

**Cambodia - Second Health Sector Support Program
Indigenous Peoples Planning Framework (IPPF) for
the Third Additional Financing**

July 6, 2015

The Third Additional Financing (AF3) of the Second Health Sector Support Program (HSSP2 – P102284) is prepared to reflect the additional donor receipts to support the Multi Donor Trust Fund (MDTF) of HSSP2. The additional funds consist of AUD 8 million (US\$ 6.26 million equivalent) and Euro 6 million (US\$ 6.74 million equivalent) from the Government of Australia and Germany, respectively. These funds will be used to: (a) cover a financing gap for an additional 6 months from July 1, 2015 to December 31, 2015, for the Service Delivery Grants (SDGs) in existing 36 Special Operating Agencies (SOAs); and (b) scaling up of Health Equity Funds (HEFs) from 61 to all 88 Operational Districts (ODs) in the country. These activities are consistent with the original Program and the First and the Second Additional Financing (AF1 and AF2) support. There is no new activity under AF3. The Original Program funds have not been fully disbursed and will be used during the implementation of AF3 to finance civil works and procurement of equipment that had already been planned as part of the original Program. The AF3 is expected to have a positive impact on the lives of people throughout Cambodia by improving their access to, and utilization of, effective and efficient health services. Since no new activities will be introduced under AF3, the nature and scale of impact that may occur on Indigenous Peoples (IP) are expected to be similar to those under the original Program and the AF1 and AF2, and the IP communities will continue to benefit from AF3.

Since activities supported by the original Program, AF1, AF2, and to be supported by AF3, have nationwide coverage accordingly, the Program will be prepared and implemented in a manner consistent with World Bank Operational Policy on Indigenous Peoples (OP 4.10). The policy is intended to ensure that indigenous people are afforded opportunities to participate in, and benefit from, the project in culturally appropriate ways. The policy requires that a process of free, prior, and informed consultation be undertaken with the affected indigenous peoples' communities, and that such consultations establish that there is broad community support for the Program. The Indigenous Peoples Planning Framework (IPPF) was prepared under the original Program. The objective of the IPPF was to identify health care priorities and constraints in ethnic minority communities, and to ensure that the Program designs and targets health care improvements are culturally appropriate and inclusive in both gender and intergenerational terms.

To ensure compliance with OP 4.10 for HSSP2, a two-step, free, prior and informed consultation process had been designed under the Original Project. The first step of this consultation process was completed during the original Program preparation and confirmed broad community support of IP communities to HSSP2. The second step was undertaken during the implementation of HSSP2 in line with provisions of IPPF and as part of the preparation for AF2 in the form of social assessment, which included free, prior and informed consultations with IP communities. IP perspectives on the access to health services were collected as inputs to further improve the project designs and amend the IPPF. Continued support of IP communities to the project was also confirmed.

During the implementation of the original Program and AF1, measures were taken to address constraints of access to health care services identified by the IP. These measures include supporting the national programs and the ministry's departments for building technical capacity

of health staff working at subnational level throughout the country, including health staff working in IP areas; and financing SDGs for 36 Special Operating Agencies (SOAs) for improving service delivery performance. These 36 SOAs are located mostly in remote and difficult to access areas where they are homes of many IPs. In the non-SOA areas, the measures include supporting health outreach activities for providing basic preventive and curative services to the people in the communities, and supporting community participation in health outreach activities and the functioning of health center management committees. The measures also include supporting the construction of additional health facilities in remote areas including areas where IP are present, in order to improve physical access to health services. To date, 121 health centers (HCs), five health posts (HPs), 26 additional delivery rooms (ADRs), two regional training centers (RTCs), one provincial referral hospital (PRH), the phase one of the national laboratory for drug quality control and 14 RHs' maternity rooms have been constructed under HSSP2, of which 57% of the HCs and HPs, 70% of ADRs, both of the RTCs, one PRH and 43% of RHs' maternity rooms were constructed in IP provinces. In addition, HEFs were strengthened to cover expenses for health care services utilized by the poor including IP. Under AF2, SDG operating costs are mandated for conducting expended package of health outreach activities regularly in remote and difficult to access areas where there also homes of IPs. The results from the health outreach activities conducted in remote and difficult to access areas will be monitored and reported in the project implementation progress reports. By the end of 2014, the HEFs have been introduced to one national hospital, 72 RHs (77% of all RHs) and 602 HCs (59% of all HCs), which led to the increased coverage of HEF in the health facilities which serve many IP communities.

AF3 for HSSP2

The following is a summary of the anticipated activities as a result of AF3.

Component A: Strengthening Health Service Delivery. Financing of SDGs in existing 36 SOAs.

Component B: Improving Health Financing. Financing HEFs in the existing 61 ODs and scaling up in 27 additional ODs (to cover all 88 ODs in the country) covering all estimated 3 million poor people or 100 percent of the poor in Cambodia by end of 2015. The existing Subsidy Schemes (SUBOS) at the HC level financed from the national budget will be streamlined into the HEF scheme. F

Component C: Strengthening Human Resources. No additional financing.

Component D: Strengthening Health System Stewardship Function. No additional financing.

Constitution of the Kingdom of Cambodia related to indigenous peoples

Legal Framework

Below describe national and international policy framework and legal instructions relevant to the IPPF preparation and the right to health.

A. Relevant Laws and Regulation in Cambodia

In Cambodia, there are no specific laws or legal instructions regarding the rights of the Indigenous Peoples. However, some existing laws and regulations are relevant. In 1997, a special Interministerial Committee for Highland Peoples Development released a General Policy for Highland Peoples Development. The draft policy, culminating from a long process of

consultations among local groups, NGOs, international development agencies and the government, explicitly states “targeted scholarship schemes” as an “actionable measure.” However, this draft policy has yet to be sent to the National Assembly.

The Cambodia Constitution (1993) supports the right to health by full consideration to disease prevention and medical treatment, free medical consultation in public facilities for the poor, and establishment of infirmaries and maternities in rural areas. Article 46 states “The state and society shall provide opportunities to women, especially to those living in rural areas without adequate social support, so they can get employment, medical care, and send their children to school, and to have decent living conditions”. Article 48 states “The State shall protect children from acts that are injurious to their educational opportunities, health and welfare”.

Indigenous Peoples are Cambodian citizens. **The Cambodian Constitution (1993)** states that all citizens have the same rights, regardless of race, color, language or religious belief (Article 31). Indigenous peoples are regarded as citizens of Cambodia. Cambodia is a signatory to a number of international instruments that protect the rights of indigenous peoples, as well as the Convention on Biological Diversity (1992), which recognizes the role of indigenous people in protecting biodiversity. In 1992, the Cambodian Government ratified the International Covenant on Economic, Social and Cultural Rights. This includes the rights to practice specific culture and the rights to means of livelihoods, NGO Forum on Cambodia.

Health Strategic Plan 2008 – 2015 (HSP2) intends to enhance sustainable development of the health sector for better health and well-being of all Cambodian, especially of the poor, women and children, contributing to poverty alleviation and socio-economic development.

Law on the Prevention and Control of HIV/AIDS was enacted by the National Assembly on June 14, 2002. The objective of this law is to determine measures for prevention and control of the spread of HIV/AIDS in the Kingdom of Cambodia.

B. International Legal Instruments which Cambodia adopted

UN Declaration on the Right of Indigenous People was adopted by the United Nations General Assembly in September 2007. Many countries in the world including Cambodia have voted in favor of this nonbinding declaration.

International Convention on the Elimination of all Forms of Racial Discrimination (“ICERD”). Article 5(e) ensures the enjoyment, on an equal footing and without discrimination, of economic, social and cultural rights, in particular the right to public health, medical care, social security and social services.

International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 includes provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; the creation of conditions which would assure to all medical service and medical attention in the event of sickness. Government of Cambodia ratified the ICESCR in 1992.

UN Convention on the Rights of the Child, rectified by the Cambodia Government in 1992: Every child has the right to facilities for the treatment of illness and rehabilitation (article 24); the right for the purposes of care, protection or treatment of his or her physical or mental health (article 25); and the right to benefit from social security, including social insurance (article 26).

C. The World Bank Policy (on Indigenous Peoples (OP4.10))

This policy contributes to the World Bank's twin goals to end extreme poverty and promote shared prosperity by ensuring that the development process fully respects the dignity, human rights, economies, and cultures of Indigenous Peoples. For all projects that are proposed for Bank financing and affect Indigenous Peoples, the Bank requires the borrower to engage in a process of free, prior, and informed consultation. The Bank provides project financing only where free, prior, and informed consultation results in broad community support to the project by the affected Indigenous Peoples. Such Bank-financed projects include measures to: (a) avoid potentially adverse effects on the Indigenous Peoples' communities; or (b) when avoidance is not feasible, minimize, mitigate, or compensate for such effects. Bank-financed projects are also designed to ensure that the Indigenous Peoples receive social and economic benefits that are culturally appropriate and gender and inter-generationally inclusive.

The Bank recognizes that the identities and cultures of Indigenous Peoples are inextricably linked to the lands on which they live and the natural resources on which they depend. These distinct circumstances expose Indigenous Peoples to different types of risks and levels of impacts from development projects, including loss of identity, culture, and customary livelihoods, as well as exposure to disease. Gender and intergenerational issues among Indigenous Peoples are also complex. As social groups with identities that are often distinct from dominant groups in their national societies, Indigenous Peoples are frequently among the most marginalized and vulnerable segments of the population. As a result, their economic, social, and legal status often limits their capacity to defend their interests in and rights to lands, territories, and other productive resources, and/or restricts their ability to participate in and benefit from development. At the same time, the Bank recognizes that Indigenous Peoples play a vital role in sustainable development and that their rights are increasingly being addressed under both domestic and international law.

Project Impact on Indigenous Peoples

The social assessment undertaken during the preparation of AF2 ascertained continued broad community support of IP communities to HSSP2. It also showed that despite the achievements made during the original project and the AF1, ethnic minorities still face challenges in accessing quality health care services and tend to be vulnerable to poor health. These challenges include:

- *Poor access to health care services:* Although health outreach activities are conducted in 100% of villages and 80-90% of children received vaccination, only 55% of villages in IP communities received antenatal care and post natal care through health outreach activities. Some children did not receive vaccination due to the short duration of health outreach activities conducted in the IP communities. The knowledge about maternal health services available at health centers is only 71%, and access to these services

maybe lower. Malaria and dengue remain key concerns for IP while typhoid fever is a key concern for villages located near waterways.

- *Costs are unaffordable:* In IP areas the coverage of HEFs at the health center level is very limited. Transport expenses were not covered by HEFs in some instances.
- *Limited ethnic minority participation in health management structure and planning process:* IP participation in health planning and monitoring process is limited to the participation in the meetings of health center management committee (HCMC). In remote and mountainous areas it is difficult to maintain the HCMC meetings regularly due to high transport costs and geographical constraints, particularly during the rainy season. At present, there is a lack of formal mechanisms at provincial and district level to facilitate consultations and dialogue with IP in the design and monitoring of provincial and district annual health operational plans and the annual health sector review processes.
- *Health workers are not from local communities:* Having health providers who can speak IP languages encourage IP to report their voice and their concerns or grievances. It is far more likely that IPs are satisfied with the costs of health services that they receive, and feel that services provided by health facilities are sensitive to their cultural and ethnic identity. Although almost every health center in IP community areas has at least one staff who can speak IP language, only 45% of health centers have health providers who can speak IP languages.
- *Limited community health education and awareness raising activities:* Some IEC/BBC materials that target IP communities have not been made available to IP communities, except IEC material for communicable diseases such as HIV, TB and malaria supported by the Global Fund projects.
- In addition, low quality of health care services, limited opening hours, staff unavailability, financial barriers, supply shortages at facilities, and professional attitudes among health care providers remain areas for further improvement.

The IPPF of AF2 has been updated to reflect lessons gained from the AF2 on measures for improving access to quality health services by ethnic minority population in the remote and difficult to access areas. The AF3 continues to improve equitable access to essential health care and preventative services. The AF3 is national in coverage and the target beneficiaries are mothers, children, and the poor, but the Program is envisioned to improve access to health care for all Cambodians especially those who live in remote areas including IP communities. Given the Program’s focus on maternal and child health, children and women of reproductive age, including children and mothers of IP communities, are expected to benefit significantly.

The table below gives an overall picture of how the Project will address key constraints identified in the recent consultations with ethnic minorities and taking into account experience learned during implementation of AF2. The exact actions to be taken, however, will likely differ in different locations reflecting the particular needs and challenges facing the different ethnic groups.

Constraints Identified by Ethnic minorities	Remedial Measures Proposed by Stakeholders	Project Plans in Mondolkiri , Ratanakiri, Stung Treng and Kratie and other areas where large populations of ethnic minorities live
Physical access.	Reduce transport cost for remote communities	Support SDGs to SOAs for conducting health outreach activities regularly following Updated Health Outreach Guidelines (of February 2013). Planning particularly on

	including IP.	expanded package of health outreach activities to remote and difficult to access areas to be added into the service delivery performance contracts of all OD SOAs. Reimburse transport costs following the policy on direct benefits of HEF schemes.
Costs are unaffordable.	Ensuring that all poor ethnic minority people will be covered by HEFs.	The project will scale-up HEFs to cover all poor, including poor ethnic minorities in the country. HEF operators will conduct awareness raising about HEF benefits for the poor ethnic minority groups and their community leaders.
Limited ethnic minority participation in health management structure and planning process.	Indigenous community participation in designing and making decisions about primary health care.	Allocate funds to ensure regular Health Center Management Committee meetings with high rate of participation from members, particularly members from remote and difficult to access communities. The performance will be monitored and followed-up by OD level. Health service providers are obligated to foster and support community participation in planning and monitoring service delivery.
Health workers are often absent from facilities.	Strategy to improve staff attendance at health facilities, balancing service delivery in remote and difficult to access communities and health facilities 24 hours opening.	Introduce the Performance Management and Accountability System for monitoring every staff performance. Strengthening accountability of SOA managers to ensure performance monitoring, including spot checks to health facilities, and linking staff attendance to SDG performance incentives. Encourage feedback on health facility opening and staff attendance through HEF monitoring system.
Health workers are not from local communities.	Induction about cultural awareness for community based health workers working in ethnic minority areas.	Every health operational district in ethnic minority areas will organize induction session about cultural awareness for health facility staff and for new staff appointed to work in indigenous/ethnic minority areas.
Competency of health worker working at HC level is limited	Strategies to improve competency of health staff working at HC level .	The MoH plans to allocate at least one secondary midwife to every HC by 2015. Training in specific modules of (Minimum Package of Activities) based on needs assessment. Logistics training for relevant health staff to improve pharmaceutical and commodity supply chain management. These activities may be financed through SDGs or the national budget. A quality of care tools level 2 assessment is being conducted in all health facilities in 2015, including health facilities in IP areas, to score technical quality and identify areas for improvement.
Limited community level health education and awareness raising activities	Increase health education and behavior change communication activities in IP communities	Allocation of budget to the National Center for Health promotion for developing IEC materials that are culturally suitable for IP. Allocation of budget to support training, provision of health education on IEC materials and monitoring.

Similar to the Original Program, two approaches will be taken to address social development issues: targeted assistance and mainstreaming. The project will target primary stakeholders by: (i) strengthening health services in particularly poor and disadvantaged geographical areas, including areas where IP communities reside, to increase access affordability and quality; and (ii) expanding social protection measures to remote areas where many IP communities are present to safeguard the most vulnerable groups from the cost of health care. With regards to mainstreaming, the principles of client-centeredness, pro-poor, social inclusion, gender equality, and stakeholder participation will be mainstreaming through the Project's support to sector reform and institutional development.

The project will build particularly on earlier program activities in Mondolkiri and Ratanakiri (which were more intensive than in Kratie and Stung Treng). The project's institutional development activities will strengthen capacity for lesson learning across the sector, and this will be particularly relevant for replicating good practices vis-à-vis ethnic minorities.

Institutional Arrangements for IPPF

Ministry of Health. The Project is embedded within the MOH's Health Sector Strategic Plan and is designed to strengthen the Ministry's capacity to move towards sector wide management. As such, MOH is responsible for the implementation of this IPPF. MoH will strengthen the National Community Participation Policy for Health to enhance stakeholder participations and expand the scope for CSOs and NGOs to improve health services, and address the particular concerns voiced by ethnic minorities.

Operational Districts. All operational districts in IP areas will monitor to ensure that all health centers in their catchment areas plan and regularly conduct expanded package of health outreach activities, Health Center Management Committee meetings and Village Health Support Group meetings with full participation of members. Each operational district will encourage local authority to raise awareness of the issues pertaining to the need for improved health services for the local community, particularly for remote and difficult to reach population, and ensure the participation of District Councils and District Development Committee in the annual health review meetings, and operational district managers in the regular local government meetings.

Health Centers. Health Centers that participate in the project play the primary role in the implementation of IPPF. All health centers in IP areas will plan and conduct health outreach activities, particularly for remote and difficult to reach population, following the Outreach Management Guidelines updated in February 2013, taking into consideration when the target population is present in the community. In addition, all health centers in IP areas will implement the Community Participation Policy for Health with the goal of organizing accessible, affordable, affective, and sustainable quality health services, adapted to the specific community needs.

World Bank. The World Bank through its Task Team will monitor the compliance with this IPPF by the borrower and the health care facility operators and the implementation of measures to address key constraints identified in the recent consultations with ethnic minorities.

Monitoring and reporting arrangements

The project will assist the Ministry of Health in its efforts to reform sector wide monitoring and evaluation to include civil society participation in the process, and to address social variables such as gender. Annual reviews of sector performance will be conducted to monitor progress on disaggregated achievements in accessibility, public and client satisfaction, and health utilization by level of health system as well as by gender. The monitoring and evaluation of the implementation of this IPPF will be carried out through the strengthened sector wide monitoring and evaluation mechanisms.

Disclosure arrangements

The borrowers make the draft IPPF available to the affected Indigenous People's communities in an appropriate form, manner, and language. Before project appraisal, the borrower sends the draft IPPF to the World Bank for review. Once the World Bank accepts the documents as providing an adequate basis for project appraisal, the World Bank makes them available to the public in accordance with the World Bank Policy on Disclosure of Information, and the borrowers makes them available to the affected Indigenous People's communities in the same manner as the earlier draft documents.