400
2	126	5	13	11	176	816
3	76				128	839
4	46				18	344
5	43				4	19
6	35				7	28
7	14					5
8						1
9					16	1
> 10	3				19	47
Grand Total	**379**	**5**	**13**	**11**	**666**	**2762**
% of +ve laboratory cases reported within 4 days	**75%**	**100%**	**100%**	**100%**	**93%**	**96%**

Annex 7e: Weaknesses in TA performance monitoring

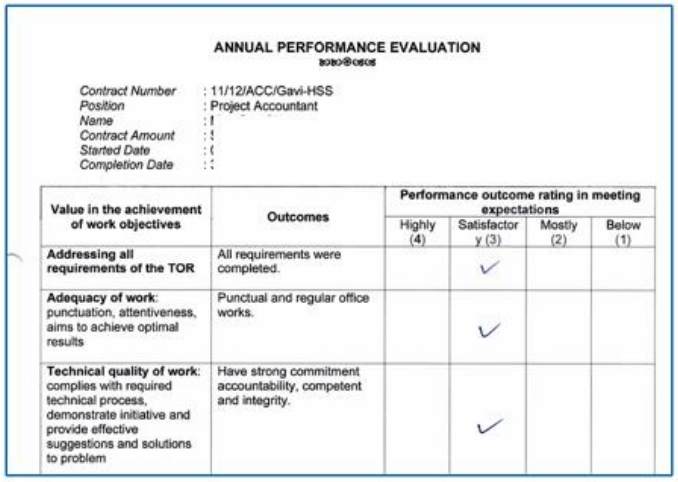
i) Generic appraisals with no link to objectives and no qualitative or quantitative feedback



ANNUAL PERFORMANCE EVALUATION

Contract Number : 10/12/ACC/Gavi-HSS
Position : Project TA Financial Management and Procurement Consultant
Name
Contract Amount
Started Date
Completion Date

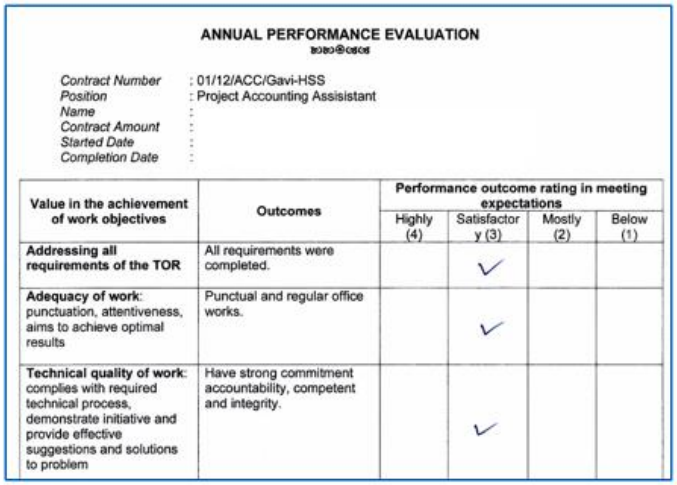
Value in the achievement of work objectives	Outcomes	Performance outcome rating in meeting expectations			
		Highly (4)	Satisfactor y (3)	Mostly (2)	Below (1)
Addressing all requirements of the TOR	All requirements were completed.		✓		
Adequacy of work: punctuation, attentiveness, aims to achieve optimal results	Punctual and regular office works.		✓		
Technical quality of work: complies with required technical process, demonstrate initiative and provide effective suggestions and solutions to problem	Have strong commitment accountability, competent and integrity.		✓		



ANNUAL PERFORMANCE EVALUATION

Contract Number : 11/12/ACC/Gavi-HSS
Position : Project Accountant
Name :
Contract Amount :
Started Date :
Completion Date :

Value in the achievement of work objectives	Outcomes	Performance outcome rating in meeting expectations			
		Highly (4)	Satisfactor y (3)	Mostly (2)	Below (1)
Addressing all requirements of the TOR	All requirements were completed.		✓		
Adequacy of work: punctuation, attentiveness, aims to achieve optimal results	Punctual and regular office works.		✓		
Technical quality of work: complies with required technical process, demonstrate initiative and provide effective suggestions and solutions to problem	Have strong commitment accountability, competent and integrity.		✓		



ANNUAL PERFORMANCE EVALUATION

Contract Number : 01/12/ACC/Gavi-HSS
Position : Project Accounting Assisistant
Name :
Contract Amount :
Started Date :
Completion Date :

Value in the achievement of work objectives	Outcomes	Performance outcome rating in meeting expectations			
		Highly (4)	Satisfactor y (3)	Mostly (2)	Below (1)
Addressing all requirements of the TOR	All requirements were completed.		✓		
Adequacy of work: punctuation, attentiveness, aims to achieve optimal results	Punctual and regular office works.		✓		
Technical quality of work: complies with required technical process, demonstrate initiative and provide effective suggestions and solutions to problem	Have strong commitment accountability, competent and integrity.		✓		

ii) Generic reports across different TA personnel

Report for monitoring and evaluation TA

III. Deliverables and Timelines:

Deliverables for year 2024	Progress update	Timeline
1. Prepare a detailed work plan, budget, and timeline of implementation and grant disbursal schedule for all immunization Communication and Monitoring and Evaluation activities	Attended all meeting with NIP staff / managers and partners to discuss on the NIP workplan and budget plan 2024 & 2025 in order to conduct developing Annual Operational Plan (AOP) by the year 2024 and also 2025 in the preceding period. The AOP has already been completed separately by provinces before the validity of implementing period. We usually share the update of immunization communication and M&E activities from the attending of the internal and external meeting or training to the NIP team during the NIP office meeting. We have been being strongly to support on Measle outbreak response to develop the vaccination workplan & budget plan, and supporting the process of outbreak	Q1 and sometime based on the requirement of the period (reprogram, campaign, outbreak response...)
	uploading from HMIS.	
3. Analyze findings on communication from the supportive supervision checklists provided by national and provincial authorities, compile the report and present to Immunization Management Team	TA for Immunization, M&E attended the Consultative workshop on the reviewing of supportive supervision checklist with NIP team, PHD & OD EPI staff. TA has joined and leaded a group to discuss on the point remaining in the form of checklist with final updating on comments. The supportive monitoring checklist divided into several parts such as the Service delivery, Logistic & Cold chain management, Disease Surveillance, Demand generation (Immunization communication) and Program management. All that parts have been compiled and analyzed as the general findings with the challenges and recommendation into an Excel sheet based on the information and data from the NIP supportive supervision checklist. The finding of the immunization communication also has compiled and analyzed together within that form after the NIP staff returned back from the mission trip, then we will get the brief of finding and share to the NIP team through the meeting for every ending of month.	Quarterly
4. Quarterly report on the	For the part of communication of supportive supervision	Quarterly

Report for Supply chain TA

III. Deliverables and Timelines:

Deliverables for year 2024	Progress update	Timeline
1. Prepare a detailed work plan, budget, and timeline of implementation and grant disbursal schedule for all immunization cold chain and vaccine logistics planning activities	Attended all meeting with NIP staff / managers and partners to discuss on the NIP workplan and budget plan 2024 & 2025 in order to conduct developing Annual Operational Plan (AOP) by the year 2024 and also 2025 in the preceding period. The AOP has already been completed separately by provinces before the validity of implementing period. We have been being strongly to support discussion on Measle outbreak response for developing the vaccination workplan & budget plan, and supporting logistics process of outbreak response activities for among selected provinces.	Q1 and sometime based on the requirement of the period (reprogram, campaign, outbreak response...)
2. Support NIP team on management of vaccine and	TA support, worked closely with NIP team to analyze vaccine stock report by provinces for immunization data	Monthly, quarterly,
	can support to the adequate supply of vaccine and other related logistics. For every Monday, NIP team always conduct the meeting to discuss on the data monitoring including the incomplete data, incorrect data, and unscheduled of data entry period from TA, then NIP manager directed to the regional team leader for taking the action immediately.	
3. Analyze findings on vaccine and cold chain part from the supportive supervision checklists provided by national and provincial authorities, compile the report and present to Immunization Management Team	TA attended the Consultative workshop on the reviewing of supportive supervision checklist with NIP team, PHD & OD EPI staff. TA has joined and leaded a group to discuss on the point remaining in the form of checklist with updating on discussion. The points in the checklist there are Service delivery, **Logistic/cold chain management**, Disease Surveillance, Demand generation (communication) and Program management. Regarding to this NIP checklist point, also communication was included in the list and collected from the field supervision trip by NIP staff as following by the activity plan accordingly. The finding of the supportive supervision trip has compiled and analyzed in form after the period of the	25-26 June 2024

Annex 8: Vaccine supply chain and cold chain management

Annex 8a: Stock reconciliation at PHD vaccine store

PHD Vaccine Store	Vaccine	Expected Stock Balance	Stock balance as per Record	Variance
Tboung Khmum	Pentavalent vaccine	4,753	4,753	-
	Inactivated Polio vaccine	1,885	1,885	-
	Pneumococcal Conjugate Vaccine	4,519	4,519	-
	Measles & Rubella	- 8,320	76,380	- 84,700.0
	BCG	3,260	3,260	-
Pursat	Pentavalent vaccine	9,798	9,700	98
	Inactivated Polio vaccine	5,155	5,150	5
	Pneumococcal Conjugate Vaccine	10,350	10,350	-
	Measles & Rubella	8,965	8,965	-
	BCG	19,660	19,560	100

Annex 8b: Stock movement from CMS to PHD vaccine store

Stock movement (CMS to PHD)	Vaccine	CMS Delivered Quantity	PVS Receipt Quantity	Variance
CMS to Mondulkil OD*	Pentavalent vaccine	2,160	2,000	160
	Inactivated Polio vaccine	1,250	1,250	
	Pneumococcal Conjugate Vaccine	4,000	3,150	850
	Measles & Rubella	7,000	7,000	
CMS to Koh Kong	Pentavalent vaccine	2,990	2,990	
	Inactivated Polio vaccine	1,300	1,300	
	Pneumococcal Conjugate Vaccine	3,000	3,000	
	Measles & Rubella	19,285	19,285	
CMS to Pursat	Pentavalent vaccine	11,540	11,540	
	Inactivated Polio vaccine	3,800	3,800	
	Pneumococcal Conjugate Vaccine	3,760	7,900	-4140
	Measles & Rubella	7,850	7,850	
CMS to Tbhong Khmum	Pentavalent vaccine	12,730	12,730	
	Inactivated Polio vaccine	3,700	3,700	
	Pneumococcal Conjugate Vaccine	12,710	12,710	
	Measles & Rubella	15,850	15,850	
CMS to Phnom Penh	Pentavalent vaccine	24,500	24,500	
	Inactivated Polio vaccine	5,300	5,300	
	Pneumococcal Conjugate Vaccine	21,160	21,160	
	Measles & Rubella	23,300	23,300	

** In Mondulkil, vaccines were delivered directly from CMS to OD as there was no PVS till June 2025*

Annex 8c: Stock movement from PHD Vaccine store to OD vaccine store

Stock movement PVS to ODVS	Antigen	CMS Delivered Quantity	PVS Receipt Quantity	Variance	Remarks
Pursat PVS to Sampov Meas OD	Pentavalent vaccine	850	850		
	Inactivated Polio Vaccine	350	350		
	Pneumococcal Conjugate Vaccine	600	600		
	Measles & Rubella	570	570		
PVS to Smach Mean Chey	Pentavalent vaccine	371	371		
	Inactivated Polio Vaccine	185	185		
	Pneumococcal Conjugate Vaccine	520		520	*Stock card for 2020 was lost.*
	Measles & Rubella	580	580		
PVS to Sre Am Bel	Pentavalent vaccine	373	373		
	Inactivated Polio Vaccine	110	110		
	Pneumococcal Conjugate Vaccine	130	130		
	Measles & Rubella	375	375		
PVS to Bakan ODVS	Pentavalent vaccine	624	0	624	
	Inactivated Polio Vaccine	185	185		
	Pneumococcal Conjugate Vaccine	500	500		
	Measles & Rubella	500	500		
PVS to Kroch Chhmar ODVS	Pentavalent vaccine	900	900		
	Inactivated Polio Vaccine	165	165		
	Pneumococcal Conjugate Vaccine	400	400		
	Measles & Rubella	500	500		
PVS to Smach Mean Chey	Pentavalent vaccine	200	200		*According to the delivery records of the Provincial Vaccine Store, All vaccines were delivered on 5th December 2024. However, as per the stock card, the vaccines were recorded as received on 2nd December 2024, which is earlier than the PVS delivery date*
	Inactivated Polio Vaccine	0	0		
	Pneumococcal Conjugate Vaccine	200	200		
	Measles & Rubella	250	250		
PVS to Mekong ODVS	Pentavalent vaccine	320	320		
	Inactivated Polio Vaccine	200		200	*Stock card data not available at OD*
	Pneumococcal Conjugate Vaccine	552		552	*Stock card data not available at OD*
	Measles & Rubella	780	1260	-480	

Annex 8d: Stock movement from ODVS to Health Center

Health Center	Vaccine	OD Delivered Quantity	Health Facility Received Quantity	Variance	Remarks
Vihear Loung	Inactivated Polio Vaccine	25		25	Stock cards were not available
	Measles & Rubella	80		80	
Prey Nhy	Pentavalent vaccine	114		114	Stock card was not available
Poeus II	Pentavalent vaccine	20		20	Stock cards were not available
	Pneumococcal Conjugate Vaccine	20		20	
	Measles & Rubella	35		35	
Boeng Khnar	Pentavalent vaccine	150	100	50	
	Inactivated Polio Vaccine	35	50	-15	
	Pneumococcal Conjugate Vaccine	130	100	30	
	Measles & Rubella	155	100	55	
Thmor Sor	Pentavalent vaccine	39	19	20	
	Measles & Rubella	35	90	-55	
Sre Am Bel	Pentavalent vaccine	71		71	No stock cards maintained
	Inactivated Polio Vaccine	25		25	No stock cards maintained
	Pneumococcal Conjugate Vaccine	93		93	No stock cards maintained
	Measles & Rubella	95		95	No stock cards maintained
O Ta Poang	Pentavalent vaccine	100	124	-24	
	Pneumococcal Conjugate Vaccine	100	50	50	
Rumlech	Pentavalent vaccine	50	40	10	
	Inactivated Polio Vaccine	25	50	-25	
Khnar Totueng	Pentavalent vaccine	50	0	50	
	Inactivated Polio Vaccine	20	0	20	
Trea	Pentavalent vaccine	18		18	Stock card was not available
	Pneumococcal Conjugate Vaccine	45	30	15	
Trapeang Chong	Pentavalent vaccine	210	150	60	
	Pneumococcal Conjugate Vaccine	50	100	-50	
	Measles & Rubella	5	200	-195	
Chroy Changva	Pentavalent vaccine	100		100	Stock cards were not available
	Inactivated Polio Vaccine	30		30	
	Pneumococcal Conjugate Vaccine	150		150	
	Measles & Rubella	100		100	
Kilo 6	Pentavalent vaccine	350	300	50	
	Inactivated Polio Vaccine	90	50	40	
	Pneumococcal Conjugate Vaccine	250		250	Stock card was not available
	Measles & Rubella	250	280	-30	
Kilo 9	Pentavalent vaccine	200		200	Stock cards before January 2025 were not available
	Inactivated Polio Vaccine	50		50	
	Pneumococcal Conjugate Vaccine	200		200	
	Measles & Rubella	300		300	
Senmonorom	Inactivated Polio Vaccine	50		50	Stock cards for 2023 not available
	Measles & Rubella	80		80	

Annex 8e: Physical count Vs stock card balance at PHD vaccine store

PHD Vaccine Store	Name of Vaccine	Quantity counted	Quantity recorded in Stock Card	Variance
Mondulkiri	Pentavalent vaccine	1,880	1,880	-
	Inactivated Polio vaccine	490	490	-
	Pneumococcal Conjugate Vaccine	1,800	1,780	20
	Measles and Rubella	600	600	-
	BCG	6,000	5,800	200
	Covid'19 Vaccine (Pfizer)	858	864	-6
Koh Kong	Pentavalent vaccine	410	400	10
	Inactivated Polio vaccine	105	105	-
	Pneumococcal Conjugate Vaccine	689	689	-
	Measles and Rubella	2,480	2,480	-
	BCG	20	20	-
	Covid'19 Vaccine (Pfizer)	2,610	2,610	-
Pursat	Pentavalent vaccine	9,695	9,700	-5
	Inactivated Polio vaccine	5,150	5,150	-
	Pneumococcal Conjugate Vaccine	10,347	10,350	-3
	Measles and Rubella	8,965	8,965	-
	BCG	19,560	19,560	-
	Covid'19 Vaccine (Pfizer)	4,080	4,080	-

Annex 8f: Physical count Vs stock card balance at OD vaccine store

OD Vaccine Store	Vaccine	Quantity counted	Quantity recorded in Stock Card	Variance
Smach Mean Chey	Measles and Rubella	985	1,010	-25
Bakan	Pneumococcal Conjugate Vaccine	380	370	10

Annex 8g: Physical count Vs stock card balance at health centre

Health Center	Vaccine	Quantity counted	Quantity recorded in Stock Card	Variance	Remarks
Soung 2	Pentavalent vaccine	21	23	-2	
	Pneumococcal Conjugate Vaccine	26	23	3	
Soung 1	Pentavalent vaccine	96	97	-1	
	Pneumococcal Conjugate Vaccine	96	97	-1	
Koh Chum	Pentavalent vaccine	50	60	-10	
	Pneumococcal Conjugate Vaccine	50	60	-10	
	Measles and Rubella	78	85	-7	
	Covid'19 Vaccine (Name: Pfizer)	100		100	No stock card
Wat Po	Pentavalent vaccine	43	42	1	
	Measles and Rubella	39	15	24	

Health Center	Vaccine	Quantity counted	Quantity recorded in Stock Card	Variance	Remarks
Prek Tnoat	Covid'19 Vaccine (Name: Pfizer)	2		2	No stock card
Prey Nhy	Measles and Rubella	31	40	-9	
Ou Raeng	Measles and Rubella	45	50	-5	
Poeus II	Pentavalent vaccine	24	21	3	
	Inactivated Polio Vaccine	25	5	20	
	Pneumococcal Conjugate Vaccine	25	21	4	
	Measles and Rubella	45	5	40	
	BCG	120	240	-120	
Pak Klong	Inactivated Polio Vaccine	50	45	5	
	Pneumococcal Conjugate Vaccine	56	52	4	
	Covid'19 Vaccine (Name: Pfizer)	42		42	
Svay Khlaing	Pentavalent vaccine	20	45	-25	
	Inactivated Polio Vaccine	15	25	-10	
	Pneumococcal Conjugate Vaccine	20	45	-25	
	Measles and Rubella	10	40	-30	
	BCG	80	100	-20	
Neang Kok	Inactivated Polio Vaccine	35	36	-1	
	Covid'19 Vaccine (Name: Pfizer)	30		30	No stock card has been registered
Steng veng	Pentavalent vaccine	53	31	22	
	Inactivated Polio Vaccine	5	10	-5	
	Pneumococcal Conjugate Vaccine	46	31	15	
	Measles and Rubella	100	5	95	
	BCG	120	20	100	
Smach Mean Chey	Pentavalent vaccine	172	178	-6	
	Inactivated Polio Vaccine	55	60	-5	
	Pneumococcal Conjugate Vaccine	174	178	-4	
	Measles and Rubella	95	95	-	
	BCG	0	500	-500	
Boeung Preav	Pentavalent vaccine	68	69	-1	
	Inactivated Polio Vaccine	30	35	-5	
	Pneumococcal Conjugate Vaccine	68	69	-1	
	Covid'19 Vaccine (Name: Pfizer)	12		12	
Chi Phat	Pentavalent vaccine	18	16	2	
	Pneumococcal Conjugate Vaccine	18	16	2	
	Covid'19 Vaccine (Name: Pfizer)	78		78	No stock card is maintained.
Boeng Khnar	Measles and Rubella	50	75	-25	
	Covid'19 Vaccine (Name: Pfizer)	54	0	54	No stock card
Thmor Sor	Inactivated Polio Vaccine	45		45	
	Covid'19 Vaccine (Name: Pfizer)	216		216	No stock card to be verified.
Sre Am Bel	Pentavalent vaccine	125	133	50	
	Inactivated Polio Vaccine	40	38	2	
	Pneumococcal Conjugate Vaccine	116	133	-67	

Health Center	Vaccine	Quantity counted	Quantity recorded in Stock Card	Variance	Remarks
	Measles and Rubella	60	70	-10	
	BCG	160	180	-20	
	Covid'19 Vaccine (Name: Pfizer)	186		186	No stock card to be verified
O Ta Poang	Pentavalent vaccine	50	52	-2	
	Inactivated Polio Vaccine	39	35	4	
	Covid'19 Vaccine (Name: Pfizer)	60	0	60	
Khnar Totueng	Pentavalent vaccine	60	61	-1	
	Inactivated Polio Vaccine	20	15	5	
	Pneumococcal Conjugate Vaccine	74	75	-1	
	Measles and Rubella	50	55	-5	
	Covid'19 Vaccine (Name: Pfizer)	60	0	60	
Trapeang Chong	Covid'19 Vaccine (Name: Pfizer)	102	7	95	No stock card since 27 June 2023
Praches Kandal	Pentavalent vaccine	32	54	-22	
	Inactivated Polio Vaccine	20	30	-10	
	Pneumococcal Conjugate Vaccine	57	124	-67	
	Measles and Rubella	5		5	
	BCG	20		20	
Senmonorom	Pneumococcal Conjugate Vaccine	175	191	-16	

Annex 8h: Stock outs at CMS

Vaccine	Stock Out Period 1		Stock Out Period 2		Stock Out Period 3		Av. # of Stock Out Days	Max # of Stock out Days
Pentavalent vaccine								
Inactivated Polio vaccine	10-Oct-22	13-Dec-22					64	64
Pneumococcal Conjugate Vaccine	8-Apr-20	20-May-20	28-Dec-20	2-Nov-20	18-Jun-22	12-Jul-22	33	42
Measles & Rubella	21-May-21	3-Jun-21	18-May-22	15-Jul-22			36	58
BCG	8-Jun-20	7-Jul-20	18-May-22	15-Jul-22			44	58

Annex 8i: Stock outs at PHD vaccine store

PHD Vaccine Store	Vaccine	Number of stock out days - 1	Number of stock out days - 2	Number of stock out days - 3	Number of stock out days - 4	Number of stock out days - 5	Average number of Stock out days	Maximum number of stock out days
Pursat	Pentavalent vaccine	12					12	12
	Inactivated Polio vaccine	62					62	62
	Pneumococcal Conjugate Vaccine	13	42				28	13
	Measles & Rubella	4	30	52	51	52	38	4
	BCG	29	36	20	15		25	29
Phnom Penh	Measles & Rubella	50	30				40	50
	BCG	13					13	13

Annex 8j: Stock outs at OD vaccine store

OD Vaccine Store	Vaccine	Number of stock out days - 1	Number of stock out days - 2	Number of stock out days - 3	Number of stock out days - 4	Number of stock out days - 5	Number of stock out days - 6	Number of stock out days - 7	Number of stock out days - 8	Average number of Stock Out days	Maximum number of stock out days
Sampov Meas	Pentavalent vaccine	18								18	18
	Inactivated Polio vaccine	21	35							28	35
	BCG	61	11	27						33	61
Senmonorom	Pentavalent vaccine	23	19	23	11	24	23			21	24
	Inactivated Polio vaccine	26	30	36	31	24	23	5	30	26	36
	Pneumococcal Conjugate Vaccine	23								23	23
	Measles & Rubella		20	21	59	30				33	59
	BCG	20	22	69	24	38				35	69
Sre Am Bel	Pentavalent vaccine	22								22	22
Bakan	Inactivated Polio vaccine	30	34							32	34
	Measles & Rubella	27								27	27
	BCG	31	29	31	31	58	24			34	58
Soung	BCG	28								28	28
Mekong	Pentavalent vaccine	7								7	7
	Inactivated Polio vaccine	52	33	25						37	52
	Pneumococcal Conjugate Vaccine	7								7	7
	BCG	26	25							26	26

`

Annex 8k: Stock outs at health centers

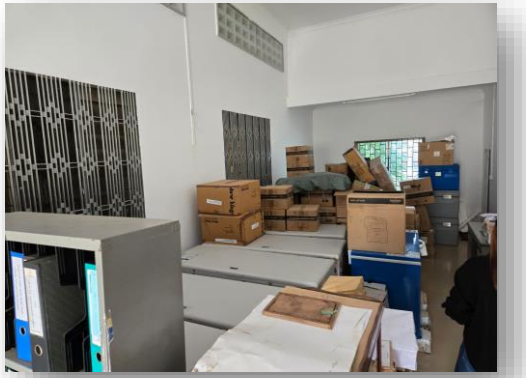
Health Center	Vaccine	Number of stock out days - 1	Number of stock out days - 2	Number of stock out days - 3	Number of stock out days - 4	Number of stock out days - 5	Number of stock out days - 6	Number of stock out days - 7	Number of stock out days - 8	Average number of Stock out days	Maximum number of stock out days
Vihear Loung Health Center	BCG	11								11	11
Soung 2	BCG	6								6	6
Soung 1	Inactivated Polio Vaccine	4								4	4
	BCG	3								3	3
Koh Chum	Inactivated Polio Vaccine	3	2	2						2	3
	Measles & Rubella	4	3							4	4
	BCG	4								4	4
Wat Po	Measles & Rubella	2	2							2	2
	BCG	7	4							6	7
Prek Tnoat	Pentavalent vaccine	29	46	20						32	46
	Inactivated Polio Vaccine	10	2							6	10
	Pneumococcal Conjugate Vaccine	76	20							48	76
	Measles & Rubella	12	10	3	3	3				6	12
	BCG	6	6	13						8	13
Prey Nhy	Inactivated Polio Vaccine	3	14	17	12	23	20			15	23
	BCG	7	8							8	8
Ou Reang	Pentavalent vaccine	29								29	29
	Inactivated Polio Vaccine	10								10	10
	Measles & Rubella	44	45	36	64	13				40	64

Health Center	Vaccine	Number of stock out days - 1	Number of stock out days - 2	Number of stock out days - 3	Number of stock out days - 4	Number of stock out days - 5	Number of stock out days - 6	Number of stock out days - 7	Number of stock out days - 8	Average number of Stock out days	Maximum number of stock out days
	BCG	14	87	24	4	7	11			25	87
Peus 1	Measles & Rubella	7								7	7
	BCG	7								7	7
Poeus II Health Center	Pentavalent vaccine	2								2	2
	Inactivated Polio Vaccine	3								3	3
	BCG	2								2	2
Svay Khlaing	Pentavalent vaccine	27	35	33	28					31	35
	Inactivated Polio Vaccine	33								33	33
	Pneumococcal Conjugate Vaccine	27	35							31	35
	BCG	33								33	33
Neang Kok	Measles & Rubella	2								2	2
Stung Veng	Pentavalent vaccine	2	4	2	3	2	2	14	9	5	14
	Inactivated Polio Vaccine	14	6	6	12	5	35	15	18	14	35
	Pneumococcal Conjugate Vaccine	19	4	3	18	6	2	3		8	19
	Measles & Rubella	4	13	8	2	15	4	5	19	9	19
Smach Mean Chey	Inactivated Polio Vaccine	10	8	45						21	45
	BCG	6								6	6
Boeung Preav	Measles & Rubella	2								2	2
Chi Phat	Pentavalent vaccine	5								5	5
	Inactivated Polio Vaccine	10								10	10
	Pneumococcal Conjugate Vaccine	5								5	5
Boeng Khnar	Pentavalent vaccine	5	6	6						6	6
	Inactivated Polio Vaccine	4	4	4						4	4
	Pneumococcal Conjugate Vaccine	9	5	6						7	9
	Measles & Rubella	56	4	3	4	30	4			17	56
Thmor Sor	Pentavalent vaccine	4	3	23	2	7				8	23
	Inactivated Polio Vaccine	3								3	3
	Pneumococcal Conjugate Vaccine	7	3	3	2	7				4	7
	Measles & Rubella	8	2							5	8
	BCG	34	17							26	34
Ta Poang	Inactivated Polio Vaccine	6	7	10	6	2				6	10
	Measles & Rubella	3	3	5	8	2	6			5	8
	BCG	7								7	7
Rumlech	Pentavalent vaccine	19	3							11	19
	Inactivated Polio Vaccine	7								7	7
	Pneumococcal Conjugate Vaccine	4								4	4
	Measles & Rubella	8	6	7	2	6	6			6	8
	BCG	8								8	8
Trea Health Center	Inactivated Polio Vaccine	6								6	6
	Pneumococcal Conjugate Vaccine	3								3	3
	BCG	7								7	7
Trapeang Chong	Pentavalent vaccine	31	8	7	2					12	31
	Inactivated Polio Vaccine	2								2	2

Health Center	Vaccine	Number of stock out days - 1	Number of stock out days - 2	Number of stock out days - 3	Number of stock out days - 4	Number of stock out days - 5	Number of stock out days - 6	Number of stock out days - 7	Number of stock out days - 8	Average number of Stock out days	Maximum number of stock out days
	Pneumococcal Conjugate Vaccine	31								31	31
	BCG	7								7	7
Praches Kandal	Inactivated Polio Vaccine	29								29	29
Kilo 6	Pentavalent vaccine	3								3	3
	Inactivated Polio Vaccine	9								9	9
	Pneumococcal Conjugate Vaccine	3								3	3
	Measles & Rubella	2								2	2
	BCG	2								2	2
Andong Teuk	Pentavalent vaccine	4	3	4						4	4
	Inactivated Polio Vaccine	40	92							66	92
	Pneumococcal Conjugate Vaccine	4	3							4	4
	Measles & Rubella	5	36	36	3	18				20	36
Sre Am Bel	Inactivated Polio Vaccine	3								3	3

Annex 8l: Empty WICR at CMS

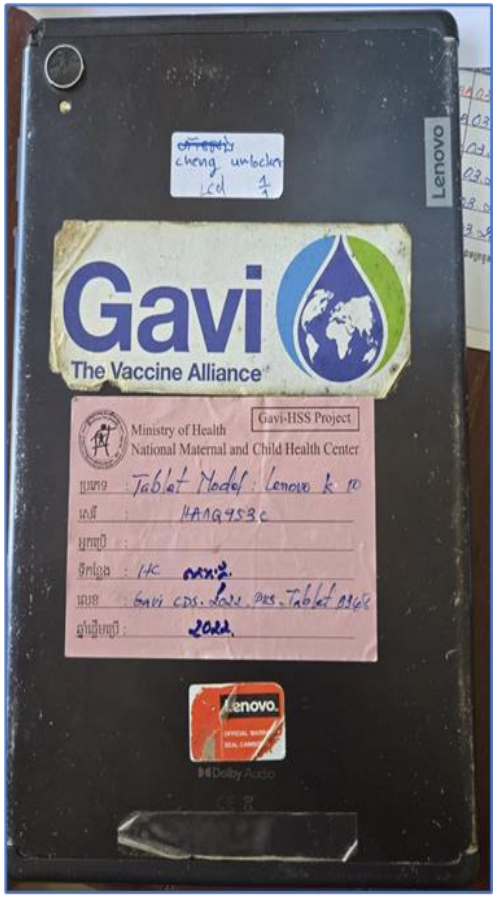
Annex 8m: Unutilised refrigerators at a PHDVS



Annex 8n: Redundant cold chain trucks at CMS

Annex 9: Gaps in Fixed Assets Management

Discrepancies in Asset Tagging and affixing of Donor Logo



Fixed Asset Not matching with the condition as per Fixed Asset Register

Sub National Level	Name of Department	Asset identity No.	Asset Description	Asset found in its location as per Fixed Asset register	Condition of Asset as per Auditor's Observation	Condition of Asset in FAR matched Observed Condition
HC	Kilo 6 HC	Gavi-CDS-2022-PP-Tablet-0255	Tablet Model: Lenovo K10 Serial: HA1QBQCN	N/A	Broken	No
HC	Ou Raeng HC	Gavi-2023-MOD-Tablet-1068	Tablet Samsung Galaxy Tab A8 Serial: 9310562	Yes	Broken	No
HC	Prey Nhy HC	Gavi-CDS-2023-PUS-TV-0707	Smart TV . Serial: 4UDJ39DTB01323	Yes	Broken	No

Fixed Asset not listed in Fixed Asset Register

Sub National Level	Name of Department	Asset identity No.	Asset Description	Asset found in its location as per Fixed Asset register	Condition of Asset as per Auditor's Observation	Condition of Asset in FAR matched Observed Condition
OD	Senmonorom	MB-2020-GAVI-MDK-11	Motorbike 100 c . Plate number: 12-1-2582	Assets not listed in FAR sheet		
HC	Ou Raeng HC	Gavi-2025-MOD-Tablet-2321	Tablet Samsung Galaxy Tab A9	Asset not listed in FAR sheet		
HC	O Ta Poang HC	Gavi-CDS-2023-PUS-TV-0705	Smart TV . Serial: 4UDJ39DTB01321	Asset not listed in FAR sheet	Broken	Asset not listed in FAR sheet
HC	Steng Veng HC		Lenovo tablet	Asset not listed in FAR sheet		
HC	Steng Veng HC		Lenovo tablet	Asset not listed in FAR sheet		
HC	Pak Klong HC		Tablet Samsung Galaxy Tab A9 Serial: R9TX50CBLPE	Asset not listed in FAR sheet		
HC	Boeung Preav HC		Samsung Galaxy A9 Serial No. r9tx50cblzj	Asset not listed in FAR sheet		
HC	Andong Teuk HC		Motorcycle SUZUKI VIVA. - Plate No.: ????12-1-6986. Model: SM-X216B	Asset not listed in FAR sheet		
HC	Thmor Sor HC		Suzuki Viva. Year: 2024. Plate No. State12-10-3004	Asset not listed in FAR sheet		
HC	Thmor Sor HC		Samsung Galaxy Tab A9. Serial No. r9tx50cbm1b	Asset not listed in FAR sheet		
HC	Thmor Sor HC		Samsung Galaxy Tab A9. Serial No. r9tx50cbm2r	Asset not listed in FAR sheet		
HC	Koh Chum HC	2025	Galaxy Tab A9+ 5G (model SM-X216B)	Asset not listed in FAR sheet		
HC	Wat Po HC	2025	CCE Haier	Asset not listed in FAR sheet		

Fixed Asset not found at the location

Sub National Level	Name of Department	Asset identity No.	Asset Description	Asset found in its location as per Fixed Asset register	Condition of Asset as per Auditor's Observation	Condition of Asset in FAR matched Observed Condition	Remark
PHD	Koh Kong	Gavi-CDS-2023-KHK-TV-0645	Smart TV	No	Not Applicable	Not Applicable	Transferred to Border Area.
National Level	NIP	Gavi-2016-NIP-Moto-048	Motorcycle SUZUKI Smash, Model FW-115SD Year 2016, Colour white , Frame No.BE4EM146916, E480 146916, ????12-1-2601	No	Not Applicable	Not Applicable	He was on his day off during the day of our verification. However, he has sent the picture of his motorcycle.
National Level	NIP	Gavi-2020-NIP-Moto-1002	Motorcycle SUZUKI VIVA - Model: FW-125SD - Year: 2020 - Colour: Black - Frame No.:BF45B TH 503812/F488 TH 503812 - Plate No.: ????12-1-5969	No	Not Applicable	Not Applicable	The asset holder had the eyes surgery; therefore, he is not able to drive the motorcycle recently, However, he has shown the picture of the motorcycle.
National Level	NIP	Gavi-2021-NIP-Moto-1357	Motorcycle SUZUKI VIVA - Model: FW-125cc - Year: 2020 - Colour: Black - Frame: BF45B TH 504098 F-488 TH 504098 - Plate: ????12-1-7999	No	Not Applicable	Not Applicable	The asset holder accompanied our team to the province. Therefore, the motorcycle is not at place. However, he has shared the picture of the motorcycle.
National Level	NIP	Gavi-2024-NIP-Moto-1658	Motorcycle SUZUKI VIVA - Model: FL-125SDR - Year: 2024 - Colour: Black Maroon - Frame No.:BF45B TH 506101/F-488 TH 506101 - Plate No.: ????12-1-9676	No	Not Applicable	Not Applicable	The asset holder accompanied our team to the province. Therefore, the motorcycle is not at place. However, she has shared the picture of the motorcycle.
National Level	NIP	Gavi-2024-NIP-Moto-1659	Motorcycle SUZUKI VIVA - Model: FL-125SDR - Year: 2024 - Colour: Black Maroon - Frame No.:BF45B TH 506094/F-488 TH 506094 - Plate No.: ????12-1-6867	No	Not Applicable	Not Applicable	The asset holder accompanied our team to the CMS. Therefore, the motorcycle is not at place. However, she has shared the picture of the motorcycle.

National Level	NIP	Gavi-2024-NIP-Moto-1660	Motorcycle SUZUKI VIVA - Model: FL-125SDR - Year: 2024 - Colour: Black Maroon - Frame No.:BF45B TH 506112/F-488 TH 506112 - Plate No.: ????12-1-6857	No	Not Applicable	Not Applicable	The asset holder accompanied our team to the province. Therefore, the motorcycle is not at place. However, she has shared the picture of the motorcycle.
National Level	NIP	Gavi-2024-NIP-Moto-1664	Motorcycle SUZUKI VIVA - Model: FL-125SDR - Year: 2024 - Colour: Black Maroon - Frame No.:BF45B TH 506309/F-488 TH 506309 - Plate No.: ????12-1-8765	No	Not Applicable	Not Applicable	The asset holder has the traffic accident; therefore, she is not able to come to work. However, she has shared the picture of the motorcycle.
OD	Soung	Gavi-2021-TBK-Moto-1292	Motor bike	No	Not Applicable	Not Applicable	Kept at home. However, made available for physical verification during next day.
OD	Soung	Gavi-CDS-2022-TBK-Tablet-0480	Tablet	No	Not Applicable	Not Applicable	Kept at home. However, made available for physical verification during next day.

Annex 10: Detailed Management Responses

Issue	Audit Recommendation	Management Action	Action Owner	Timelines
The design of national immunisation governance mechanisms needs strengthening	Recommendation 1 To strengthen the independence and functionality of national immunisation governance bodies MoH should: • Include independent leadership to chair the NITAG to adhere to WHO guidance. To adhere to the national administrative protocols, NITAG decisions are sanctioned by the TWGH, which is chaired by the minister. • Finalise and operationalise ToRs for all governance bodies, clearly defining mandates, reporting lines, and meeting frequency. • Establish a secretariat responsible for convening meetings, recording minutes, maintaining documentation, and tracking action points. • Strengthen linkages between national and sub-national TWGs, requiring regular reporting and structured feedback mechanisms. • Operationalise the CSO oversight body within the existing TWGH by including CSOs on the agenda and allowing participation in meetings where agenda items will be discussed. Additionally, CSOs should be participate in meetings subnational levels where operationalisation of their mandate occurs.	**Action 1** • NITAG was endorsed in 2025 to strengthen its recognition and relevance within the current national context. The current ToRs and responsibilities for the NITAG are clearly defined. The independent leadership of the NITAG Chair will be progressively strengthened, in line with WHO guidance, by expanding the membership to include additional independent experts. To adhere to the national administrative protocols, NITAG decisions will be sanctioned by the TWGH, which is chaired by the minister. • The ToRs for all governance bodies have been finalised and endorsed, with mandates, reporting lines, and meeting frequencies clearly defined. The finalisation and operationalisation of the MCH-TWG ToRs including the clarification of mandates, reporting lines, and meeting frequency are currently underway. • The Secretariat responsible for convening meetings, recording minutes, maintaining documentation, and tracking action points has been established and is reflected in the officially endorsed ToR (in Khmer). • To strengthen linkages between national and sub-national TWGs, requiring regular reporting and structured feedback mechanisms: - NIP will support PHD EPI to attend and present on Immunisation agenda in the Pro-TWG meeting semesterly, - PHD EPI will provide the copied report of the Pro-TWG to NIP - NIP will review or compile the reports from sub national level and report to the TWGH/NITAG and feedback to sub-national EPI. • Operationalisation of the CSO oversight function within the existing TWGH/NITAG will be strengthened by including Immunisation-focused CSOs on the meeting agenda and enabling their participation in sessions where relevant agenda items are discussed. In addition, we agree that CSOs should participate in subnational meetings where the implementation of their mandate takes place.	**Action 1** MoH/NIP in collaboration with NITAG and TWGH Secretariate, EPI sub national level and CSOs	**Action 1** 31 March 2027

Issue	Audit Recommendation	Management Action	Action Owner	Timelines
Challenges in internal audit and assurance arrangements	Recommendation 2 To strengthen the internal audit and assurance functions and improve oversight and follow-up of recommendations, the MoH through NMCHC/NIP should: • Enhance IAD capacity through targeted training and mentoring, with AP support, on risk-based audit planning, evidence-based reporting, and prioritisation of findings. • Institutionalise coordination between the IAD and AP, including joint annual planning, harmonised risk assessments, and coordinated follow-up of recommendations. • Establish a centralised tracking system for all audit and review recommendations, with clear responsibilities, defined timelines, and escalation protocols for overdue actions. • Work with Gavi country team to review, understand and align AP's scope of work with the current operational context to maintain the independence and assurance functions of the AP.	**Action 2** • NMCHC/NIP will enhance IAD capacity through targeted training and mentoring, with AP support, on risk-based audit planning, evidence-based reporting, and prioritisation of findings. • NMCHC/NIP will institutionalise coordination between the IAD and AP, including joint annual planning, harmonised risk assessments, and coordinated follow-up of recommendations. • NMCHC/NIP has established a centralised tracking system for all audit and review recommendations, with clear responsibilities, defined timelines, and escalation protocols for overdue actions. • NMCHC/NIP will work with Gavi country team to review, understand and align AP's scope of work with the current operational context to maintain the independence and assurance functions of the AP.	**Action 2** MoH/NMCHC/NIP in coordination with IAD and the AP	**Action 2** 31 December 2026

Issue	Audit Recommendation	Management Action	Action Owner	Timelines
Strategic and operational planning needs to be strengthened to achieve programme objectives	Recommendation 3 To enhance strategic and operational planning for immunisation MoH/NMCHC/NIP should: • Hasten the development of the 2026–2030 NIS, applying lessons from the NIS 2021–2025 by ensuring that the development is country-led, participatory, and reflective of the current immunisation landscape. • Strengthen the M&E framework within the next NIS by incorporating clear indicator timelines, qualitative feedback mechanisms, and a formal schedule for annual and mid-term reviews. • Develop a structured planning calendar with defined milestones, roles, and responsibilities to ensure timely preparation, review, and presentation for approval of AOPs to the respective stakeholders and committees before the start of each fiscal year.	**Action 3** • NIP will develop NIS 2026–2030, applying lessons from the NIS 2021–2025 and ensure that the development is country-led, participatory, and reflective of the current immunisation landscape, and NIS is aligning with HSP4, Immunisation Agenda 2030 and Western Pacific Regional Framework for VPDs and Immunisation. • Develop the M&E framework within the next NIS by incorporating clear indicator timelines, qualitative feedback mechanisms, and a formal schedule for annual and mid-term reviews. • Develop a structured planning calendar with defined milestones, roles, and responsibilities to ensure timely preparation, review, and presentation for approval of AOPs to the respective stakeholders and committees before the start of each fiscal year.	**Action 3** MoH/NIP in collaboration with identified partners	**Action 3** 31 March 2027

Issue	Audit Recommendation	Management Action	Action Owner	Timelines
National response to growing incidence of measles cases should be intensified	Recommendation 4 To reduce the surge in the number of measles cases in the Country, MoH/NIP in collaboration with PHDs should: • Ensure routine immunisation services consistently reach children at the recommended ages (9 and 18 months) and prioritise follow-up of those who missed doses through facility-based and outreach sessions. • Expand outreach to underserved populations, including urban poor, ethnic minorities, migrants, and border communities, by deploying mobile teams and integrating vaccination with other health services including work done by the CSOs. • Intensify health education and community engagement, implementing targeted communication campaigns to address vaccine hesitancy, reinforce the benefits of complete vaccination, and counter misinformation. • Strengthen VPD surveillance systems (as detailed in Section 4.2.3 to ensure rapid case detection, reporting, and outbreak investigation, enabling early response and containment. • Train health personnel in active case finding, outbreak investigation, and micro-planning to improve field response and surveillance sensitivity.	**Action 4** • Following the nationwide rollout of the EIR in 2026, the NIP will strengthen the identification, monitoring, and tracking of all eligible populations to ensure routine immunisation services consistently reach children at the recommended ages of 9 and 18 months, while prioritising follow-up of those who miss doses through both facility-based and outreach sessions. -National Center for Health Promotion is developing Implementation Guidelines for the Policy on Community Participation, which will standardise VHSG's scope of work and strengthen domestic financing support. NIP to engage with NCHP to ensure vaccine priorities are embedded into VHSG's scope of work in order to strengthen outreach and reach underserved populations. • To expand outreach to underserved populations, including urban poor, ethnic minorities, migrants, and border communities, NIP will 1) strengthen the immunisation service delivery assessment using village level data, prioritisation of high risk communities (mapping approach), 2) strengthen collaboration with local authorities and other existing CSOs in the localities to support the immunisation service delivery, 3) explore the feasible integration of health service delivery based on local assessment (HR assessment, needs assessment, funds availability, etc.) and 4) mobilise Government funds at all levels and explore possibility of deploying mobile teams. • Intensify health education and community engagement, implementing targeted communication campaigns to address vaccine hesitancy, reinforce the benefits of complete vaccination, and counter misinformation (through Health Promotion Working Group of MoH). • Strengthen VPD surveillance systems to ensure rapid case detection, reporting, and outbreak investigation, enabling early response and containment - especially during the outbreak period. • Train health personnel in active case finding, outbreak investigation, and micro-planning to improve field response and surveillance sensitivity.	**Action 4** MoH/NIP in coordination with PHDs and CSOs	**Action 4** 31 December 2027

Issue	Audit Recommendation	Management Action	Action Owner	Timelines
Vaccine Preventable Disease (VPD) surveillance systems need strengthening to ensure timely detection and response	Recommendation 5 To strengthen VPD surveillance performance, timeliness, and coverage, the MoH/NIP, in collaboration with PHDs and ODs, should: • Engage WHO to expand user access rights for MRSRS v2.3 and explore enhancements such as offline functionality and multi-user capability. This engagement should include an understanding of data ownership and sustainable access to the data for the country within the reduced funding environment and ownership/retention of country data. • Designate national focal points within NIP to progressively assume WHO's current roles in VPD data collection, analysis, reporting, and publication to promote sustainability. • Identify and train health centre-based surveillance focal persons to manage case investigation, specimen handling, and data reporting. • Strengthen private-sector participation by issuing guidance, providing training, and distributing VPD surveillance tools and reporting templates, with regular follow-up to ensure compliance. • Review and revise specimen-collection protocols to allow trained health centre staff to collect and submit specimens directly, where capacity and infrastructure permit, reducing delays in response.	**Action 5** Cambodia NIP will continue strengthening VPDs and AEFI surveillance system by: • Engaging WHO to expand user access rights for MRSRS v2.3 and explore enhancements such as offline functionality and multi-user capability. This engagement will include an understanding of data ownership and sustainable access to the data for the country within the reduced funding environment and ownership/retention of country data. • Designating national focal points within NIP to progressively assume WHO's current roles in VPD data collection, analysis, reporting, and publication to promote sustainability. • Identifying and training health centre-based surveillance focal persons to manage case investigation, specimen handling, and data reporting. • Strengthening private-sector participation by issuing guidance, providing training, and distributing VPD surveillance tools and reporting templates, with regular follow-up to ensure compliance. • Review and revision of specimen-collection protocols to enable trained health centre staff to collect and submit specimens directly, where capacity and infrastructure allow, thereby reducing delays in response	**Action 5** MoH/NIP in collaboration with partners	**Action 5** 31 July 2027

Issue	Audit Recommendation	Management Action	Action Owner	Timelines
CSO engagement and coordination requires strengthening	Recommendation 6 To strengthen CSO engagement and coordination and accelerate the delivery of zero-dose objectives, the MoH/NIP should: • Establish a CSO coordination mechanism within NIP, with clearly defined responsibilities for planning, oversight, and reporting to a national-level strategic committee with appropriate reporting to the TWGH. • Streamline approval processes and decision-making within NIP to avoid delays in activity implementation. • Engage Gavi to review and adjust the current payment mechanism to ensure timely disbursement of funds and avoid disruptions in project delivery.	**Action 6** NIP has a focal person to coordinate and work with the CSOs. NIP will also: •Formally establish **a CSO coordination mechanism within NIP in the written document,** with clearly defined responsibilities for planning, oversight, and reporting to a national-level strategic committee with appropriate reporting to the TWGH. • Streamline approval processes and decision-making within NIP to avoid delays in activity implementation by identifying an officer with this clear role and responsibility. • Engage Gavi to review and adjust the current payment mechanism to ensure timely disbursement of funds and avoid disruptions in project delivery.	**Action 6** MoH/NIP	**Action 6** 31 December 2026

Issue	Audit Recommendation	Management Action	Action Owner	Timelines
The design, coordination and monitoring of technical assistance needs to be improved	Recommendation 7 To improve the design, coordination, and monitoring of technical assistance and ensure sustainability and impact, the MoH/NMCHC/NIP should: • Develop a comprehensive transition plan that embeds capacity-building and structured skills transfer into all TA engagements, ensuring eventual handover of TA-supported functions to national staff. • Collaborate with TA partners to ensure that all progress reports and milestone achievements are reviewed, validated, and formally endorsed by NIP prior to submission to Gavi. • Strengthen the design of TA contracts by including clearly defined deliverables, milestones, and timelines, and by establishing a performance review process that directly links staff appraisals to agreed outputs. • Institutionalise a TCA monitoring framework within NIP to track capacity-building progress, validate deliverables, and measure the long-term impact of technical assistance on programme performance.	**Action 7** • NIP will develop a comprehensive transition plan that embeds capacity-building and structured skills transfer into all TA engagements, ensuring eventual handover of TA-supported functions to national staff. • NIP will collaborate with TA partners to ensure that all progress reports and milestone achievements are reviewed, validated, and formally endorsed by NIP prior to submission to Gavi. Joint partner-NIP TCA monitoring meetings will be regularly organised to track the progress and measure the long-term impact of TA on programme performance. • NIP will strengthen the design of TA contracts (hired at NIP) by including clearly defined deliverables, milestones, and timelines, and by establishing a performance review process that directly links staff appraisals to agreed outputs.	**Action 7** MoH/NIP	**Action 7** 31 December 2027
Accuracy of immunisation coverage data requires strengthening to support data driven decision making	Recommendation 8 To improve accuracy of immunisation coverage data and strengthen evidence-based decision making, the NIP should: • Institutionalise regular data quality assessments, including detailed desk reviews and field verification of administrative data. • Develop and implement a Data Quality Improvement Plan that defines timelines, responsibilities, and tools for validating data at all reporting levels. • Establish a formal mechanism for systematic validation of administrative coverage figures before national reporting and submission to Gavi or WHO/UNICEF.	**Action 8** • NIP will institutionalise regular data quality assessments, including detailed desk reviews and field verification of administrative data with the support from Partners to guide and make the toolkits or include in the Immunisation In Practice. • NIP will develop and implement a Data Quality Improvement Plan that defines timelines, responsibilities, and tools for validating data at all reporting levels. • NIP will: establish a formal mechanism for systematic validation of administrative coverage figures before national reporting and submission to Gavi or WHO/UNICEF.	**Action 8** MoH/NIP	**Action 8** 30 June 2027

Issue	Audit Recommendation	Management Action	Action Owner	Timelines
There are opportunities exist to enhance the design and interoperability of the EIR	Recommendation 9 To improve the design, interoperability, and scalability of the EIR, the MoH/NIP, in collaboration with relevant stakeholders, should: • Expedite endorsement of the National Digital Health Strategy (2021–2030) to establish a clear governance mandate and empower oversight structures for digital health. • Operationalise the Digital Health Steering Committee and Technical Working Group, with defined terms of reference, regular meetings, and clear accountability for guiding EIR development and implementation. • Recruit a dedicated digital health expert within the MoH to oversee EIR project management, coordination, and reporting. • Ensure system design and evaluation include: · Alignment with national and international EIR standards; · Structured end-user feedback during design and testing; · Provisions for interoperability with HMIS and other national systems; · Inclusion of private-sector reporting; and · Comprehensive data management and security features, including audit trails, encryption, and role-based access controls.	**Action 9** • Expedite endorsement of the National Digital Health Strategy (2021–2030) to establish a clear governance mandate and empower oversight structures for digital health. • Operationalise the Digital Health Steering Committee and Technical Working Group, with defined terms of reference, regular meetings, and clear accountability for guiding EIR development and implementation. • Recruit a dedicated digital health expert within the MoH to oversee EIR project management, coordination, and reporting. • Ensure system design and evaluation include: · Alignment with national and international EIR standards; · Structured end-user feedback during design and testing; · Provisions for interoperability with HMIS and other national systems; · Inclusion of private-sector reporting; and · Comprehensive data management and security features, including audit trails, encryption, and role-based access controls. • Streamline the coordination body between ministries and stakeholders, in the evolving situation of digital innovation at Royal Government of Cambodia.	**Action 9** DGC of MPTC, NIP of NMCHC, DDH, DPHI	**Action 9** 31 December 2027

Issue	Audit Recommendation	Management Action	Action Owner	Timelines
The vaccine forecasting processes should be enhanced	Recommendation 10 To strengthen ownership and improve forecasting processes, the MoH/NIP should: • Designate dedicated personnel within NIP to lead the forecasting process, update their job descriptions to include this responsibility, and ensure clear accountability. • Build forecasting capacity through structured mentoring, peer learning, and skills transfer initiatives from partners and technical assistance providers. • Develop and institutionalise SOPs and work instructions that document data sources, parameters, and review protocols for forecasting accuracy. • Establish an annual post-forecast review mechanism to compare forecasted versus actual vaccine usage and incorporate lessons into subsequent planning cycles.	**Action 10** • NIP will collaborate with UNICEF to strengthen forecasting capacity through mentoring and on-the-job training. A structured capacity-building plan will be developed to ensure sustainable skills transfer and reduced reliance on external support over time. **NIP has already designated a staff member as the NIP Logistics Officer. The role will be formalised to lead the forecasting process by updating the job description to explicitly include forecasting responsibilities and by establishing clear lines of accountability.** • NIP will develop and formalise standard operating procedures (SOPs) and work instructions for vaccine forecasting. These documents will define data sources, forecasting assumptions, parameters, and review processes to promote consistency, transparency, and improved forecasting accuracy. • NIP will institute an annual post-forecast review process to assess variances between forecasted and actual vaccine utilisation. Findings from these reviews will be documented and used to refine forecasting methodologies and inform future planning cycles.	**Action 10** MoH/NIP	**Action 10** 31 March 2027
Vaccine inventory management and stock visibility challenges should be addressed	Recommendation 11 To enhance vaccine inventory management and stock visibility at National and sub national level, MoH/NIP: • In collaboration with other donor partners should expedite the development and implementation of the mSupply eLMIS • Should periodically conduct data checks in NATDID and reconcile the data after obtaining the necessary approvals • In collaboration with PHDs and ODs should standardise and enforce comprehensive record keeping practices, ensuring that all inventory transactions are consistently and promptly documented on stock cards. Staff should receive focused training on proper stock card completion, regular updates, and reconciliation procedures, supported by supervisory reviews and periodic checks to verify compliance and accuracy	**Action 11** • NIP, with key donor partners, will prioritise and accelerate implementation of the identified system solution (mSupply/eLMIS) to strengthen vaccine inventory management and real-time stock visibility nationwide. • NIP, in collaboration with PHDs and ODs, will standardise record keeping practices and provide training or refresher training to EPI staff for the proper stock card completion, updates, and reconciliation procedures, supported by supervisory reviews and periodic checks to verify compliance and accuracy (with the updates of CCE SOP on stock card completion)	**Action 11** MoH/NIP,CMS, PHDs and ODs in collaboration with Partners	**Action 11** 31 July 2027

Issue	Audit Recommendation	Management Action	Action Owner	Timelines
Cold chain management practices need to be improved	Recommendation 12 To improve the cold chain operations. MoH/NIP with support from partners should • Conduct a comprehensive CCE assessment that includes quantifying the aging of existing equipment and identifying units due for replacement. The assessment should also evaluate electricity access at various locations to guide appropriate CCE procurement decisions • Build capacity of cold chain officers and NIP officers at sub national level in cold chain management through on-the-job training and mentorship programmes • Develop detailed preventive maintenance plans that outline daily, weekly, and monthly activities, along with comprehensive checklists to support and document these tasks. Ensure that the checklists are used consistently at all levels. • Include calibration of cold chain trucks as part of the preventive activities of the 3PL provider • Install power backup systems at PHD and OD vaccine stores that keep significant quantities of vaccines as other cold chain contingency plan like use of cooler boxes may not be applicable to them. • Expand the scope of support supervision to comprehensively cover key elements of cold chain management, including oversight of preventive and corrective maintenance activities, systematic archiving and utilisation of temperature monitoring data, and other critical areas.	**Action 12** • Conduct a comprehensive national CCE assessment to map the functionality, age profile, and remaining service life of existing equipment at all levels. The assessment will identify CCE units requiring repair, replacement, or decommissioning and will include a systematic evaluation of electricity availability and reliability at each site. Findings will be used to inform evidence-based CCE replacement planning, and prioritisation, for future procurement, in coordination with UNICEF. • NIP, with support from partners, will strengthen the capacity of cold chain officers and NIP staff at sub-national levels through a blended learning approach. This will include the use of e-learning modules on cold chain management, complemented by on-the-job training, mentorship, and supportive supervision. • Develop standardised preventive maintenance checklists for cold chain equipment and integrate these checklists into existing SOPs. Their use will be enforced at all levels through staff orientation, regular supportive supervision, and periodic reviews to ensure consistent application and compliance. • NIP will update the service agreement with the 3PL provider to formally include routine calibration of cold chain trucks as part of preventive maintenance activities. Calibration schedules, responsibilities, documentation requirements, and reporting procedures will be clearly defined, and compliance will be monitored through regular performance reviews and supportive supervision. • NIP will develop and disseminate guidance for sub-national levels requiring the inclusion of power backup availability in their Annual Operational Plans (AOPs). This will enable PHDs and ODs that store significant quantities of vaccines to plan and budget for appropriate backup power solutions • NIP will revise and expand the scope of supportive supervision for cold chain management at national and sub-national levels. Supervisory visits will comprehensively cover key elements including preventive and corrective maintenance activities, proper archiving and utilisation of temperature monitoring data, stock management, and other critical operational areas. Supervisors will be trained on the expanded checklist, and findings will be documented with follow-up actions to ensure compliance, continuous improvement, and evidence-based decision-making.	**Action 12** MoH/NIP, CMS, PHDs in collaboration with partners	**Action 12** 30 September 2027

Issue	Audit Recommendation	Management Action	Action Owner	Timelines
Fixed asset management controls need to be improved	Recommendation 13 To strengthen fixed asset management controls at national and sub national level, NIP in collaboration with PHDs and ODs should: • Enforce management oversight by instituting regular spot checks and annual physical verification exercises, ensuring results are documented and reconciled with the FAR. • Implement a robust asset tagging and labelling process to ensure all Gavi-funded assets are promptly and consistently tagged and display donor identification logos. • Ensure continuous updating of the Fixed Asset Register, capturing new procurements, changes in condition or location, and disposals, with supporting documentation. • Establish formal procedures for asset transfers, ensuring all relocations are properly approved and recorded. • Provide training and supervision for staff responsible for asset management to promote compliance with fixed asset control procedures and strengthen accountability.	**Action 13** • NIP (Programme and Finance teams), PHDs and ODs will enforce management oversight by: - Conducting physical verification at all levels to ensure all documentations are consistent and reconciled with FAR, and donor logos are displayed - Establishing formal procedures of documentation and validation across levels, to update FAR with new procurements, changes, disposals, and transfers to be regularly reviewed, validated and maintained at PHD, OD and HC levels - Providing trainings and supervision for staff responsible for asset management	**Action 13** MoH/NIP, PHDs and ODs	**Action 13** 31 October 2026