Indigenous Peoples Plan

Project Number: 48118-005
July 2021

Cambodia: Greater Mekong Subregion Health Security Project (Additional Financing)

Prepared by Ministry of Health, Kingdom of Cambodia for the Asian Development Bank.

ABBREVIATIONS

ADB	–	Asian Development Bank
CARES	–	COVID-19 Active Response and Expenditure Support
COVID-19	–	Coronavirus Disease
CRIS	–	Cambodia Rapid Immunization Support
DPHI	–	Department of Planning and Health Information
EA	–	Executing Agency
ELC	–	Economic Land Concession
EMG	–	Ethnic Minority Groups
GMS	–	Greater Mekong Subregion
GRM	–	Grievance Redress Mechanism
IA	–	Implementing Agency
ICU	–	Intensive Care Units
IP	–	Indigenous Peoples
IHR	–	International Health Regulations
IPC	–	Infection Prevention Control
IPP	–	Indigenous Peoples Plan
Lao PDR	–	Lao People's Democratic Republic
LASED	–	Land Allocation for Social and Economic Development Project
MOH	–	Ministry of Health
NPDIP	–	National Policy on Development of Indigenous Peoples
OP	–	Operational Priority
PAM	–	Project Administration Manual
PFM	–	Public Financial Management
PMU	–	Project Management Unit
PPE	–	Personal Protective Equipment
RRT	–	Rapid Response Teams
SDG	–	Sustainable Development Goals
SLC	–	Social Land Concessions
RGC	–	Royal Government of Cambodia
SPS	–	Safeguard Policy Statement
WHO	–	World Health Organization

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EXECUTIVE SUMMARY

i. This Indigenous Peoples Plan (IPP)[1] is prepared for the additional financing project (hereinafter called the project) of the ongoing project, "Greater Mekong Subregion Health Security Project." The additional financing has been categorized as "B" for indigenous peoples as per Asian Development Bank (ADB) Safeguard Policy Statement (SPS), 2009 and the impacts are positive on indigenous peoples.

ii. Project investments support three outputs: (i) regional cooperation and communicable disease control in border areas improved, (ii) national disease surveillance and outbreak response system strengthened, and (iii) laboratory services and hospital infection prevention and control (IPC) improved. The proposed additional financing will support the Ministry of Health (MOH) in responding to the coronavirus disease (COVID-19) pandemic. It will (i) support laboratory services and IPC to 8 provincial hospitals and 73 district referral hospitals; (ii) equip 14 provincial hospitals to provide emergency clinical care for COVID-19 patients, including upgraded oxygen supply; and (iii) strengthen surveillance and response capacity for COVID-19 and other communicable diseases nation-wide

iii. The IPP is based on the policy principle as set out under the safeguard requirement-3 on Indigenous Peoples of ADB's SPS, 2009 and national laws and regulations on Indigenous Peoples of Royal Government of Cambodia (RGC). The IPP provides the guidance necessary to support culturally appropriate project implementation for indigenous people's beneficiaries. The project will facilitate that indigenous peoples are aware of the additional support provided by the government during the COVID-19 pandemic.

iv. The project is expected to have positive impacts on indigenous peoples in terms of better health care in the project area. The project will cover 81 hospitals across various parts of the country of which some hospitals fall within the provinces having the presence of indigenous peoples. IP residents have been reported in project coverage areas of 10 hospitals out of the 89 hospitals. The proportion of IP population in these areas consists for 3.9 % of the total population. The project will not negatively affect the indigenous peoples but will bring benefit to the people, including indigenous peoples, who are living in the project areas.

v. During project preparation, consultation was restricted due to the COVID-19 travel restrictions. Virtual consultations were undertaken with selected hospital staff. However, consultation with indigenous peoples and other beneficiaries were not undertaken due to above reason. This will continue during project implementation. Disclosure of IPP related information will be shared with the indigenous people's beneficiaries during consultations in the form of leaflets or brochures translated into the local language. The IPP will also be disclosed at ADB's website and the website of Ministry of Health (MOH). The monitoring reports on IPP implementation will also be posted on the ADB website.

vi. The project will provide urgent support to the Government of Cambodia's efforts to mitigate the adverse health, social, and economic impacts of the COVID-19 pandemic through support to scale-up health system capacity for prevention, detection and response to emerging health threats. The project will contribute to the achievement of the Sustainable Development Goals (SDGs). The project will benefit the indigenous peoples in terms of better access to health

[1] This is similar to the Ethnic Group Development Plan (EGDP) as prepared for the original project. However, in the context of Cambodia, the terminology, "Indigenous Peoples Plan (IPP) is more relevant.

services, including for female and vulnerable beneficiaries. There will be no negative impact on indigenous peoples. The IPP provides guidance to support culturally-appropriate project implementation for indigenous peoples beneficiaries, and to develop measures to minimize and mitigate any unavoidable adverse impacts.

vii. The project will follow the existing grievance redress mechanism (GRM) of the ongoing project. This will facilitate to develop mechanisms to resolve complaints in a timely manner through a transparent process that is gender responsive, culturally appropriate, and readily accessible to all indigenous beneficiaries. The beneficiaries including the indigenous people beneficiaries can also address their concerns through their representative. The complaint will be assessed and negotiated in to a solution between the project representative (focal point) and local authorities, and then fed back to the communities as part of the participatory planning process. If the complaint is not resolved amicably, it will be taken to the Project Management Unit (PMU) or MOH steering committee under the MOH People are also free to approach the country's legal system at any time they wish to. People can also approach ADB's accountability mechanism and may submit complaints directly.

viii. The implementation of the IPP will be monitored by the PMU to avoid any negative impacts to indigenous peoples. Monitoring and reporting of the IPP under the project will follow the overall project monitoring and reporting arrangements already established under the ongoing project. The PMU with the support of the national safeguard, community development and gender specialist, will monitor the IPP implementation. Progress on the implementation of the IPP will be integrated into the overall project's progress report. However, it is also proposed that standalone annual monitoring reports will be prepared for the IPP and will be submitted to ADB by the PMU. IPP monitoring reports will be disclosed on ADB's website as well as on the website of MOH.

ix. The implementation arrangements remain consistent with the original project. The MOH, through its Department of Planning and Health Information (DPHI), will be the executing agency for the additional financing project. The existing project management unit (PMU) will support the project director in managing, monitoring, and administering the project. MOH has already an existing PMU for the ongoing and original component which shall further be expanded with designated expert for the implementation of IPP for additional financing components. The PMU will be supported by a total of 14 consultants that includes 1 international consultant and 13 national consultants. Under the national consultants, there will be 1 community development specialist who will be the focal point to coordinate the implementation of IPP. The indicative cost for implementing and monitoring the IPP is estimated at $8,800. MOH will bear the cost as part of their counterpart contribution and will use the funds as and when required. The project implementation period will be from 1 November 2021 to 31 October 2023. The IPP will be implemented in parallel with other activities.

I. DESCRIPTION OF THE PROJECT

A. Background

1. The original health security project[2] is helping Cambodia, the Lao People's Democratic Republic (Lao PDR), Myanmar, and Viet Nam to comply with the International Health Regulations (IHR).[3] It is developing core health system capacities to respond to public health threats of national and international concern.[4] Project investments support three outputs: (i) regional cooperation and communicable disease control in border areas improved, (ii) national disease surveillance and outbreak response system strengthened, and (iii) laboratory services and hospital infection prevention and control (IPC) improved. The proposed additional financing will support the Ministry of Health (MOH) in responding to the coronavirus disease (COVID-19) pandemic. It will (i) support laboratory services and IPC to 8 provincial hospitals and 73 district referral hospitals; (ii) equip 14 provincial hospitals to provide emergency clinical care for COVID-19 patients, including upgraded oxygen supply; and (iii) strengthen surveillance and response capacity for COVID-19 and other communicable diseases nation-wide.

B. Rationale

2. The Asian Development Bank (ADB) approved the original project on 22 November 2016, for a total of $125 million equivalent to Cambodia, the Lao PDR, Myanmar, and Viet Nam. Additional financing of $20 million was approved for the Lao PDR on 22 May 2020 and $30 million for Myanmar on 8 October 2020 to support a new project output for emergency response to the COVID-19 pandemic. The completion date for the original project is 31 March 2022, and the loan closing date is 30 September 2022. As of 30 June 2021, against an elapsed implementation period of 79%, the original project in Cambodia is rated *on track* under ADB's project performance rating system.[5] Cumulative contract awards and disbursements for Cambodia are $15.28 million (72.52% of ADB financing) and $15.05 million (71.27% of ADB financing, including advances of $1.5 million), respectively. Of the ten outcome and output indicators for Cambodia, four are already achieved, and six are partially achieved. The delivery of expected outputs is rated *successful.* As of June 2021, all 7 (100%) actions in the gender action plan (GAP) are being implemented; 7 (64%) of 11 targets are on track; and 4 targets (36%) have not yet met their respective targets. Project covenants, including all safeguard covenants, are either complied with or are being complied with. The project implementation risks have been adequately mitigated, and the management of risks is rated *successful*.

3. The Government of Cambodia has requested (i) a $25 million concessional loan from ADB's ordinary capital resources, and (ii) a $5 million JFPR grant as additional financing for the Greater Mekong Subregion (GMS) Health Security Project. The proposed additional financing will strengthen health system capacity to respond to COVID-19 and other public health threats. As of

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[2] The original project comprises (i) loans to Cambodia (SDR15,012,000 [$21 million]), the Lao People's Democratic Republic (Lao PDR) (SDR2,856,000 [$4 million]), Myanmar (SDR8,616,000 [$12 million]), and Viet Nam (SDR56,946,000 [$80 million]); and (ii) a grant to the Lao PDR ($8 million). The Asian Development Bank (ADB) provided loans (additional financing) to the Lao PDR ($20 million) and Myanmar ($30 million). ADB also provided project preparatory technical assistance of $1.3 million to Cambodia, the Lao PDR, Myanmar, and Viet Nam. ADB. Greater Mekong Subregion Health Security Project; ADB. Greater Mekong Subregion Health Security Project (Additional Financing) (Lao PDR); ADB. Greater Mekong Subregion Health Security Project (Additional Financing) (Myanmar); and ADB. Technical Assistance: Greater Mekong Subregion Health Security Project.

[3] WHO. 2016. *International Health Regulations (2005).* Third Edition. Geneva.

[4] World Health Organization (WHO). 2016. *International Health Regulations (2005). Third Edition.* Geneva.

[5] ADB. 2020. Project Performance Monitoring. *Project Administration Instructions.* PAI 5.08. Manila.

7 July 2021, Cambodia has recorded 55,187 confirmed cases of COVID-19, with 748 deaths.[6] Cambodia's early efforts to build response capacity for COVID-19 were guided by MOH's Response Plan for COVID-19.[7] This plan prioritized nine focus areas for health system strengthening specific to COVID-19 readiness.[8] Despite success in keeping confirmed COVID-19 cases low throughout 2020, an outbreak that commenced on 20 February 2021 has resulted in a surge of new infections and sustained community transmission. The World Health Organization (WHO) has highlighted the risk of silent transmission, with 66% of cases in this outbreak being asymptomatic.[9] Cambodia's highly mobile population is a driver of COVID-19 spread. Up to 4.1 million people per year migrate internally. Migrant workers face social and economic barriers to accessing health services, increasing the risk of COVID-19 cases remaining undetected.[10]

4. In 2021, MOH incorporated the roll-out of COVID-19 vaccination as a key pillar of the country's response.[11] As of 7 July 2021, Cambodia had administered 6.6 million COVID-19 vaccine doses. (footnote 5) The rollout of vaccines is primarily through provincial and district hospitals, which run COVID-19 vaccination clinics. Given a potential for new variants of the virus to impede vaccine efficacy, continued strengthening of the health system to prevent, detect, and respond to COVID-19 is needed.[12] Despite marked improvements in the capacity of Cambodia's health system over the past 5 years, deficiencies remain. In 2020, MOH assessed Cambodia's compliance with core health system capacity requirements of the IHR as 50%.[13] Cambodia scored below average on the Global Health Security Index.[14] The COVID-19 pandemic has highlighted a need to scale-up successful ongoing investments to address remining deficiencies for surveillance and outbreak response, laboratory, IPC, and health service provision.

5. **Surveillance and response.** The increase in COVID-19 cases and related community transmission has overwhelmed surveillance and response capabilities at the sub-national level. Gaps in provincial capabilities for data management, contact tracing, and quarantine impede outbreak management. Rapid response teams lack trained surge staff.[15] Weak capacity for risk communication has hampered community adoption of protective practices.

6. **Laboratory and IPC.** Laboratory and IPC in 8 provincial hospitals and 73 district referral hospitals not supported under the original project is in urgent need of upgrading. Assessments found inadequate and outdated laboratory equipment for diagnosis and clinical management, including for COVID-19 comorbidities. There are 62 hospitals requiring renovation of laboratory rooms. Supplies of antigen-detecting rapid diagnostic tests for COVID-19 are insufficient to support contact tracing efforts.[16] Equipment for IPC, including autoclaves, washing machines, and waste management systems, requires replacement.

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[6] WHO. Coronavirus Disease (COVID-19) Dashboard (accessed 7 July 2021).
[7] MOH. 2020. *Cambodia Response Plan for COVID-19 – March 2020 to February 2021*. Phnom Penh.
[8] The plan aligns with the focus areas of WHO's Strategic Preparedness and Response Plan for COVID-19. WHO. Forthcoming. *2019 Novel Coronavirus (2019 nCoV): Strategic Preparedness and Response Plan.* Geneva.
[9] WHO. 2021. *Cambodia Coronavirus Disease 2019 (COVID-19) Situation Report #37*. Geneva.
[10] Inkochasan et. Al. 2019. Access to health care for migrants in the Greater Mekong Subregion: policies and legal frameworks and their impact on malaria control in the context of malaria elimination. Bangkok.
[11] MOH. 2021. *National Deployment and Vaccination Plan For COVID-19 Vaccines*. Phnom Penh.
[12] WHO. The effects of virus variants on COVID-19 vaccines. March 2021
[13] WHO. Electronic State Parties Self-Assessment Annual Reporting (accessed 28 April 2021).
[14] Johns Hopkins, Center for Health Security. Global Health Security Index.
[15] Rapid response teams at provincial and district levels are teams of health staff formed to investigate outbreaks, support testing and contact tracing, and manage other outbreak response measures.
[16] The use of antigen detecting diagnostic tests has been incorporated under the national testing strategy alongside real-time PCR. Rapid tests are used to support timely outbreak investigation and contact tracing for high-risk populations.

7. **Health service provision**. Provincial and district hospitals nationwide lack equipment and appropriately trained personnel for clinical management of severe COVID-19 cases, particularly oxygen therapy. Non-invasive ventilation requires a constant oxygen supply. Sub-national level hospitals are dependent on private sector oxygen providers, where reliability and adequacy of supply is a constraint.[17] The oxygen baseline assessment found hospitals lack clinical equipment and appropriately skilled health staff to administer oxygen therapy. A shortage of ambulances impedes timely transfer of critically ill COVID-19 patients. There are 14 hospitals identified for ADB support, with the remaining hospitals supported by other development partners. In parallel with the health impacts of COVID-19, there is mounting evidence of an increase in the incidence of gender-based violence and psycho-social issues linked to the pandemic.[18] Front-line hospital staff, who are often the first point of contact for affected individuals, are poorly equipped to identify and respond to these issues.

8. The project meets ADB's eligibility criteria for additional financing, which is an efficient modality for the expedited delivery of support to build subnational health system capacity for responding to COVID-19. The approach leverages MOH's experience in implementing targeted interventions with provincial and district referral hospitals, enabling rapid nationwide scale-up. The proposed additional financing has been determined to be technically feasible, economically viable, and financially sound. The project meets the criteria for COVID-19 fast-track processing.[19]

9. The project is consistent with the ADB Strategy 2030's operational priorities (OPs) to (i) address remaining poverty and reduce inequalities by achieving better health for all (OP1); (ii) accelerate progress in gender equality in human development (OP2); and (iii) foster regional cooperation and integration, including the promotion of regional public goods to mitigate cross-border risks of communicable disease (OP7).[20] The project contributes to the ADB country partnership strategy for Cambodia 2019–2023, through strengthening human capital.[21] It also contributes to the collective goal of the GMS countries to improve the GMS health system response to acute public health threats.[22]

C. Impact, Outcome, and Outputs

10. The project is aligned with the following impact: GMS public health security strengthened[23]. The project will have the following outcome: GMS health system performance with regard to health security improved.

11. The impact and outcome of the overall project remain unchanged from the original project. The additional financing will contribute to Cambodia's progress towards compliance with the requirements of the IHR and the Asia Pacific Strategy for Emerging Diseases, in-line with the

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[17] Around 72% of provincial and district referral hospitals source oxygen from suppliers in their provinces. The remaining use suppliers in Phnom Penh and neighboring provinces. Department of Hospital Services. 20201. *Baseline Oxygen Assessment*. Phnom Penh.

[18] CARE International. 2020. *CARE Rapid Gender Analysis for COVID-19 Cambodia*. Phnom Penh.

[19] ADB. 2020. *Comprehensive Response to the COVID-19 Pandemic*. Manila. The project enables the rapid scale-up of Cambodia's COVID-19 response through investment in equipment and human resource capacity critical to mitigating the spread and impacts of COVID-19.

[20] ADB. 2018. *Strategy 2030: Achieving a Prosperous, Inclusive, Resilient, and Sustainable Asia and the Pacific.* Manila.

[21] ADB. 2020. *Cambodia: Country Partnership Strategy, 2019-2023 - Inclusive Pathways to a Competitive Economy*. Manila.

[22] ADB. 2019. *Greater Mekong Subregion Health Cooperation Strategy 2019–2022.* Manila.

[23] Defined by the GMS Health Security Project.

original project outcome indicators[24]. This will be achieved through a nationwide scale-up of investment at the subnational level across the priority capacity areas of: (i) surveillance and risk communications, (ii) laboratory and IPC; and (iii) health service provision. Activities under the additional financing will be delivered through existing project outputs 2, 3 and 4.

12. **Output 2: National disease surveillance and outbreak response systems strengthened**. The project loan will finance (i) a nationwide program of trainings to strengthen subnational capacity for communicable disease prevention, detection and response; (ii) outbreak response vehicles for provincial and national agencies, and (iii) health education campaigns to enhance communities' preparedness for COVID-19 and other communicable disease threats.

13. The JFPR grant will finance computer hardware for central, provincial and district health agencies to enhance COVID-19 outbreak management and contact tracing efforts. It will support COVID-19 specific trainings for (i) surveillance staff on data management tools,[25] (ii) RRTs on outbreak management, and (iii) health and non-health staff on COVID-19 risk communications.

14. **Output 3: Laboratory services and hospital IPC improved.** The project loan will support 8 provincial hospitals and 73 district referral hospitals not included under the original project. It will (i) equip laboratories in these 81 hospitals for communicable disease diagnostics and clinical management, including COVID-19 rapid testing; (ii) renovate laboratories in 62 of these hospitals; (iii) install modern solid waste treatment systems to 42 hospitals, and (iv) supply autoclaves, washing machines and other IPC equipment to hospitals where upgrading is required. Female and male hospital staff will be trained on laboratory and IPC practices.

15. **Output 4: Emergency preparedness and response capacity for COVID-19 strengthened.** The JFPR grant will enhance COVID-19 clinical care capacity in 14 provincial hospitals. It will equip hospitals with (i) oxygen plants for onsite generation of oxygen supply, (ii) clinical equipment for provision of oxygen therapy, and (iii) an ambulance for the transportation of COVID-19 patients requiring emergency care. Female and male clinical staff will be trained on oxygen therapy and the management for COVID-19 patients. Staff will also be trained to identify and provide support and referral options to persons affected by gender-based violence and mental health issues linked to the pandemic. Technicians will be trained in operation and maintenance of oxygen plants and ambulances.

D. Project Description and Reach

16. The additional financing component will cover hospitals in various provinces across Cambodia such as Banteay Meanchey, Battambang, Kampong Cham, Kampong Chhnang, Kampong Speu, Kampong Thom, Kampot, Kandal, Koh Kong, Kratie, Mondul Kiri, Preah Vihear, Prey Veng, Pursat, Ratanakiri, Siemreap, Preah Sihanouk, Svay Rieng, Takeo, Oddar Meanchey, Kep and Tbong Khmum. Details on the list of hospitals to be covered under the additional financing is provided in **Table 1**.

[24] WHO. 2017. *Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies.* Geneva.
[25] Including the Event Monitoring System, Media Screening System, and WHO's 'Go Data" tool.

Table 1: List of Hospitals

No	Year	Province/NH	OD Name	HFAC Name	HFAC Type	HFAC Level	HFAC Status	Started date	End date
1	2020	Banteay Meanchey	Poipet	10223. Or Chrov Referral Hospital_RH	OD Referral Hospital	CPA1	Active	01/08/2019	31/12/2020
2	2020	Banteay Meanchey	Poipet	10224. Peace Malay Referral Hospital_RH	OD Referral Hospital	CPA1	Active	01/08/2019	31/12/2020
3	2020	Banteay Meanchey	Preah Net Preah	10301. Preah Net Preah_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
4	2020	Banteay Meanchey	Preah Net Preah	1031202. Phnom Srok_RH	OD Referral Hospital	CPA1	Active	01/06/2015	31/12/2020
5	2020	Banteay Meanchey	Thma Puok	1040802. Svay Chek_RH	OD Referral Hospital	CPA1	Active	01/01/2017	31/12/2020
6	2020	Banteay Meanchey	Serei Sophon	10501. Serei Sophon Referral Hospital_RH	OD Referral Hospital	CPA1	Active	01/07/2019	31/12/2020
7	2020	Battambang	Thma Koul	20101. Thmar Koul_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
8	2020	Battambang	Thma Koul	20119. Bavil Referral Hospital_RH	OD Referral Hospital	CPA1	Active	01/01/2020	31/12/2020
9	2020	Battambang	Sangkae	20517. Roka_RH	OD Referral Hospital	CPA1	Active	01/01/2017	31/12/2020
10	2020	Battambang	Sangkae	20518. Ek Phnom_RH	OD Referral Hospital	CPA1	Active	01/01/2017	31/12/2020
11	2020	Kampong Cham	Chamkar Leu	30101. Chamkar Leu_RH	OD Referral Hospital	CPA2	Active	01/01/2016	31/12/2020
12	2020	Kampong Cham	Choeung Prey	30201. Choeung Prey_RH	OD Referral Hospital	CPA2	Active	01/01/2016	31/12/2020
13	2020	Kampong Cham	Kampong Cham - Kg. Siem	30301. Kampong Cham Prov. Hosp._PH	Provincial Hospital	CPA3	Active	01/01/2006	31/12/2020
14	2020	Kampong Cham	Prey Chhor	30801. Prey Chhor_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
15	2020	Kampong Cham	Srey Santhor	30901. Srey Santhor_RH	OD Referral Hospital	CPA2	Active	01/01/2006	31/12/2020
16	2020	Kampong Cham	Stueng Trang	30325. Hun Sen Stung Trang_RH	OD Referral Hospital	CPA1	Active	01/10/2011	31/12/2020
17	2020	Kampong Cham	Batheay	30213. Batheay_RH	OD Referral Hospital	CPA2	Active	01/01/2016	31/12/2020
18	2020	Kampong Cham	Koh Sotin	30610. Koh Sotin Referral Hospital_RH	OD Referral Hospital	CPA1	Active	01/10/2018	31/12/2020
19	2020	Kampong Cham	Kang Meas	30915. Kang Meas Referral Hospital_RH	OD Referral Hospital	CPA1	Active	01/01/2019	31/12/2020
20	2020	Kampong Chhnang	Kampong Chhnang	40101. Kampong Chhnang_Prov Hosp_PH	Provincial Hospital	CPA3	Active	01/01/2006	31/12/2020
21	2020	Kampong Chhnang	Kampong Tralach	40201. Kampong Tralach_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
22	2020	Kampong Chhnang	Boribo	40301. Boribo_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
23	2020	Kampong Speu	Kampong Speu	50101. Kampong Speu Prov. Hosp._PH	Provincial Hospital	CPA3	Active	01/01/2006	31/12/2020
24	2020	Kampong Speu	Kong Pisey	50201. Kong Pisey_RH	OD Referral Hospital	CPA2	Active	01/01/2006	31/12/2020
25	2020	Kampong Speu	Ou Dongk	50301. Ou Dong_RH	OD Referral Hospital	CPA2	Active	01/01/2006	31/12/2020
26	2020	Kampong Speu	Phnom Srouch	50117. Trapeang Kraloeung_RH	OD Referral Hospital	CPA1	Active	01/01/2015	31/12/2020
27	2020	Kampong Thom	Baray and Santuk	60101. Baray and Santuk_RH	OD Referral Hospital	CPA2	Active	01/01/2006	31/12/2020
28	2020	Kampong Thom	Kampong Thom	60201. Kampong Thom Prov. Hosp._PH	Provincial Hospital	CPA3	Active	01/01/2006	31/12/2020

No	Year	Province/NH	OD Name	HFAC Name	HFAC Type	HFAC Level	HFAC Status	Started date	End date
29	2020	Kampong Thom	Stong	60301. Stong_RH	OD Referral Hospital	CPA2	Active	01/01/2006	31/12/2020
30	2020	Kampot	Chhouk	70217. Bun Rany Hun Sen Koh Sla_RH	OD Referral Hospital	CPA1	Active	01/06/2012	31/12/2020
31	2020	Kandal	Ang Snuol	80126. Ang Snuol Referral Hospital_RH	OD Referral Hospital	CPA1	Active	01/05/2015	31/12/2020
32	2020	Kandal	Kean Svay	80201. Kean Svay_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
33	2020	Kandal	Ksach Kandal	80401. Khsach Kandal_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
34	2020	Kandal	Muk Kam Poul	80513. Bunrani Hun Sen Rokakong_RH	OD Referral Hospital	CPA2	Active	01/01/2010	31/12/2020
35	2020	Kandal	Ponhea Leu	80632. RH Pognealeu_RH	OD Referral Hospital	CPA2	Active	01/05/2016	31/12/2020
36	2020	Kandal	Saang	80701. Hopital saang_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
37	2020	Kandal	Takhmao	80801. Cheychumnash Hosp._PH	Provincial Hospital	CPA3	Active	01/01/2006	31/12/2020
38	2020	Kandal	Takhmao	80817. Kandal Stung Referral Hospital_RH	OD Referral Hospital	CPA1	Active	01/05/2016	31/12/2020
39	2020	Kandal	Lvea Em	80901. Lvea Em_RH	OD Referral Hospital	CPA1	Active	01/09/2012	31/12/2020
40	2020	Kandal	Leuk Deak	81001. Leuk Deak_RH	OD Referral Hospital	CPA1	Active	01/07/2015	31/12/2020
41	2020	Koh Kong	Smach Mean Chey	90101. Koh Kong Prov. Hosp._PH	Provincial Hospital	CPA2	Active	01/01/2006	31/12/2020
42	2020	Koh Kong	Srae Ambel	90201. SraeAmbel_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
43	2020	Kratie	Chhlong	100101. Chhlong_RH	OD Referral Hospital	CPA2	Active	01/01/2006	31/12/2020
44	2020	Mondul Kiri	Sen Monorom	11010702. Koh Nhek_RH	OD Referral Hospital	CPA1	Active	01/01/2016	31/12/2020
45	2020	Preah Vihear	Tbeng Meanchey	130104011. Chamksan_RH	OD Referral Hospital	CPA1	Active	01/07/2018	31/12/2020
46	2020	Prey Veng	Kamchay Mear	140201. Kamchay Mear_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
47	2020	Prey Veng	Mesang	140601. Mesang_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
48	2020	Prey Veng	Peam Ror	140801. Neak Leung Hospital_RH	OD Referral Hospital	CPA2	Active	01/01/2006	31/12/2020
49	2020	Prey Veng	Svay Antor	141201. Svay Antor_RH	OD Referral Hospital	CPA1	Active	01/02/2015	31/12/2020
50	2020	Prey Veng	Sithor Kandal	141101. Sithor Kandal_RH	OD Referral Hospital	CPA1	Active	01/01/2015	31/12/2020
51	2020	Prey Veng	OD Baphnom	140101. RH Baphnom_RH	OD Referral Hospital	CPA1	Active	01/05/2015	31/12/2020
52	2020	Prey Veng	Peam Chor	140701. Peam Chor_RH	OD Referral Hospital	CPA1	Active	01/01/2017	31/12/2020
53	2020	Prey Veng	Kanhchriech	140401. Kanhchriech_RH	OD Referral Hospital	CPA1	Active	01/01/2017	31/12/2020
54	2020	Pursat	Bakan	150101. Bakan_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
55	2020	Pursat	Sampov Meas	150201. Pursat Prov. Hosp._PH	Provincial Hospital	CPA3	Active	01/01/2006	31/12/2020
56	2020	Pursat	Kravanh	150234. Phnom Kravanh_RH	OD Referral Hospital	CPA1	Active	01/01/2016	31/12/2020
57	2020	Pursat	Krakor	150233. Krakor_RH	OD Referral Hospital	CPA1	Active	01/01/2014	31/12/2020

No	Year	Province/NH	OD Name	HFAC Name	HFAC Type	HFAC Level	HFAC Status	Started date	End date
58	2020	Ratanakiri	Borkeo	160201. Borkeo RH_RH	OD Referral Hospital	CPA1	Active	01/01/2013	31/12/2020
59	2020	Siemreap	Kralanh	170101. Kralanh_RH	OD Referral Hospital	CPA2	Active	01/01/2006	31/12/2020
60	2020	Siemreap	Siem Reap	170201. Siem Reap Prov. Hosp._PH	Provincial Hospital	CPA3	Active	01/01/2006	31/12/2020
61	2020	Siemreap	Sot Nikum	170301. Sotr Nikum_RH	OD Referral Hospital	CPA2	Active	01/01/2006	31/12/2020
62	2020	Siemreap	Angkor Chhum	170401. Angkor Chum_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
63	2020	Siemreap	Angkor Chhum	170410. Puok_RH	OD Referral Hospital	CPA1	Active	01/10/2014	31/12/2020
64	2020	Preah Sihanouk	Preah Sihanouk	180101. Preah Sihanouk Prov. Hosp_PH	Provincial Hospital	CPA3	Active	01/01/2006	31/12/2020
65	2020	Svay Rieng	Romeas Hek	200201. Romeas Hek_RH	OD Referral Hospital	CPA2	Active	01/01/2006	31/12/2020
66	2020	Svay Rieng	Svay Rieng	200316. Svay Chrum_RH	OD Referral Hospital	CPA1	Active	01/02/2015	31/12/2020
67	2020	Svay Rieng	Svay Teap	200402. Svay Teap_RH	OD Referral Hospital	CPA1	Active	01/01/2015	31/12/2020
68	2020	Svay Rieng	Svay Teap	200403. Samki Romduol Referral Hospital_RH	OD Referral Hospital	CPA	Active	01/04/2019	31/12/2020
69	2020	Takeo	Ang Rokar	210101. AngRoka_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
70	2020	Takeo	Bati	210201. Bati_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
71	2020	Takeo	Daun Keo	210301. Takeo Prov Hospital_PH	Provincial Hospital	CPA3	Active	01/01/2006	31/12/2020
72	2020	Takeo	Kirivong	210401. Kirivong_RH	OD Referral Hospital	CPA2	Active	01/01/2006	31/12/2020
73	2020	Takeo	Prey Kabass	210501. Prey Kabass_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
74	2020	Takeo	Prey Kabass	20151102. Angkor Borei RH_RH	OD Referral Hospital	CPA1	Active	01/01/2017	31/12/2020
75	2020	Takeo	Koh Andeth	210601. Koh Andeth_RH	OD Referral Hospital	CPA1	Active	01/01/2016	31/12/2020
76	2020	Oddar Meanchey	Samraong	220101. Oddar Meanchey Prov Hosp_PH	Provincial Hospital	CPA2	Active	01/01/2006	31/12/2020
77	2020	Oddar Meanchey	Anlong Veng	220201. Anlong Vaeng_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
78	2020	Kep	Kep	230101. Kep Prov. Hosp._PH	Provincial Hospital	CPA1	Active	01/01/2006	31/12/2020
79	2020	Tbong Khmum	Kroch Chhmar	250301. Kroch Chhmar_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
80	2020	Tbong Khmum	O Reang Ov	250501. O Reang Ov_RH	OD Referral Hospital	CPA1	Active	01/01/2006	31/12/2020
81	2020	Tbong Khmum	Dambae	250701. Dambe_RH	OD Referral Hospital	CPA1	Active	01/01/2017	31/12/2020

II. LEGAL AND POLICY FRAMEWORK

A. Relevant National Laws Concerning Indigenous Peoples

17. Cambodia has various laws and regulations pertaining to the indigenous peoples such as Constitution of Kingdom of Cambodia, Land law 2001, Forestry Law 2003, Protected Area Law of 2005, Land Concessions 2003 and 2005, Decentralization Reform of 2005, Registration of Lands of Indigenous Communities 2009, National Policy on Development of Indigenous Peoples (NPDIP), However, most of the policies are not relevant for the project because the project benefits indigenous peoples and does not have any adverse impacts on indigenous peoples. The project does not involve any land acquisition or involuntary resettlement or loss of income and livelihood. Some of the relevant policies that are applicable are described below:

18. **Cambodia Constitution and the Land Law:** In the context of Cambodian legal framework, Article 31 of the Cambodian Constitution states that “All Cambodian citizens shall be equal before the law, enjoying the same rights, freedom and fulfilling the same obligations regardless of race, color, sex, language, religious belief, political tendency, birth origin, social status, wealth or other status”; and the promulgation of the 2001 Cambodian Land Law marks explicit recognition of collective land rights of indigenous communities by the State that offer a unique chance for indigenous peoples in Cambodia to exercise their rights to self-determined development that include:

- Ownership of the lands is granted by the State to indigenous communities as collective ownership, including all the rights and protections enjoyed by private owners. The exercise of collective ownership rights are the responsibility of the traditional authorities and decision-making mechanisms of the indigenous community, according to their customs and subject to laws such as the law on environment protection. (Article 26).
- No authority outside the community may acquire any rights to immovable properties belonging to an indigenous community. (Article 28).

19. Indigenous communities have the right to collective ownership of their lands, which gives them all the rights and protection of ownership as enjoyed by private landowners. The lands of indigenous communities include residential and agricultural land and encompass land actually cultivated and the lands reserved for shifting cultivation. Indigenous communities shall continue to manage their community land according to their traditional customs, pending the determination of their legal status. Once they are registered as legal entities, communities can apply for the registration of their collective title (Land Law 2001, Article 23 to 25).

20. **National Policy on Development of Indigenous Peoples (NPDIP):** The 2009 National Policy on Development of Indigenous Peoples (NPDIP) provides the main policy framework related to indigenous land rights in Cambodia. It also sets out policy directions in the fields of culture, education, vocational training, health, environment, land, agriculture, water resources, infrastructure, justice, tourism and industry, and mines and energy. National Policy on the Development of Indigenous Peoples" has various goals, (i) Indigenous peoples shall have a living standard beyond starvation and extreme poverty, (ii) Indigenous peoples shall be provided for at least nine years of fundamental education and shall be provided for appropriate vocational skill training courses according to their needs and based on the geographical areas in which they live, (iii) Indigenous peoples have been provided for good healthcare services and (iv) The cultures of

indigenous peoples have been carefully protected and safeguarded.Chapter-2 of the policy discusses about multi sectoral policy where health sector is also given priority in the policy and suggests the provision as below under section-3:

- Encourage the promotion of hygiene, the use of clean water and publicity that may raise awareness about these health issues to indigenous peoples.
- Encourage the appropriate study and use of herbal medicines according to the code of formulas, as well as the use of contemporary medicines, in order to ensure the welfare of indigenous peoples.
- Take and strengthen measures on the prevention, treatment and reduction of malaria, tuberculosis, AIDS, cholera and other diseases that exist in the areas where indigenous peoples live, particularly vaccinations for children, pregnant women and nutrition programs.
- Promote participation from the communities in development and healthcare works, especially for women and children, and prioritize free care service for poor indigenous peoples.
- Strengthen the health sector relating to women, mothers and infants by providing information on education and necessary services for women and families on primary health issues, particularly reproductive health.
- Develop the health system appropriately according to the conditions of the areas where indigenous peoples live by establishing health stations, health centers and referral hospitals to provide healthcare and treatment services to indigenous peoples.
- Expand the training programs and grant encouragement rewards to indigenous peoples and volunteer workers serving indigenous peoples, including traditional midwives.
- Provide special opportunities to indigenous peoples in the development of human resources in the health sector in order to enable them to participate in and receive appropriate healthcare at any time.

21. **Other Policy Considerations:** Apart from its Constitution and other national laws, Cambodia has adopted and supports the UN Declaration of Rights of Indigenous Peoples (IP) by way of ending discrimination and promoting the rights of Cambodia's recognized IPs.

22. The Cambodian government initiated a decentralization program to be more responsive to community needs, indigenous peoples included. In the mid-1990s, the Cambodian government created the Inter-Ministerial Committee for Ethnic Minorities Development and the Inter-Ministerial Committee for Highland Peoples Development to address indigenous peoples' issues. The Department of Ethnic Minority Development at the Ministry of Rural Development was established in 1999 after the Inter-Ministerial Committee was abolished. The Department mainly works to maintain the culture, beliefs and traditions of IPs through a formal process of establishing the identity and conditions of IP groups in Cambodia (a total of 56 IP groups has been recognized as legal IP groups). The Department operates through IP Offices in the provinces. IPs are represented in the formal governance structures in Cambodia from the village, commune and through to the district/provincial levels.

B. ADB Safeguard Policy Statement of 2009 for Indigenous Peoples

23. According to ADB's Safeguard Policy Statement (SPS) 2009, the objectives of indigenous peoples safeguards are to design and implement projects in a way that fosters full respect for indigenous peoples' identity, dignity, human rights, livelihood systems, and cultural uniqueness as defined by them. It ensures that ADB-assisted development interventions that may impact indigenous peoples will be consistent with the needs and aspirations of affected indigenous communities and compatible with their culture and social and economic institutions. This IPP recognizes indigenous peoples' vulnerability and ensures that all project impacts will be addressed by the implementing agency. The implementing agency will ensure that affected indigenous peoples have the opportunity to fully participate in and benefit equally from project interventions. The following are the principles of ADB SPS for indigenous peoples:

(i) Screen early on to determine (a) whether indigenous peoples are present in, or have collective attachment to, the project area; and (b) whether project impacts on indigenous peoples are likely;
(ii) Undertake a culturally-appropriate and gender-sensitive assessment of social impacts] or use similar methods to assess potential project impacts, both positive and adverse, on indigenous peoples;
(iii) Undertake meaningful consultations with affected indigenous peoples communities and concerned indigenous peoples organizations to solicit their participation (a) in designing, implementing, and monitoring measures to avoid adverse impacts or, when avoidance is not possible, to minimize, mitigate, or compensate for such effects; and (b) in tailoring project benefits for affected indigenous peoples communities in a culturally appropriate manner;
(iv) Ascertain the consent of affected indigenous peoples communities to the following project activities: (a) commercial development of the cultural resources and knowledge of Indigenous Peoples; (b) physical displacement from traditional or customary lands; and (c) commercial development of natural resources within customary lands under use;
(v) Avoid, to the maximum extent possible, any restricted access to and physical displacement from protected areas and natural resources. Where avoidance is not possible, ensure that the affected indigenous peoples communities participate in the design, implementation, and monitoring and evaluation of management for such areas and natural resources and that their benefits are equitably shared;
(vi) Prepare an Indigenous Peoples Plan (IPP) that is based on the [assessment of social impacts] with the assistance of qualified and experienced experts and that draw on indigenous knowledge and participation by the affected indigenous peoples communities. The IPP includes a framework for continued consultation with the affected indigenous peoples communities during project implementation; specifies measures to ensure that indigenous peoples receive culturally appropriate benefits; identifies measures to avoid, minimize, mitigate, or compensate for any adverse project impacts; and includes culturally appropriate grievance procedures, monitoring and evaluation arrangements, and a budget and time -bound actions for implementing the planned measures;
(vii) Disclose a draft IPP, including documentation of the consultation process and the results of the [assessment of social impacts] in a timely manner, before project appraisal, in an accessible place and in a form and language(s) understandable to affected Indigenous Peoples communities and other

stakeholders. The final IPP and its updates will also be disclosed to the affected Indigenous Peoples communities and other stakeholders;

(viii) Prepare an action plan for legal recognition of customary rights to lands and territories or ancestral domains when the project involves (a) activities that are contingent on establishing legally recognized rights to lands and territories that indigenous peoples have traditionally owned or customarily used or occupied, or (b) involuntary acquisition of such lands;

(ix) Monitor implementation of the IPP using qualified and experienced experts; adopt a participatory monitoring approach, wherever possible; and assess whether the IPP's objective and desired outcome have been achieved, taking into account the baseline conditions and the results of IPP monitoring. Disclose monitoring reports.

C. Objectives of the Indigenous Peoples Plan

24. The additional financing project has been categorized as ''B'' for indigenous peoples and the category remains the same for the original project. This categorization has been prepared in accordance with the ADB's SPS on indigenous peoples safeguards. According to the Indigenous People's Safeguards Sourcebook "indigenous peoples safeguards are triggered when a project affects either positively or negatively and either directly or indirectly the indigenous peoples." [26] The additional financing project is expected to have positive impacts on indigenous peoples in terms of better health care in the project area. The project will bring positive benefits to indigenous peoples in project areas, specifically with respect to health care. The project's Indigenous People's Plan (IPP) will maximize the anticipated benefits for indigenous groups

25. The IPP provides the guidance necessary to support culturally appropriate project implementation for IP beneficiaries. The project will facilitate that IPs are aware of the additional support provided by the government during the COVID-19 pandemic. The project will deploy culturally appropriate and gender sensitive consultation processes while engaging IPs. The IPP specifies safeguard provisions to be monitored during project implementation to ensure that IPs can benefit from project activities.

III. SOCIAL IMPACT ASSESSMENT

A. Indigenous Peoples in Cambodia

26. Indigenous Peoples are people living in the territory of the Kingdom of Cambodia, who have particular ethnic, social, cultural and economic unity and who practice their traditional lifestyles according to custom. Their agricultural and plantation works on the plots of land they occupy are done according to the custom of collective usage of the land. There are a number of indigenous peoples in Cambodia, such as the Punong, Kuoy, Tumpuon, Charay, Kroeung, Prov, Kavet, Stieng, Kraol, Mil, Kachak, Por, Khaonh, Chorng, Suoy, Thmaun, Lun, Saauch, Roder, Khe, Raang, Spung, Laeun, Samre and other indigenous peoples. Those indigenous peoples

[26] According to the Indigenous People's Safeguards Sourcebook, "The borrower/client is responsible for assessing projects and their environmental and social impacts, preparing safeguard plans, and engaging with affected communities through information disclosure, consultation, and informed participation following all policy principles and safeguard requirements." ADB. June 2013. Indigenous Peoples Safeguards. A Planning and Implementation Good Practice Sourcebook (Draft Working Document).

(approximately 1 percent of total population) live in a number of provinces, such as Ratanakiri, Mondulkiri, Kratie, Preah Vihear, Kampong Thom, Stung Treng, Oddar Meanchey, Tbong Khmum, Pursat, Kampong Speu, Koh Kong, Battambang, Preah Sihanouk, Siem Reap and other areas.

27. The indigenous peoples practice different cultures, traditions, customs, beliefs and languages according to their particular group. As for the main occupations to make their living are shifting cultivation based on their tradition by slashing and burning forests for rotation farming, collection of forest byproducts, hunting, fishing and livestock. Their livelihoods depend entirely on the natural environment. They face hardship and shortages of roads and means of transportation. In terms of the health sector, the indigenous peoples are vulnerable people. While talking about the education sector, their educational level is very limited. Therefore, their living standards are also low.

28. The largest of the ethnic groups in Cambodia are the Khmer who comprise approximately 90% of the total population and they mainly live within the lowland Mekong subregion and the central plains. The remaining 10% are non-Khmer ethnic groups, comprising of Chams (predominantly Muslim and originally from Vietnam), ethnic Vietnamese, ethnic Chinese, and the indigenous Khmer Loeu (hill-tribes). The non-indigenous ethnic minorities include immigrants and their descendants who live among the Khmer and have mostly adopted, at least nominally, Khmer culture and language[27]. Ethnic minority groups (EMGs) are very mixed group, but typically live in the highlands and mountains. In Cambodia, EMGs mainly live in the north eastern provinces, with some small groups living elsewhere in the north-west and scattered throughout the country. Most of these EMGs are fully assimilated in Khmer society and may no longer identify themselves as EMGs, which would exclude them as per ADB's definition. Province wise population and IP is provided in **Table 2**.

Table 2: Province wise Indigenous People

#	Province	Total Population	Number of Indigenous People (IP)	% of IP to Total Population	Name of IP
1	Banteay Meanchey	8,59,545	0	0	
2	Battambang	9,87,400	820	0.1%	Kouy, Tompuonn, Charay, Kroeung & Kachak
3	Kampong Cham	8,95,763	0	0	
4	Kampong Chhnang	5,25,932	0	0	
5	Kampong Speu	8,72,219	1,154	0.1%	Kouy, Phnong & Saouch
6	Kampong Thom	6,77,260	12,825	2%	Kouy
7	Kampot	5,92,845	0	0	
8	Kandal	11,95,547	0	0	
9	Kep	41,798	0	0	
10	Koh Kong	1,23,618	350	0.3%	Chorng
11	Kratie	3,72,825	38,059	10%	Phnong, Kouy, Sting,Mil, Kroal, Thmorn & Khaonh
12	Mondul Kiri	88,649	39,619	45%	Phnong, Kouy, Sting,Mil, Kroal, Thmorn, Tompuonn, Charay & Kroeung
13	Phnom Penh	21,29,371	0	0	
14	Preah Vihear	2,51,352	14,402	6%	Phnong & Kouy
15	Prey Veng	10,57,428	0	0	

[27] World Heritage Encyclopedia. List of Ethnic Groups.

#	Province	Total Population	Number of Indigenous People (IP)	% of IP to Total Population	Name of IP
16	Pursat	4,11,759	1,420	0.3%	Phnong
17	Ratanakiri	2,04,027	97,774	48%	Phnong, Kouy, Sting, Tompuonn, Charay Kroeung, Kavet, Lun, Kachak & Praov
18	Pailin	71,600	0	0	
19	Preah Sihanouk	3,02,887	126	0.04%	Saouch
20	Siemreap	10,06,512	441	0.04%	Kouy
21	Stung Treng	1,59,565	10,399	7%	Phnong, Kouy,Kroeung, Praov, Kavet, Sting,Topuonn, Charay, Lun & Kachak
22	Svay Rieng	5,24,554	0	0	
23	Takeo	8,99,485	0	0	
24	Oddar Meanchey	2,61,252	740	0.28%	Phnong, Kouy,Sting,Kroal, Thmorn,Tompuonn,Charay & Kavet.
25	Tbong Khmum	7,75,296	1,641	0.21%	Sting
	TOTAL	**1,52,88,489**	**2,19,770**	**1.44%**	

Note:
1. Total Population: Based on the Cambodia General Population Census 2019.
2. Number of IP: Based on the 2010 Commune Database and 2020 IP Identity Recognition of the Ministry of Rural Development.

B. Indigenous Peoples in Project Areas

29. The project will cover 81 hospitals across various parts of the country of which some hospitals fall within the provinces having the presence of indigenous peoples. These provinces are Kampong Speu, KampongThom, Koh Kong, Mondul Kiri, Preah Vihear, Pursa, Ratanakiri, Siemreap, Preah Sihanouk and Oddar Meanchey. IP residents have been reported in the coverage areas of the 10 hospitals among these 89 hospitals and the proportion of this IP population consists for 3.9 % of the total population coverage under these 10 hospitals. There are diverse indigenous peoples such as Souys, Kouy, Chornk, Phnong, Kouy, Por and Cha Ray/Tom Pun residing within the project area especially in these ten provinces. Indigenous peoples in these areas maintain their own distinct language and socio-cultural practices; however, they do assimilate with mainstream population. The project will bring positive benefits to indigenous peoples in project areas, specifically with respect to health care.

30. Out of the total coverage of 81 hospitals, there are 10 hospitals which consist of IP beneficiaries. These hospitals are; Kampong Speu (Kampong Speu province), Kampong Thom (Kampong Thom province), Smach Mean Chey (Koh Kong province), Sen Monorom (Mondul Kiri province), Tbeng Meanchey (Preah Vihear province), Kravanh (Pursat province), Borkeo (Ratanakiri province), Angkor Chhum (Siemreap province), Preah Sihanouk (Preah Sihanouk province and Anlong Veng (Oddar Meanchey province). Details are provided in **Table 3**.

Table 3: Indigenous People Beneficiaries

#	OD Name	HFAC Type	Year of Establishment	Village/Town/City	Province	Total Beneficiaries	IP Beneficiaries	Name of the IPs	% of IP
1	Kampong Speu	Provincial Hospital	01/01/2017	Angserei village/Sangkat Roka Thom/Khan Chbar Moun	Kampong Speu	2,39,986	Yes	• Kuoy • Phnorng • Saoch • Others	0.68%
2	Kampong Thom	Provincial Hospital	01/01/2006	Village 6, Sangkat Kg Thom, Krong Stung Sen	Kampong Thom	1,13,218	Yes	Kouy	0.4%
3	Smach Mean Chey	Provincial Hospital	01/01/2020	Village 1, Sangkat Smacg mean Chey, Krong Khemerak Phumin	Koh Kong	1,85,802	Yes	Chorng	0.50%
4	Sen Monorom	OD Referral Hospital	01/01/2017	Village Raing Sey Commune Sre Sang Kom, district Koh Nhek	Mondul Kiri	90,815	Yes	• Phnong • Krao • Stieng • Kouy • Tumpuon • Kroeung	15%
5	Tbeng Meanchey	OD Referral Hospital	01/01/2017	Chamksan village/Chamksan commune/Chamksan district.	Preah Vihear	57,224	Yes	Kouy	2.40%
6	Kravanh	OD Referral Hospital	01/01/2016	Village Kroch Chmar , commune Leach , district Phnom Kravanh	Pursat		Yes	• Pnorng • Others	1.50%
7	Borkeo	OD Referral Hospital	01/01/2016	Village Mouy, commne La Minh, district Borkeo	Ratanakiri	84,793	Yes	• Charay • Tompoun • Kachak • Phnorng • Kravet • Kroeung	50%
8	Angkor Chhum	OD Referral Hospital	01/01/2006	Kok Thmei village/Pouk commune/Pouk district.	Siemreap		Yes	Kouy	0.20%
9	Preah Sihanouk	Provincial Hospital	01/01/2006	Phum 4 village/Sangkat 4/Krong Preah Sihanouk.	Preah Sihanouk	2,21,360	Yes	Saouch	0.05%
10	Anlong Veng	OD Referral Hospital	01/01/2006	Ou Chancheng village/Anlong Veng commune/Anlong Veng district	Oddar Meanchey	1,60,079	Yes	• Kuoy • Phnorng • Toumpuo • Kraol • Charay • Tmoun • Kravet	0.70%

C. Socio-Economic Profile

31. Following section describes briefly about the socio-economic profile of the provinces of concerned project hospitals where IP beneficiaries live. There are 10 hospitals where IP beneficiaries are found. The socio-economic information as presented below is province wise for each respective hospital where IP beneficiaries exist. The information is collected through various secondary sources such as (i) Cambodia General Population Census 2019; (ii) The 2010 Commune Database and 2020 IP Identity Recognition of the Ministry of Rural Development, (iii) Cambodia Country Poverty Analysis 2014, ADB and (iv) Cambodia Demographic and Health Survey (2010 and 2014).

32. **Demography:** The total population of the 10 provinces covered is 41,99,535 (4.20 million). Siemreap province has the highest population among the 10 IP provinces and Mondul Kiri has the lowest population. Population below 15 years are found to be highest in Ratanakiri (35% of total province population) and lowest in Preah Sihanouk province (22.7% of total province population). Details on demographic profile of the 10 provinces are provided in **Table 4**.

Table4: Demographic Profile

#	Province	Total Population	% to the total population	% of Population Age Under 15 Year Old
1	Kampong Speu	8,72,219	20.8	28.8
2	Kampong Thom	6,77,260	16.1	32.5
3	Koh Kong	1,23,618	2.9	29.4
4	Mondul Kiri	88,649	2.1	35.0
5	Preah Vihear	2,51,352	6.0	33.5
6	Pursat	4,11,759	9.8	33.1
7	Ratanakiri	2,04,027	4.9	35.0
8	Preah Sihanouk	3,02,887	7.2	22.7
9	Siemreap	10,06,512	24.0	32.4
10	Oddar Meanchey	2,61,252	6.2	33.7
	CAMBODIA	**41,99,535**	100.0	**29.4**

33. **Indigenous People:** The overall composition of the indigenous people in all the 10 provinces is only about 1.44 %. The presence of indigenous people is very high in only two of the provinces Ratanakiri (48 %) and Mondul Kiri (45 %). Besides Preah Vihear which has 6 % of the indigenous people and Kampong Thom which has 2 % of the IP population, all other 6 provinces have less than 1 % indigenous peoples in their respective provinces. Details are provided in **Table 5**.

Table 5: Indigenous People Composition

#	Province	Total Population	% of IP Population
1	Kampong Speu	8,72,219	0.1
2	Kampong Thom	6,77,260	2.0
3	Koh Kong	1,23,618	0.3
4	Mondul Kiri	88,649	45.0
5	Preah Vihear	2,51,352	6.0
6	Pursat	4,11,759	0.3
7	Ratanakiri	2,04,027	48.0
8	Preah Sihanouk	3,02,887	0.04
9	Siemreap	10,06,512	0.04

10	Oddar Meanchey	2,61,252	0.25
	CAMBODIA	**41,99,535**	**1.44**

34. **Education:** The overall literacy rate among the 10 provinces having IP beneficiaries in the project hospitals is 88.5 %. In Kampong Speu, the literacy rate is the highest at 89.7 % followed by Preah Sihanouk 89.4 %. Among the provinces,` the lowest rate of literacy is evident in Ratanakiri (74.2 %) and Mondul Kiri (75.8 %) and in the rest of the provinces the literacy rate is at least 80 % or more. The primary school education attended by 6 to 11 years is seen more in Oddar Meanchey at 91.1% Pursat 90.9 % and Koh Kong at 90.8 %. The primary level is attainment is the lowest in Mondul Kiri province which is 77.7 %. Similarly, the secondary school education attended by 12 to 14 years is seen more in Koh Kong at 94.5% Pursat 92.8 % and Preah Sihanouk 91.8 %. The secondary level is attainment is the lowest in Mondul Kiri province which is 80.4 %. Similarly, the upper secondary school education attended by 15 to 17 years is seen more in Pursat 70.4 % and Koh Kong 69.4 %. The upper secondary level is attainment is the lowest in Mondul Kiri province which is 50.6 %. Details are provided in **Table 6**.

Table 6: Literacy Status

#	Province	% of Literacy Rate of Population Age 7 +	% of Population Currently Attending School by Age		
			06-11 (Primary)	12-14 (Secondary)	15-17 (Upper Secondary)
1	Kampong Speu	89.7	90.5	91.7	62.2
2	Kampong Thom	82.0	88.4	89.5	66.4
3	Koh Kong	85.2	90.8	94.5	69.4
4	Mondul Kiri	75.8	77.7	80.4	50.6
5	Preah Vihear	79.8	82.2	84.3	55.4
6	Pursat	88.3	90.9	92.8	70.4
7	Ratanakiri	74.2	78.2	85.6	61.5
8	Preah Sihanouk	89.4	89.6	91.8	66.4
9	Siemreap	81.6	88.3	89.3	64.1
10	Oddar Meanchey	81.7	91.1	90.8	58.5
	CAMBODIA	**88.5**	**90.6**	**91.6**	**67.6**

35. **Household access to amenities:** Among the 10 provinces having IP beneficiaries , the overall ownership of the houses is 90.7 %. The highest ownership is found in Kampong Speu (97.7 %) followed by Kampong Thom and Pursat. The ownership is low in Preah Sihanouk province which is 83.3 %. The percentage of households using city power or a generator as a source of lighting varies to a greater extent when the provincial data are compared. Overall 84 % of the households use city power or generator for lighting their households. The usage of this is high in the province of Preah Sihanouk (94.5%), Kampong Speu (88.6%) and Pursat (81.8%). The use of city power or generator is low in the provinces of Ratanakiri, Preah Vihear, Oddar Meanchey and Mondul Kiri. Firewood or charcoal is used as a cooking fuel in 68.7 % of the households in all the 10 provinces covered. More than 90 % of the households in the provinces of Oddar Meanchey, Preah Vihear, Kampong Thom and Pursat are using firewood and charcoal as cooking fuel. The low use of these fuels is seen in Koh Kong and Preah Sihanouk provinces. Access to toilet is a problem as overall 17.2 % of the households in all the 10 provinces do not have toilets at their homes. The problem of toilet is more in the provinces of Ratankiri, Preah Vihear and Mondul Kiri where more than 44 % of the households do not have toilets. Similarly,

majority about 62.6 % of the households in the 10 provinces are having only one room in their respective dwelling units. Most of the households in Pursat (81%), Siemreap (72.7%) and Kampong Thom (69 %) provinces are having one room in their dwelling units. Details are provided in **Table 7**.

Table 7 : Household use / access to different amenities

#	Province	% of Households Owned House	% of Households Using City Power and/or Generator as Source of Light	% of Households Using Firewood and/or Charcoal as Source of Cooking Fuel	% of Households No Use Toilet/None	% of Households Has Only One Room
1	Kampong Speu	97.7	88.6	70.3	22.2	52.8
2	Kampong Thom	95.9	69.9	90.7	18.6	69.0
3	Koh Kong	87.6	75.9	53.6	18.5	56.0
4	Mondul Kiri	86.2	53.8	75.7	44.0	61.1
5	Preah Vihear	93.6	44.3	91.1	46.8	51.1
6	Pursat	95.8	81.8	90.3	21.9	80.9
7	Ratanakiri	88.6	44.2	82.9	48.8	49.6
8	Preah Sihanouk	83.3	94.5	41.4	16.5	56.8
9	Siemreap	92.5	76.5	81.9	20.6	72.7
10	Oddar Meanchey	93.9	52.8	91.5	29.5	60.4
	CAMBODIA	**90.7**	**84.0**	**68.7**	**17.2**	**62.6**

36. **Health Status:** Disability of members aged 5 years and above is reported from all the provinces without any major variations. Overall, about 4.9 % of the population in all the provinces in this age group of 5 and above are suffering from disability of different degrees. It is found that percentage of delivery by skilled providers as per 2010 data was 71%, however, it has increased up to 89% in 2014. Deliveries by skilled health care provider are also a problem as about 29 % of the deliveries are conducted by unskilled providers. The deliveries attended by unskilled attendant is more than 50 % in the provinces of Preah Vihear, Mondul Kiri, Ratanakiri and Kampong Thom. In Koh Kong and Preah Sihanouk provinces, more percentage of deliveries (79.2%) are attended by skilled health care providers. The health treatment seeking behavior is high as 92.2 % of sick persons have sought at least one treatment for their health ailments as per the 2010 data , however, it has increased up to 95.1% in the 2014 data which shows growing awareness and demand for health facilities and health services. This is very high in Pursat province and low in Koh Kong province. For seeking treatment overall about 18 % of persons borrowed money as per the 2010 survey data, and this is reported be high in provinces of Kampong Thom (37.8%) and Pursat (33.3%). However, this has seen a downward trend as shown in the 2014 survey data that overall percentage of people borrowed money for treatment is 12.4%. Similarly, the overall under-five mortality rate per 1,000 live Births was 54 as per the survey data in 2010 whcih was reduced to 35 in 2014. This is high in the provinces of Mondul Kiri (106), Ratanakiri (106) and Preah Vihear (118). This indicator is reported low at 47 in the province of Oddar Meanchey. Details are provided in **Table 8**.

Table 8: Health Indicators of different provinces

#	Province	% of Population Aged 5+ With Any Disability	% of Delivered by Skilled Providers	% of Sick Persons who Sought At Least One Treatment	% of Persons Who Borrowed Money When Seeking for Health Care	Under-Five Mortality Rate per 1,000 live Births
1	Kampong Speu	4.5	68.2	93.7	15.8	73
2	Kampong Thom	5.3	47.7	90.6	37.8	67
3	Koh Kong	4.2	79.2	85.2	14.4	63
4	Mondul Kiri	4.9	38.4	93.3	7.1	106
5	Preah Vihear	5.4	28.2	87.6	15.9	118
6	Pursat	5.6	73.9	98.7	33.3	57
7	Ratanakiri	3.6	38.4	93.3	7.1	106
8	Preah Sihanouk	5.7	79.2	85.2	14.4	63
9	Siemreap	4.5	72.7	86.6	15.2	60
10	Oddar Meanchey	4.8	64.4	93.9	13.3	47
	CAMBODIA	**4.9**	**71.0**	**92.2**	**18**	**54**

37. **Economy:** The overall poverty rate among the 10 provinces is 22.9 %. This is low in the provinces of Preah Sihanouk (15.6%) and Koh Kong (20.3%). In all other provinces it varies between 27 % to 37 %. Employment is not a problem as 98.7 % of the population aged 15 years and above are engaged in some kind of work. The overall migration rate is 21. 5 % and this is high in the provinces of Preah Sihanouk, Oddar Meanchey and Koh Kong. The lowest rate of migration is in the province of Pursat, Kampong Speu and Kampong Thom. Details are provided in **Table 9**.

Table 9 : Poverty, Employment and Migration pattern

#	Province	Poverty Rate (%)	% of Employment Rate of Those Aged 15+	% of migrants
1	Kampong Speu	27.7	99.4	10.0
2	Kampong Thom	29.1	99.1	9.7
3	Koh Kong	20.3	99.2	35.1
4	Mondul Kiri	32.9	99.2	31.3
5	Preah Vihear	37.0	98.9	25.2
6	Pursat	27.8	98.5	12.1
7	Ratanakiri	36.2	99.5	23.7
8	Preah Sihanouk	15.6	93.1	51.1
9	Siemreap	28.8	98.2	15.8
10	Oddar Meanchey	34.3	99.7	37.3
	CAMBODIA	**22.9**	**98.7**	**21.5**

D. Situation of Indigenous Peoples in the COVID-19 Pandemic

38. Indigenous Peoples are vulnerable to COVID-19 due to their lack access to health care services. This lack of access presents a barrier to the early detection and timely treatment of COVID-19 infection amongst ethnic group members. Therefore, the government has a role in ensuring indigenous peoples receive information about COVID-19 prevention and are able to access medical assistance and emergency care regardless of status and without any discrimination.

IV. MEANINGFUL CONSULTATION AND INFORMATION DISCLOSURE

A. Consultation and Participation Mechanisms

39. During project preparation, consultation was carried out virtually with some of the hospital staff. Due to the COVID-19 related constraints, meaningful consultations were not undertaken with the IP beneficiaries and people which shall be done during project implementation and the results of the consultation meetings will be clearly summarized and added in the social safeguard monitoring reports. Consultation will continue during project implementation, with relevant stakeholders being identified. Provincial hospitals and OD referral hospitals covered under the additional financing will communicate with beneficiaries including the IP beneficiaries on the enhanced services available to them and specifically services related to COVID-19.

40. The IPP is designed to ensure that indigenous peoples will continue to be consulted during project implementation and actively participate in project activities, while also ensuring that the issues and concerns of indigenous peoples are heard, recognized, and responded to by the project implementers. During implementation, the project staff will use simple language and culturally-appropriate consultation methods to:

(i) ensure that the head of village and commune in IP areas are consulted and made aware of the additional support provided by the government during the COVID-19 pandemic;
(ii) share the benefits as outlined in the IPP with the IP beneficiaries
(iii) share relevant IPP related information materials translated into local languages with the beneficiaries including the IP beneficiaries;
(iv) explain the purpose of the additional financing.

B. Information Disclosure

41. Information on the IPP will be disclosed and made available to the IPs and beneficiaries in the form of leaflets or brochures translated into the local language. For indigenous peoples where a large number of adults cannot read, materials will be produced in popularized form. The MOH through its PMU and the provincial implementing agencies along with assistance from national safeguard, communication and gender specialist, will be in charge of disclosing IPP related information and project's benefits to the IPs. The IPP for the additional financing will also be disclosed in the ADB and MOH websites. The monitoring reports on IPP implementation will also be posted on the ADB website as well as on MOH website. The disclosure mechanism of

the additional financing components will follow the ongoing and original loan implementation disclosure mechanism.

V. PROJECT BENEFITS, IMPACTS, AND MITIGATION MEASURES

A. Benefits

42. The project impact and outcome remain unchanged from the original project. The project will provide urgent support to the Government of Cambodia's efforts to mitigate the adverse health, social, and economic impacts of the coronavirus disease (COVID-19) pandemic through support to scale-up health system capacity for prevention, detection and response to emerging health threats. The project will contribute to the achievement of the Sustainable Development Goals (SDGs) including: (i) no poverty (SDG 1); (ii) good health and well-being (SDG3); (iii) gender equality (SDG5); and (iv) reduced inequalities (SDG10). The additional financing will scale-up project activities to all 81 hospitals in the country, benefitting the country's population covering both rural and urban areas. Since 2011, ADB's support to Cambodia's health sector focused on regional communicable disease control projects. These projects have driven improvements in public health system capacity for preventing, detecting and responding to public health threats. These achievements demonstrate ADB's comparative advantage in delivering targeted support for responding to emerging health threats. Leveraging this advantage, the government has requested ADB's support to scale-up the health sector's response to COVID-19. The proposed project will strengthen the capacity of the public health system to prevent and treat COVID-19, mitigating health and social impacts and indirectly contributing to poverty reduction.

43. The project design focuses on mitigating the impact of a COVID-19 outbreak on the population's health and the associated social and economic burdens. Project improvements at the output level pertain to the capacity of the 89 targeted referral hospitals to provide clinical care for COVID-19 and other emerging disease threats and subnational capacity of the timely detection of and response to emerging disease threats. At the outcome level, the investment contributes to Cambodia's progress towards compliance with the minimum core public health capacities for responding to public health risks of national and international concern. Effectively responding to such threats reduces the social and economic burden of pandemics that fall disproportionately on poor

B. Mitigation Measures

44. The purpose of this IPP is to (i) outline the potential positive and negative impacts of the project on indigenous peoples, (ii) specify actions to mitigate any negative impacts that may occur during implementation, which are likely to be negligible; and (iii) specify actions to enhance benefits to indigenous people. Table 10 describes the identified potential positive and negative impacts, as well as the measures to mitigate the unavoidable negative impacts that may occur during implementation. The goal is for IPs beneficiaries to receive health service benefits to fight the COVID-19 that are culturally-appropriate and gender-responsive.

45. During project preparation, consultations with indigenous peoples and beneficiaries were restricted due to the COVID-19 situation. Consultation with IPs beneficiaries will be continued during project implementation. To increase support for indigenous peoples and achieve positive outcomes for IPs in the project, the project management unit at central level (PMU) and

representatives of the implementing agencies will ensure full implementation of the IPP. To facilitate this process, key features of this IPP are mirrored in the project administration manual (PAM). No negative project impacts were identified that would require mitigation measures. However, lack of participation of IPs may cause small scale hindrance to the desired positive impacts.

Table 10: Potential Positive and Negative Impacts and Mitigation Measures

Additional Financing Outputs	Anticipated Positive Impacts	Anticipated Negative Impacts	Proposed Mitigation Measures
National disease surveillance and outbreak response systems strengthened • a nationwide program of trainings to strengthen subnational capacity for communicable disease prevention, detection and response; • outbreak response vehicles for provincial and national agencies, • health education campaigns to enhance communities' preparedness for COVID-19 and other communicable disease threats • finance computer hardware for central, provincial and district health agencies **Laboratory services and hospital IPC improved** • equip laboratories in 8 provincial hospitals and 73 district referral hospitals for communicable disease diagnostics and clinical management, including COVID-19 rapid testing; • renovate laboratories in 62 of these hospitals • Install modern solid waste treatment systems to 42 hospitals • Supply autoclaves, washing machines and other IPC equipment to hospitals where upgrading is required **Emergency preparedness and response capacity for COVID-19 strengthened** equip 14 provincial hospitals with • oxygen plants, for onsite generation of oxygen supply • clinical equipment for provision of oxygen therapy • an ambulance for the transportation of COVID-	Indigenous Peoples beneficiaries are knowledgeable on the purpose of strengthening emergency preparedness and response capacity for COVID-19 and the targets as below: • By 2020, Cambodia, the Lao PDR, Myanmar, and Viet Nam apply harmonized standard case definitions, and reporting procedures for notifiable communicable diseases (baseline: NA), including disaggregation by sex and age • By 2021, all border provinces states, or regions targeted by the project conduct two cross-border activities per year • By 2023, electronic reporting system for COVID-19, with case data disaggregated by sex, established and in routine use by 24 provinces and 1 municipality as per national regulations (Baseline: NA; Q2 2021) • By 2023, 50 targeted laboratories have been audited at least once for quality and biosafety (Baseline: 0; Q2 2021) • By 2023, at least 2 staff members (one of them female) in 50 targeted laboratories trained in national laboratory biosafety standards and practice (Baseline: 0; Q2 2021) • By Q3 2023, at least 50% of ICU doctors and nurses in 14 provincial and district referral hospitals have improved knowledge on clinical management for COVID-19 (Baseline: 0, Q2 2021) • By Q3 2023, 14 referral hospitals with provision of uninterrupted oxygen source (Baseline: 0, Q2 2021) • By 2023, at least 50% of front-line health care workers in 14 provincial hospitals have increased	• Only indirect negative impacts are possible as some of the indigenous peoples may not fully benefit from the project due to high demand for health services all over the country or may be due to lack of awareness about the facilities to be provided under the project	• Consult indigenous peoples adequately and ensure their awareness of the additional support provided by MOH during the COVID-19 pandemic at least prior to implementation of the project's additional financing components and once during middle of the implementation. • Ensure the participation of indigenous people's leaders, representatives, and community members at the consultations to be carried out during project implementation • Share IPP-related information including the GRM and project benefits with the IP beneficiaries during implementation

Additional Financing Outputs	Anticipated Positive Impacts	Anticipated Negative Impacts	Proposed Mitigation Measures
19 patients requiring emergency care.	knowledge on support and referral measures for survivors of GBV (Baseline: 0; Q2 2021)		
	• Project impacts are regularly monitored to ensure the IPP is properly implemented.	None	Conduct internal monitoring on the implementation of IPP and submission of monitoring report. Provide training on IPP implementation to Project Management Unit (PMU) staffs and the focal in each project area

COVID-19 = coronavirus disease, IPP = Indigenous Peoples Plan, IPC = infection prevention and control, MOH = Ministry of Health, PPE = personal protective equipment.

VI. GRIEVANCE REDRESS MECHANISM

46. The ADB SPS states that the borrower/client is required to establish and maintain a GRM to ensure effective resolution of indigenous peoples beneficiaries' concerns and grievances about project implementation. ADB's SPS 2009 requires the establishment of a responsive, readily accessible, and culturally-appropriate GRM capable of receiving and facilitating the resolution of affected persons' concerns and grievances about the physical, social, and economic impacts of the project. The GRM aims to: (i) reduce conflict, risk of undue delay, and complication in project implementation; (ii) improve quality of project activities and outputs; (iii) ensure that the rights of affected parties are respected; (iv) identify and respond to unintended impacts of projects on individuals; and, (v) maximize participation, support and benefit to local communities. The GRM has already been established and operational since the effectiveness of the ongoing project. The additional financing will follow the existing GRM and consultation process

47. The additional financing will follow the existing grievance redress mechanism of the ongoing project. This will facilitate to develop mechanisms to resolve complaints in a timely manner through a transparent process that is gender responsive, culturally appropriate, and readily accessible to all indigenous beneficiaries. Regular meetings and consultations will seek to minimize dissatisfaction among project affected people. Local stakeholder's opinions and concerns will be part of the project planning and implementation. The participatory approach will encourage people to raise any concerns before conflicts may appear in the design and implemented on project activities. Grievance redress mechanism will be disclosed to affected communities using staff from health facilities who will organize outreach activities to explain complaint mechanism. The beneficiaries including the indigenous people beneficiaries can also address their concerns through their representative. The complaint will be assessed and negotiated in to a solution between the project representative (focal point) and local authorities, and then fed back to the communities as part of the participatory planning process. If the complaint is not resolved amicably, it will be taken to the PMU or MOH steering committee under the MOH. The project representative at various levels through the national social safeguard specialist in the PMU will be responsible for reporting any grievances up to the appropriate level. The particular activities will be carried out after such conflict is resolved satisfactorily. In case where affected households or IPs do not have the writing, skills or are unable to express their grievance verbally, they are allowed to seek assistance from any recognized local group or village head or commune chief. Throughout the grievance redress process, the project proponent especially the working

group will ensure that the concerned affected IPs are provided with copies of complaints and decisions or resolution reached.

48. The additional financing project will benefit the people including indigenous peoples as beneficiaries and is not expected to have major grievances. However, any unanticipated impacts will be mitigated in accordance with ADB's SPS. People are also free to approach the country's legal system at any time they wish to. People can also approach to ADB's accountability mechanism and may submit complaints directly.

VII. MONITORING AND REPORTING

49. The implementation of the IPP will be monitored by the PMU to: (i) ensure that indigenous peoples benefit from the additional financing, (ii) record the number of IP beneficiaries, types of benefits etc, (iii) ensure that mitigation measures designed to address negative social impacts and measures to enhance positive impacts are adequate and effective, (iv) determine if the indigenous peoples have any issues or concerns regarding project implementation, (v) determine that adequate consultation is taking place, and (vi) propose corrective actions when needed. The MOH through Department of Planning and Health Information (DPHI) and the PMU will be responsible for monitoring the IPP, making sure that it is implemented per the ongoing project and the reporting follows the existing and established systems.

50. Monitoring and reporting of the project for IPP will follow the overall project monitoring and reporting arrangements already established under the ongoing project. The PMU, with the support of the national safeguard, community development and gender specialist, will monitor the IPP implementation and ensure compliance with ADB's SPS requirements. All IPP related data will be disaggregated by gender to the extent possible. The progress of IPP implementation will be reported highlighting compliance issues and corrective actions, if identified. Progress on the implementation of the IPP will be integrated into the overall project's progress report. However, it is also proposed that standalone annual monitoring reports will be prepared for the IPP and will be submitted to ADB by the PMU. IPP monitoring reports will be disclosed on ADB's website as well as on the website of MOH. IPP monitoring reports will be disclosed on ADB's website as well as on the website of MOH.

51. In addition to IPP monitoring, ADB will conduct loan review missions at least once a year that will also review the progress of IPP implementation. A project completion report within 6 months of physical completion of the project will be prepared. The project completion report will be for the entire project (ongoing project plus additional financing) and will analyze project implementation, project performance and achievements against the targets, and expected project impacts. The project completion report will also include a section on IPP implementation to report whether the objectives of IPP have been achieved, that indigenous peoples have positively benefited from the additional financing, and that no indigenous peoples have been negatively impacted.

VIII. INSTITUTIONAL ARRANGEMENTS

A. Executing Agency and Implementing Agency

52. The implementation arrangements remain consistent with the original project. The MOH, through its Department of Planning and Health Information (DPHI), will be the executing agency for the additional financing project. The State Secretary, MOH will be the project director. The existing project management unit (PMU) will support the project director in managing, monitoring, and administering the project. National implementing agencies (NIA) are the Department of Communicable Disease Control, the Department of Hospital Services, the National Institute for Public Health, the National Malaria Center (CNM). Provincial implementing agencies (PIA) are the 24 provincial and 1 municipal health departments.

B. Project Management Unit

53. MOH has already an existing PMU for the ongoing and original component which shall further be expanded with designated expert for the implementation of IPP for additional financing components. The PMU will be supported by a total of 14 consultants that includes 1 international consultant and 13 national consultants. Under the national consultants, there will be 1 community development specialist who will be the focal point to coordinate the implementation of IPP and the community development specialist will work closely with 1 gender specialist and 1 safeguard specialist (safeguard specialist is mainly responsible for environment aspect) . Overall roles and responsibilities of institutional mechanism for the implementation of additional financing component is described in Table 11 and depicted in Figure-1.

C. Community Development Specialist

54. A national community development specialist (consultant) will be engaged under the consulting services who will support the PMU to coordinate, implement and monitor safeguards activities including the implementation of IPP. Detailed tasks of the specialist will be, but not limited, to as follow:

- Assist in planning, monitoring to improve CDC services for MEV's in hotspots along economic corridors in targeted border areas and in reporting progress of implementation;
- Improve the capacity of RRT and community for risk analysis and risk assessment and risk communication;
- Conduct regular integrated community's male-female and ethnic groups BCC review to measure knowledge, attitude, practice and identify BCC approaches to fit with community's male-female and ethnic-groups;
- Monitor and report on Ethnic groups development plan (EGDP) implementation progress and constraints;
- Regularly consult EG's beneficiaries and other stakeholders;
- Help ensure that the project is aligned with national ethnic minority laws, policies and plans;
- Closely work with ADB CARM to seek guidance from social safeguards experts to ensure requirements is met and improve EGDP reporting;

- Closely work with IAs and provincial implementing units in improving CDC services for MEVs in hotspots along economic corridors in targeted border areas;
- Work with CDC department to supervise health staff and village health workers for CDC, community preparedness, strengthening diseases reporting and other identified priorities;
- Work with CDC department to supervise RRT for risk analysis and risk assessment;
- Coordinate in updating BCC and IEC materials for communities in response to diseases outbreak and health education;
- Prepare a detailed IPP implementation plan, which takes into consideration institutional opportunities and constraints, and integrate this plan into project outputs and activities
- Regularly conduct consultation with IPP beneficiaries and other stakeholders as part of IPP implementation;
- Assist PMU to carry out meaningful consultations with affected people and beneficiaries to facilitate their informed participation regarding social aspects of the project;
- Ensure provision of information to affected people and beneficiaries including the IPs regarding project components, potential social impacts during various project phases, and proposed mitigation measures. This includes women's participation in consultation and stakeholder involvement including the IPs
- Coordinate and report on project specific Grievance Redress Mechanism (GRM);
- Prepare reports on progress of implementation of community development implementation and IPP with specific targets and activities integrated in the overall implementation plan;
- Work closely with the PMU team and with IPP focal person in the IAs to ensure participation of IP representative and communities in project implementation, and seek guidance from social safeguards experts in ADB CARM;
- Regularly updates checklists of monitoring of community preparedness and response to diseases outbreak; and checklist for IPPs consultation;
- Assist EA/IA/PMU to prepare the bi-annual monitoring report on implementation of IPP
- Undertake other tasks as maybe assigned by the HSP Project Director.

55. Overall roles and responsibilities of various implementation organizations are provided in **Table 11** and the organization chart is depicted in **Figure-1**.

Table 11: Project Implementation Organizations – Roles and Responsibilities

Project Implementation Organizations	Management Roles and Responsibilities
Ministry of Health Project Steering Committee	• Provide overall guidance for COVID-19 preparedness and response actions to the project • Organize high level consultations in the event of COVID-19 outbreaks • Approve the additional financing's annual operational plan, procurement plan, and budget, ensuring harmonization with other Official Development Assistance projects • Review progress of the additional financing quarterly
Executing Agency: MOH/DPHI	• Be responsible for overall project implementation and ensure compliance to all covenants in the loan agreement

Project Implementation Organizations	Management Roles and Responsibilities
	• Recruit and supervise individual consultants and contractors • Conduct steering committee meetings and procurement review committee meetings • Coordinate with core ministries and development partners including ADB • Provide technical guidance, supervise, and monitor all project activities • Oversee the progress and deliverables of contractors • Establish, supervise, and monitor the advance account • Responsible for project financial statements and have it audited • Establish a strong financial management system and submit timely withdrawal applications to ADB; ensure financial audits are conducted as per agreed timeframes and recommended actions are addressed
Implementation Agencies: DCDC, DHS, NIPH, CNM, and ## 24 provincial health departments, and 1 municipal health department.	• Oversee planning and implementation of project activities at hospital level • Accept the equipment and supply, ensure quality, quantity, and specifications of equipment provided • Monitor and oversee acceptance of minor renovation works provided by contractors • Oversee the maintenance, repair, and operation of equipment supplied under the project • Review and approve hospital workplans for capacity building and training • Ensure compliance at the hospital level, to all project safeguards requirements, especially environmental safeguards for minor works • Collate activity and safeguards monitoring data and prepare reports as required by MOH.
Project Management Unit (under DPHI)	• Oversee project administration, implementation management and financial management under the direction of MOH/DPHI. • Coordinate with implementing agencies on project activity planning and delivery • Monitor and provide support to ensure compliance with ADB safeguards requirements during project implementation • Ensure collection and synthesis of project monitoring data in accordance with the project DMF and safeguards plans • Prepare project reports in accordance with ADB requirements • Assist in preparation of project financial statements in accordance with ADB requirements • Assist in monitoring and administering the advance accounts • Organize/facilitate steering committee and procurement committee review meetings for MOH

Project Implementation Organizations	Management Roles and Responsibilities
ADB	• Approve AOPs, budget allocation, procurement plan and project activities. • Review project implementation and compliance of Loan Agreement twice a year, including related policy actions and project activities • Disburse loan proceeds to the consultants and the contractors

ADB = Asian Development Bank; DCDC= Department MOH of Diseases Control; CNM = National Malaria Center; DHS = Department of Hospital Services; DMS = Department of Medical Services; DPHI= Department of Health Information; EA = Executing Agency; IA = Implementing Agency; MOH = Ministry of Health; NIPH = National Institute for Public Health; PMU = project management unit, WHO = World Health Organization.
Source: Asian Development Bank.

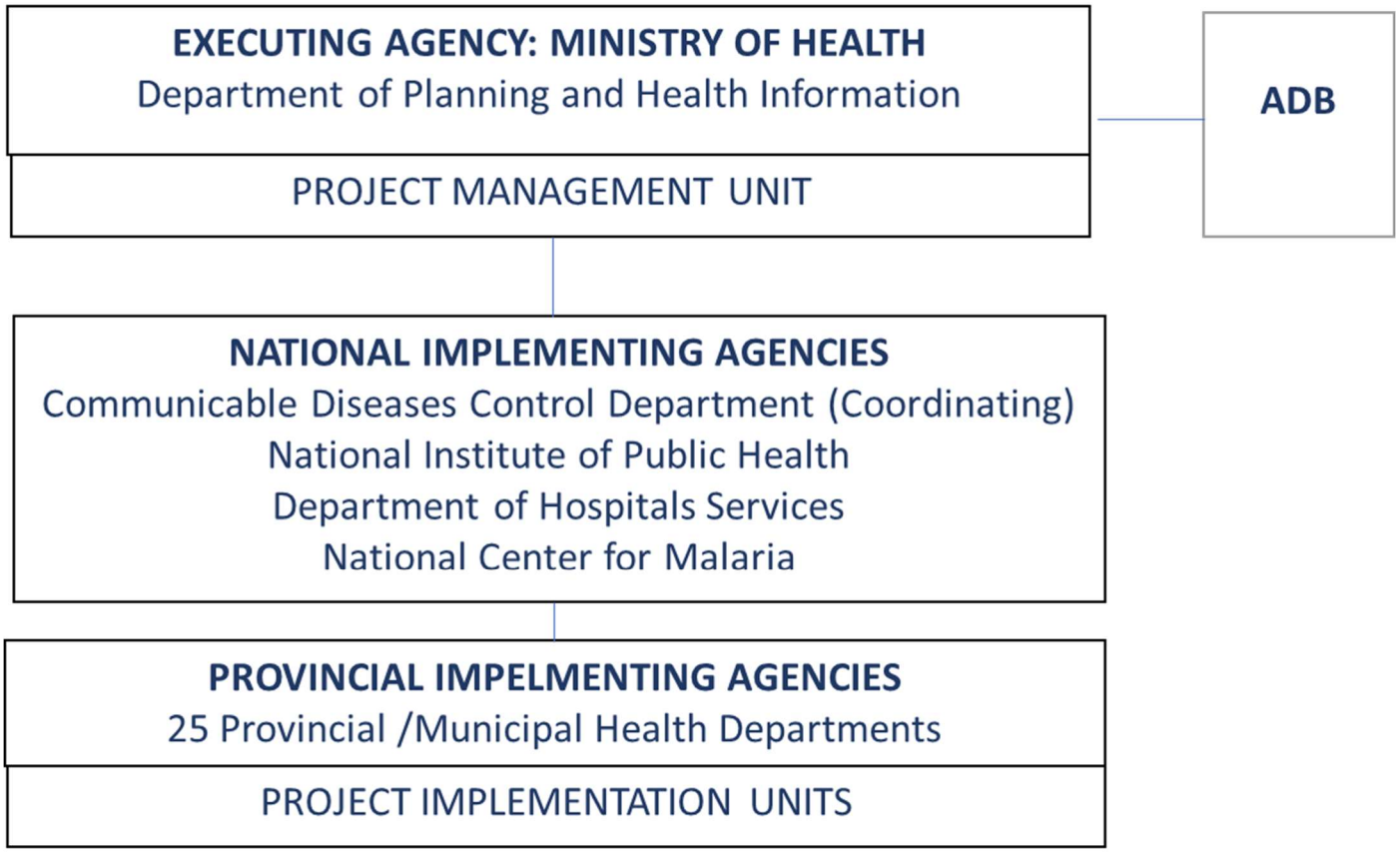

Figure 1: Organization Structure

IX. BUDGET AND FINANCING

56. The indicative cost for implementing and monitoring the IPP is estimated to be 8,800 (Refer to **Table 12**). MOH will bear the cost as part of their counterpart contribution and will use the funds as and when required.

Table 12: Indicative IPP Implementation Budget

Items	Unit	Quantity	Unit price ($/ unit)	Amount ($)
Consultation and Information Sharing	Number	10	500	2,500
Interpretation/translation into IP languages and leaflet/brochure	Lump sum			2,500
Grievance Redress+ Monitoring	Lump sum			3,000
Total				**8,000**
Contingency (10%)				**800**
GRAND TOTAL				**8,800**

X. INDICATIVE IMPLEMENTATION SCHEDULE

57. Given the urgent nature of the purpose of the loan, it will have approximately two years implementation period, from 1 November 2021 to 31 October 2023. The IPP will be implemented in parallel with other activities.