

Ministry of Health
Health Equity and Quality Improvement Project (H-EQIP) (P167351)
Supplemental Indigenous Peoples' and Ethnic Minority Consultations

Indigenous Peoples Planning Framework
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1. Introduction

Cambodia's public health care system has experienced dramatic improvement since the late 1990's when health services were mostly provided by non-governmental organizations (NGOs) following two decades of civil war and intense political instability. Increasing political stability since the late-1990s has enabled a re-building of the public health system. Health sector reform has been guided by a long-term process of national health planning, with the Ministry of Health (MoH) increasingly assuming the lead in health-system planning and development. Development partners have provided technical and financial assistance for health policy-making and the implementation of activities in support of MoH objectives, as outlined in the Health Strategic Plans.

The first comprehensive Health Strategic Plan (HSP1) was implemented in 2002–2007. The second Health Strategic Plan (HSP2) is currently being implemented and focuses on three priority areas: maternal and child health, communicable diseases and non-communicable diseases. HSP2 identifies the need for improvement in health-service delivery, health financing, human resources for health, health information systems and health-system governance. The 2011 mid-term review of the HSP2 stated that further progress on outcome indicators would require more focus on governance, management, regulation, and increased community involvement, especially at district and provincial levels. The MoH is currently finalizing the third Health Strategic Plan (HSP3) 2016–2020. World Bank coordinated pool funding supported the implementation of the two previous Health Strategic Plans through the Health Sector Support Project (HSSP1) and the Second Health Sector Support Program (HSSP2). The proposed Health Equity and Quality Improvement Program (H-EQIP) will support targeted parts of the larger HSP-3 program, specifically those related to financial protection and improving the quality of health services.

While there have been tremendous improvements in health-system performance, reflected in substantial health gains, in comparison with other countries in the region, there is still much room for improvement. There have been strategic recruitment efforts to address both the shortage and the skill-mix of government health staff, particularly in maternal health, with a significant increase in the number of midwives and a more modest increase in nurses since 2005. Nurses and midwives together comprise 68% of the public health workforce, reflecting a focus on rural and primary care services. Improvements have been made in service coverage, especially in the delivery of maternal and child health care following the implementation of the Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality, providing increased coverage of skilled birth attendance and other safe motherhood services. Cambodia is on track to achieve the health-related Millennium Development Goals as indicated by preliminary findings of the 2014 Cambodia Demographic and Health Survey. The overall maternal mortality ratio fell from 472 per 100,000 live births in 2005 to 206 in 2010 and 170 in 2014. Under-five mortality decreased from 83 per 1,000 live births in 2005 to 54 in 2010 and 35 in 2014. The total fertility rate has also fallen from 3.4 in 2003 to 2.7 in 2014.

The provision of health care in Cambodia is a mixed health system comprised of numerous service providers, with various funding sources. Private practitioners and clinics are particularly frequented for curative care, whereas health promotion and prevention activities, such as essential reproductive, maternal, neonatal and child health, tuberculosis, malaria and HIV/AIDS control, are the domain of the public sector. In rural areas only 23.5% of unwell or injured patients sought care first in the public sector, while 64.7% sought care for their last

episode at private providers, according to the 2014 Cambodian Demographic and Health Survey.

The successful expansion of the health infrastructure, relatively low levels of utilization, and the rapid increase in the number of private providers all focus attention on the limitations of public health-service delivery, in particular the persistently low quality of care. The health reform process is dynamic and requires a balance between supply and demand initiatives over time. Improving the quality of care is now the priority in health-system strengthening. Providing access for the poor has been at the heart of health reforms. Health Equity Funds (HEF) have proved to be an effective mechanism for providing access to health services and financial protection for the poor, as well as a regular source of supplementary income for public health facilities. Now reaching national coverage, the MoH and donor partners are working together to create a uniform model and a central administration of the district-based HEFs within the MoH. Due to the development of quality care initiatives and the reduction of financial barriers to access services, utilization of public health facilities is slowly increasing.

Remaining challenges include high neonatal mortality, high numbers of children being stunted, the double disease burden of high communicable and non-communicable diseases, as well as high rates of adolescent pregnancy. There are also significant concerns around quality of care and significant inequalities in health outcomes by socio-economic status and between urban and rural populations; with provinces that contain concentrations of indigenous peoples'/ ethnic minorities populations displaying the lowest health outcome indicators in the country, markedly lower than rural averages and significantly lower than urban averages.

2. Project Description

The H-EQIP will build on the innovations supported in the Second Health Sector Support Program (HSSP2), particularly HEFs and SDGs, and aims to increase the sustainability of these innovations by improving their resourcing and management as envisaged in the RGC's HSP-3. It will further strengthen the results-based focus of both HEFs and SDGs with a specific goal of improving quality of health service delivery and utilization of services by the poor. In addition, the Project will use a multi-pronged approach to strengthening health systems, especially to support improvements in quality of care, by focusing on enhancing provider knowledge through both pre-service and in-service training, improved availability of critical infrastructure in health facilities, and strengthening Public Financial Management (PFM). Using a set of disbursement-linked indicators (DLIs), the Project will disburse funds against targets achieved on these health system strengthening measures. Another key strategic shift is to attain institutional sustainability through a transfer of responsibility for third party HEF verification from an internationally recruited firm to an independent Government agency which will be established by June 2018, and extending this responsibility to include verifying SDG results at all levels of the health system. The final IPPF for the H-EQIP had been publicly disclosed on the MOH's website and the World Bank's website in April 01, 2016 and April 11, 2016, respectively.

In June 2018, nineteen months since H-EQIP project effectiveness, an additional financing (AF) is proposed. The AF would support the supply side readiness and availability of key services that are or will be integrated into the expanded HEF benefit package, with a focus on non-communicable diseases including cervical cancer screening and treatment, diabetes and hypertension screening and treatment. Long-term family planning services will also be supported. This will be done through additional three additional new DLI indicators under

Component 3 (subcomponent 3.1): (a) new DLI on availability and utilization of cervical cancer screening and treatment services; (b) new DLI on availability and utilization of diabetes and hypertension screening and treatment services; and (c) new DLI on availability and utilization of long-term family planning services. As with the original project, the AF will be national in scope and coverage.

The social assessment conducted during the preparation of the Original Project is still applicable to ongoing and proposed new activities. During the implementation of the Original Project, steps were taken to address issues found during preparation based on the free, prior and informed consultations with affected IP communities. Such measures include: (i) providing Fixed Lump-sum Grants to health facilities for spending on emergency needs for providing quality of service delivery; (ii) conducting the NQEMP to regularly monitor quality of health service delivery, including ensuring proper diagnosis and treatment, improving infection prevention and control, and ensuring service availability -- 24 hours opening and staff attendance -- so that IP can access health care services at any time as needed; (iii) providing additional performance-based SDG for improving coverage of health care services in remotes/difficult to access areas so that IP in remote and difficult to access communities can receive basic preventive and curative services; (iv) financing HEF scheme to pay for health care services on behalf of the poor, including poor IP; and (v) construction of new health facilities for bringing health services closer to IP. Regular client interviews have been conducted with users, including those from ethnic minorities, as part of the implementation of the Original Project, which found that they are satisfied with the services provided and that no negative impacts occurred to them under the project. The Indigenous Peoples Planning Framework (IPPF) and measures as described above remain valid for the activities proposed under the AF. The nature, scale and scope of impact that may occur on IP under the AF are expected to be similar to those under the Original Project, and IP communities will continue to benefit from the Project.

Project Component Descriptions

The H-EQIP will build on the innovations supported in the Second Health Sector Support Program (HSSP2), particularly HEFs and SDGs, and aims to increase the sustainability of these innovations by improving their resourcing and management as envisaged in the RGC's HSP-3. It will further strengthen the results-based focus of both HEFs and SDGs with a specific goal of improving quality of health service delivery and utilization of services by the poor. In addition, the Project will use a multi-pronged approach to strengthening health systems, especially to support improvements in quality of care, by focusing on enhancing provider knowledge through both pre-service and in-service training, improved availability of critical infrastructure in health facilities, and strengthening Public Financial Management (PFM). Using a set disbursement-linked indicators (DLIs), the Project will disburse funds against targets achieved on these health system strengthening measures. Another key strategic shift is to attain institutional sustainability through a transfer of responsibility for third party HEF verification from an internationally recruited firm to an independent Government agency which will be established by June 2018, and extending this responsibility to include verifying SDG results at all levels of the health system.

COMPONENT 1: Strengthening Health Service

This Component will expand the current SDGs into a mechanism for providing performance-based financing to different levels of the Cambodian primary and secondary health system based on achievement of results. The SDGs at health centers and hospitals will be performance-linked against delivery of a basic and comprehensive package of services. This will include critical reproductive, maternal, neonatal, child and adolescent health services. Nutrition will also be one of the indicators prioritized covering early breast feeding, vitamin A supplementation, deworming, iron folic acid supplementation and growth monitoring. The Project aims to use performance-based payments under SDGs to complement the RGC's proposed fixed grants to health facilities, particularly by streamlining the funds flow and reporting arrangements envisaged for the same. These new lump-sum grants will form part of the SDG system through joint Prakas to be issued by the Ministry of Economy and Finance (MEF) and MOH, and are intended as a complement to the facilities' operational budget.

Sub-component 1.1: Service Delivery Grants: Health Centers

The Project will provide SDGs to HCs to help finance the MPA of HCs. The amount and payment of the grants will be based on the utilization (i.e. quantity) of services provided and on the quality of services. Initially, the OD, with its HCs will be considered as one unit and will implement the joint Prakas issued by the MOH specifying services to be provided. The quantity and quality of service delivery by the HCs, including utilization by the poor and vulnerable will be systematically determined by the respective OD through a new, standardized supervision checklist to be detailed in the updated SDG manual, and applied quarterly. The results would be cross-checked and verified by an independent agency (initially by the Health Equity Fund Implementer, HEFI, and, after its establishment, by the independent government agency acting as a payment certification agency (PCA) proposed for HEFs. Once the results have been verified, the MOH will inform MEF to make relevant SDG payments. Eligible categories of expenditure for SDGs at the HC level would include minor works, goods, and emergency purchase of drugs and/or recurrent costs including supplies, short term staff, consumables, communications, maintenance, transportation, accommodations, training, other incidental expenses and performance bonuses for health workers.

Sub-component 1.2: Service Delivery Grants: Referral Hospitals

This sub-component aims to incentivize improvements in the quality of care at the secondary level, improve performance in capacity building activities for in-service and pre-service candidates, and promote utilization of services by HEF beneficiaries. Using a new standardized supervisory checklist, to be included in SDG Manual, hospitals will be measured quarterly on their performance on structure, process, and outcomes. Structural measures will comprise the context in which care is delivered, including infrastructure, staff, financing and equipment. Process measures will include the technical and interpersonal process and actions that make up health care as reflected in the transactions between patients and providers and staff throughout the delivery of health care. Facilities will also be encouraged and rewarded for initiating quality improvement processes including self-assessments of quality and patient safety, continuous quality improvement, peer to peer evaluations and adverse event audits. Outcomes refer to the effects of health care on the status of patients and populations and will be considered to be a result of inputs and processes of care. The results would be cross-checked and verified by the independent agency (initially the HEFI and subsequently the PCA). Eligible categories of expenditure for SDGs at the hospital level are similar to health centers and include minor works, goods, drugs and/or recurrent costs including supplies, short term staff, consumables, communications, maintenance, transportation, accommodation, other incidental expenses as well as performance bonuses for health workers.

Sub-component 1.3: Service Delivery Grants: PHDs and ODs

These SDGs aim to strengthen the management of ODs and PHDs. The performance of ODs and PHDs will be measured every six months by the Quality Assurance Office (QAO) of MOH, against their self-reported activities on a score card to be detailed in the SDG Manual, measuring key supervisory processes and health system outputs. These include: (i) timely completion of quality checklists for health facilities in their jurisdiction; (ii) contribution to capacity building activities for in-service and pre-service training; (iii) drug stock outs in health facilities, human resources availability; (iv) Health Management Information System (HMIS) reports submitted; (v) quarterly review meetings and system functionality. Similar to the other SDG grants, the proposed independent PCA would verify the PHDs' and ODs' performance. Eligible SDG categories of expenditure for ODs and PHDs will include minor works, goods, and/or recurrent costs including supplies, short term contracts, consumables, communications, maintenance, transportation, accommodation, other incidental expenses as well as performance bonuses.

COMPONENT 2: Improving Financial Protection and Equity

This component will continue to support the HEF system and co-finance with the RGC the cost of health services for the poor. The current HEF system is expected to evolve with changes in Government policy on beneficiaries and benefit packages and social health protection. Vouchers will be fully integrated into the HEF. This component would build on the current success of the HEF system, aiming to improve the quality of services, increase utilization by the poor, and ensure sustainability by transferring implementation responsibility to the RGC.

COMPONENT 3: Ensuring Sustainable and Responsive Health Systems

Sub-component 3.1: Health System Strengthening

This sub-component will support a program of activities designed to improve supply side readiness and strengthen the institutions that will be implementing project activities. This includes the implementation of comprehensive pre-service and in-service training programs for health workers, equipment of health facilities to meet minimum standards for the provision of obstetric and neonatal care, carrying out of enhanced health service quality monitoring, improved timeliness of SDG and HEF payments, and establishment of sustainable health service purchasing arrangements.

Financing for this sub-component will be provided based on results tracked by DLIs, which are a set of tracer indicators with annual targets, aimed at measuring performance against health system strengthening actions.

The AF is proposed to support the supply side readiness and availability of key services that are or will be integrated into the expanded HEF benefit package, with a focus on non-communicable diseases including cervical cancer screening and treatment, diabetes and hypertension screening and treatment. Long-term family planning services will also be supported.

Sub-component 3.2: Health Infrastructure Improvements

Approximately US\$13 million from Component 3 is expected to finance civil works as per priorities identified by MOH in their civil works plan 2016-2020. Prioritization will be based on access issues, attention to remote areas, concerns around patient safety and improving maternal and neonatal survival. A joint assessment with RGC, to identify priorities for infrastructure investments, will be undertaken and the final list of civil works will be identified

in the first half of 2016. The expected type of investments will include maternity wards and other infrastructure for emergency maternity and neonatal services, HCs and hospitals.

Sub-component 3.3: Project Management, Monitoring and Evaluation

Project management will be integrated into the responsible departments of the MOH. This Component will support provision of technical and operational assistance for the day-to-day coordination, administration, procurement, financial management, environmental and social safeguards management, and monitoring and evaluation of the Project, including the carrying out of financial audits of the Project. The subcomponent will also support capacity strengthening of responsible departments within the MOH to smoothly transfer the responsibility of project management from the currently existing Secretariat under HSSP2 to the relevant departments, as well as to support other implementation needs.

A technical assistance (TA) grant from the Japan Policy and Human Resources Development (PHRD) Trust Fund, a programmatic Trust Fund administered by the World Bank, of an amount of US\$1 million will provide complementary financing to Component 3. The grant is expected to contribute to the strengthening of Cambodia's Health Information System to ensure availability of relevant, timely and high quality health and health-related data to allow for evidence-based policy formulation, decision-making and management and planning. Support will be provided in four areas: (i) support for upgrading the HMIS including development of policy/regulation, protocols/guidelines and reporting system; (ii) TA to improve data management, analysis, interpretation, reporting, use, and dissemination (at central and decentralized levels); (iii) strengthening medical record systems including expansion of Patient Medical Registration System database; and (iv) enhancement and integration of disease surveillance and response systems (communicable diseases as well as non-communicable diseases). This financing has been approved in principle but will become available upon formal endorsement by the Japanese Government and the PHRD Unit and will be funded by Japan PHRD Trust Fund under its Performance and Results with Improved Monitoring and Evaluation window.

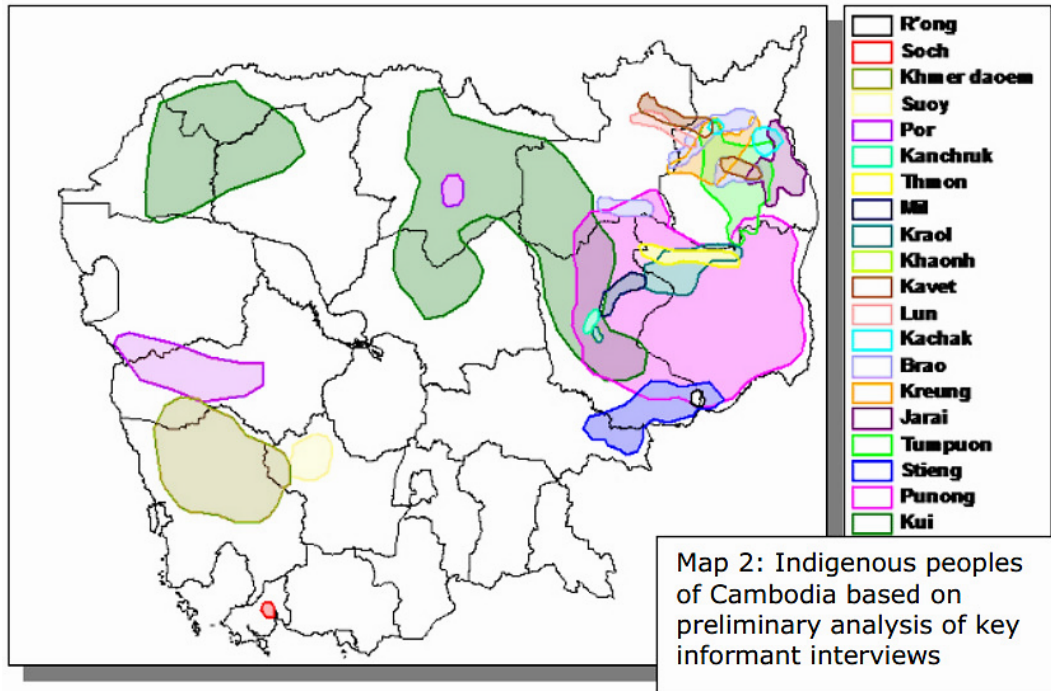
COMPONENT 4: Contingent Emergency Response

The objective of the contingent emergency response component, with a provisional zero allocation, is to allow for the reallocation of financing in accordance with the IDA Immediate Response Mechanism in order to provide an immediate response to an eligible crisis or emergency, as needed.

The Program beneficiaries are the population of Cambodia, particularly the poor and vulnerable, and health care providers working in the public health sector.

The map below gives an overview of the geographical distribution of Indigenous Peoples in Cambodia¹:

¹ Source: NGO Forum (Cambodia) 2006.



The Cambodian definition of ethnic minorities does not include Vietnamese, Chinese and other groups who are considered ‘migrants’, despite many living in Cambodia for generations due mainly to they reside in areas with easier access to public services and most of them are not as poor as people living in remote and mountainous areas. If a wider definition of ‘ethnic’ groups were to be applied to include Cham, Lao, Vietnamese and Chinese populations, then the non-ethnic Khmer population is estimated to be approximately 6% of Cambodia’s total population. Indigenous Peoples’ groups are dispersed widely across Cambodia, but are mainly concentrated in twelve province; they are presented below in descending order of population density, detailing the different ethnic groups present in each of the provinces.

Province	Indigenous Peoples Groups Present
1 Ratanakiri:	Phnong, Kreung, Jarai, Tumuon, Brao, Kavet, Kachak, Lun, Raadaer.
2 Kratie:	Phnong, Kraol, Steang, Thmoon, Kuoy, Mil, Khnong.
3 Mondulkiri:	Phnong, Kreung, Jarai, Kaol, Steang, Thmoon, Kuoy, Tumpuon.
4 Preah Vihear:	Kuoy, Poar.
5 Kampong Thom:	Kuoy.
6 Stung Treng:	Phnong, Kreung, Jarai, Kuoy, Tumpuon.
7 Odar Meanchey:	Kuoy, Phnong, Tumpuon, Jarai, Kreung, Steang, Kavet, Kraol, Kachak, Raadear, Kek.
8 Kampong Cham:	Steang.
9 Pursat:	Poar, Chong.
10 Kampong Speu:	Suoy.
11 Bantey Meanchey:	Kuoy.
12 Koh Kong:	Chong.

3. Potential Issues and Impacts on IPs

Due to the nature of the program the consultation with indigenous peoples/ ethnic minorities undertaken during the Social Assessment did not foresee any potential adverse effects of implementing the proposed H-EQIP. The consulted indigenous peoples/ ethnic minorities did not express any concerns about possible negative impacts of the proposed project due to its focus on improving access to quality health services and increasing protection against health related impoverishment through increased utilization of the HEF. During the consultation process conducted as part of the Social Assessment, participants overwhelmingly expressed support for the project if it would result in positive improvements to the health of their communities and the cultural appropriateness of services available at the hospital and Health Centres.

- Scale and magnitude of impacts (i.e., adverse, benign, reversible/irreversible, negative/positive, etc.) well described

Program Component	Potential Impacts	Scale of Impacts
<p>Component 1: Strengthening Health Service Delivery.</p> <p>Sub-component 1.1: Service Delivery Grants: Health Centres.</p> <p>Sub-component 1.2: Service Delivery Grants: Hospitals.</p>	<p>The project will rebuild the SDGs as a mechanism for providing performance-based financing to primary and secondary health facilities based on the actual achievement of results.</p> <p>The SDGs at health centers and hospitals will be performance-linked against delivery of a basic and comprehensive package of services. This will include critical reproductive, maternal, neonatal, child and adolescent health services. Nutrition will also be one of the indicators prioritized covering early breast feeding, vitamin A supplementation, deworming, iron folic acid supplementation and growth monitoring. The payment of Service Delivery Grants (SDGs) will be based on the utilization of services provided and quality of services, including increased utilization of services by the poor and indigenous/ ethnic minority populations.</p> <p>Eligible categories of expenditure include: minor works, goods, and emergency purchase of drugs and/or recurrent costs including supplies, short term staff, consumables, communications, maintenance, transportation, accommodations, training, other incidental expenses and performance bonuses for health workers. It is expected that these grants will translate into improved management, better provider behaviour, increased community participation and strengthened health service delivery at the Health Centre level.</p> <p>SDGs will be used to incentivize improvements in the quality of care available at health facilities, including the promotion of and increased utilization of services by HEF beneficiaries; to improve pre-service practical training and the provision of on-the-job training support for Health staff. The project will also introduce a specific performance based financing approach to improve the quality of targeted services.</p>	<p>Positive: Medium.</p>

<p>Sub-component 1.3: Service Delivery Grants: PHDs and ODs.</p>	<p>SDGs for PHDs/ ODs are aimed at strengthening management functions integral to the delivery of efficient high quality primary and secondary health services.</p>	
<p>Component 2: Improving Financial Protection and Equity.</p>	<p>This component of the project will build on the previous achievements related to the Health Equity Fund (HEF) system, aiming to improve the quality of services, increase utilization by the poor and indigenous populations, and ensure HEF sustainability by transferring implementation responsibility to the RGC.</p> <p>It is expected that this support will translate into increased utilization of the HEF by the poor and indigenous/ ethnic minority populations through enhancing targeting efficiency and reduced inclusion and exclusion errors, particularly for indigenous/ ethnic minority groups.</p>	<p>Positive: High.</p>
<p>Component 3: Ensuring Sustainable and Responsive Health Systems.</p> <p>Sub-component 3.1: Health System Strengthening.</p> <p>Sub-component 3.2: Health Infrastructure Improvements</p>	<p>This component aims to strengthen the Ministry of Health’s systems and support the management of the project.</p> <p>It is expected that this support will translate into increased efficiency of health systems management and increased responsiveness to the health needs of target beneficiaries, including the culturally specific health needs of indigenous peoples/ ethnic minorities.</p> <p>On the supply side, these SDGs will focus on addressing some of the key bottlenecks for improving the quality of services through improvements in the knowledge and practical skills of health providers, as well as through strengthening the health facilities to meet minimum standards for selected priority health interventions.</p> <p>The component also aims to strengthen institutional performance, specifically to support the establishment of new institutional structures to provide third party verification of HEFs and SDGs, and strengthening health information system.</p> <p>The AF will support the supply side readiness and availability of key services that are or will be integrated into the expanded HEF benefit package, with a focus on non-communicable diseases including cervical cancer screening and treatment, diabetes and hypertension screening and treatment. Long-term family planning services will also be supported.</p> <p>It is expected that this support will translate into improved access to primary care in marginalized communities, competency based training for health workers posted in Health Centres and the linking the payment of SDGs to health service performance and quality improvements.</p>	<p>Positive: Medium.</p>

Sub-component 3.3: Project Management, Monitoring and Evaluation.	The PHRD Grant is expected to contribute to the strengthening of Cambodia’s Health Information System to ensure availability of relevant, timely and high quality health and health-related data to allow for evidence-based policy formulation, decision-making and management and planning.	
Component 4: Contingent Emergency Response.	<p>The objective of the contingent emergency response component (<i>with a provisional zero allocation of funds</i>), is to allow for the reallocation of financing to provide an immediate response to an eligible crisis or emergency, as needed.</p> <p>The Global Climate Risk Index for 1994–2013 ranked Cambodia 12th most vulnerable country as 33% of its land is designated as a high flood risk zone. The Climate Risk Index for 2013 (<i>10 most affected countries</i>) ranked Cambodia as the second most affected country in 2013, after the Philippines. Many indigenous peoples and ethnic minorities reside in flood vulnerable areas. It is expected that this support will translate into improved health response when natural disasters occurs.</p>	Positive: Medium.

4. Legal, Policy and Regulatory Frameworks

- OP 4.10 presented and with rational for triggering

The World Bank safeguard policy on Indigenous Peoples (OP4.10) is triggered as the proposed program is nation-wide in coverage and includes the 12 provinces where indigenous peoples/ ethnic minorities reside and the predominantly indigenous peoples’ populated provinces of Mondulkiri and Ratanakiri. The World Bank OP 4.10 required that a process of free, prior, and informed consultation be undertaken with the affected indigenous peoples’ communities. The consultation focused on nine indigenous/ ethnic minority groups in four of the provinces with the highest concentrations of indigenous/ ethnic minority peoples. Whilst the World Bank Operational Policy on Indigenous People is primarily aimed at identifying possible adverse effects of the proposed program on indigenous peoples and ethnic minorities it also uses the consultation process to identify additional measures that may be required to provide indigenous peoples/ ethnic minorities with culturally appropriate program benefits and increase their participation during program implementation, monitoring, and evaluation.

- Country policies, laws, rules and regulations applicable to IPs

The Land Law (2001) is the only law identified that explicitly provides recognition of the rights of indigenous communities. According to Article 23: “An indigenous community is a group of people who reside in the territory of the Kingdom of Cambodia whose members manifest ethnic, social, cultural and economic unity and who practice a traditional lifestyle, and who cultivate the lands in their possession according to customary rules of collective use”. “Prior to their legal status being determined under a law on communities, the groups actually existing at present shall continue to manage their community and immovable property according to their traditional customs and shall be subject to the provisions of this law.”

The most important legal document in Cambodia is the Constitution of the Kingdom of Cambodia (1993). Article 72 of the Constitution is directly related to health, stating: “The health of the people shall be guaranteed. The State shall pay attention to disease prevention and medical treatment. Poor people shall receive free medical consultations in public hospitals, infirmaries and maternity clinics. The State shall establish infirmaries and maternity clinics in rural areas.” Cambodia’s Constitution (1993) recognizes and respects human rights guaranteed by international laws. Article 31 of the Constitution states that all Khmer citizens shall be equal before the law, enjoying the same rights and freedom and obligations regardless of race, colour, sex, language, religious belief, political tendency, national origin, social status, wealth or other status. However, the Constitution does not include specific reference to the country’s indigenous peoples or ethnic minorities.

In 2009 the Royal Government of Cambodia (RGC) issued the **National Policy on Indigenous People Development**. The policy provides general guidance to different government departments/ relevant institutions.

In relation to health policy, the **Health Strategic Plan 2008-15** has no specific mention of indigenous peoples or the identification of measures to address the specific health barriers that they face. Ethnic minorities are mentioned once in relation to cross cutting challenges. The Rectangular Strategy is the guiding policy document in Cambodia and sets-out a broad social protection framework. The **Rectangular Strategy Phase III** (2013) has two brief references to indigenous peoples related to land registration/ titling and does not mention ethnic minorities. The **National Strategic Development Plan (NSDP) 2014-2018** specifically mentions both indigenous peoples and ethnic minorities several times. Priority is focused on strengthening the existing national targeting mechanism (ID-Poor), enhancing targeting efficiency, reducing inclusion and exclusion errors, particularly of ethnic minorities. The NSDP mentions that an area of particular concern is the north-eastern provinces, where indigenous communities mainly dwell, these provinces are predominantly rural and to an extent ‘un-integrated’ in the national mainstream. Related to health the NSDP focuses on ensuring equitable access to quality health services by all Cambodians, maintaining high coverage of routine vaccine immunization; strengthening good governance, leadership, management and accountability mechanism in the context of decentralization and de-concentration, and enhancing local governance and community monitoring of health services efficiency. One of the rural development indicators (9.05) focuses on the number of ethnic minority communities whose identities have been recognized (*the measurable unit is community, the 2013 baseline target was 100, with a 2015 target set for 160 and a 2018 target set for 250*).

- Relevant international agreements host country entered into applicable to the project presented and fully explained (e.g., ILO 169)

Related to international law, Cambodia has signed the Convention on the Elimination of Racial Discrimination, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the International Convention on the Elimination of All forms of Discrimination Against Women, the Convention on the Rights of the Child, the Convention on Biological Diversity and voted in favour of UN Declaration on the Rights of Indigenous Peoples at the UN General Assembly. These international instruments contain a number of provisions related to the protection of the rights of indigenous peoples. While it has signed the ILO’s Discrimination (Employment and Occupation) Convention (No. 111), it has not signed the ILO’s Convention on Indigenous and Tribal Peoples (No. 169).

Overall Cambodia has been incorporating the provisions of human rights treaties into national legislation. However, some provisions of Cambodian laws are vague and contain loopholes, which weaken the enforcement of Cambodia's international human rights obligations. Cambodia has a mixed record on fulfilling its reporting requirements in relation to international legal commitments. For example in relation to the Convention on the Elimination of Racial Discrimination, Cambodia did not submit reports and present itself to the relevant UN Committee for questioning related to the country's performance between 2000 and 2010. After a ten year absence, in 2010 Cambodia presented and discussed six periodic reports with the Committee. In its concluding observations the Committee voiced concern regarding the treatment of minorities in Cambodia. On the issue of legislation in particular it noted a "lack of uniform and faithful implementation and enforcement of laws" and recommended that legislation be completed to ensure that definition is legally entrenched and widely disseminated and understood by all.

Cambodia faces many obstacles related to the reality of the administrative, legal and political practices of provincial and national departments/ state agencies in relation to the implementation, enforcement and observance of existing laws and policies. This was articulated in 2005 by the Special Rapporteur on the Human Rights and Fundamental Freedoms of Indigenous Peoples, Mr Rodolfo Stavenhagen: "The main problem is the 'implementation gap', the vacuum between existing legislation and administrative, legal and political practice; concluding that the divide between form and substance constitutes a violation of the human rights of indigenous people."²

5. Implementation and monitoring arrangements

Ministry of Health

The institutional arrangements are based on the implementation experience of HSSP2 as well as the PFM reforms envisaged in the country. The implementing agency for the project will be the MOH, acting through its technical departments, national programs as well as the PHDs, ODs, referral hospitals and health centers. As such, the Preventive Service Department of MoH is responsible for overseeing the implementation of this IPPF and related IPPs. The MoH will strengthen the implementation of the Community Participation Policy (CPP) to enhance community level participation to better participate in decisions related to improving health services for indigenous persons/ ethnic minorities, and respond more effectively to their particular concerns and cultural health needs.

Operational Districts

All Operational Districts with high concentrations of indigenous persons/ ethnic minorities will conduct regular monitoring and reporting to ensure that all Health Centers in their catchment areas plan and regularly conduct expanded packages of health outreach activities, Health Center Management Committee (HCMC) meetings and Village Health Support Group (VHSG) meetings with the full participation of members.

Health Centers:

² Source: Report submitted to the 62nd session of the UN Commission on Human Rights.

The Health Centers that participate in the program play a primary role in the implementation of the IPPF. All Health Centers located in areas with concentrated populations of indigenous persons/ ethnic minorities will plan and conduct regularly: (1) health outreach activities, particularly for remote and difficult to reach population, following the Outreach Management Guidelines (*updated February 2013*); and (2) Health Center Management Committee meetings and the meeting with Village Health Supported Group with full participation of their memberships, including representatives from IP communities. All Health Centers in areas with concentrated populations of indigenous persons/ ethnic minorities will ensure budget availability to efficiently implement the CPP. The goal of which will be to engage with indigenous/ ethnic minority community representatives to facilitate accessible, affordable, and high quality health services, that are adapted to the specific indigenous/ ethnic minority cultural needs of those residing within their catchment areas.

World Bank:

The World Bank through its Task Team will monitor compliance with this IPPF, the relevant activities of health care facility operators, and the implementation of measures to address key constraints identified in the recent Social Assessment consultations with indigenous persons and ethnic minorities.

- Monitoring arrangements

The project will assist the MoH reform sector wide monitoring and evaluation to include indigenous/ ethnic minority community representatives, CSOs and NGOs in the process to address identified social/ cultural variables. National, provincial and district level annual reviews of health sector performance will aim to disaggregate achievements in accessibility and health utilization to increase knowledge and understanding on the health and access issues experienced by indigenous persons'/ ethnic minorities. As part of program's mid-term review and final evaluation, social issues, including social safeguard issues and indigenous persons'/ ethnic minority related issues will be reflected upon an appropriate action plan; developed and monitored. The program will support capacity building within the MoH to better gather, analyse and use data disaggregated by health facilities serving areas with high concentrations of indigenous persons'/ ethnic minority populations.

MoH Social Safeguards Official

The MoH shall assign a Social Safeguards Official (SSO) to be responsible for:

- (i) Overseeing the implementing activities as per the approved IPPF/ IPPs and ensure that indigenous peoples/ ethnic minorities in target areas are actually receiving culturally appropriate services from the program
- (ii) Conduct public consultative meetings and facilitate Social Assessments related to specific sub-projects in indigenous peoples/ ethnic minority communities during the Program midterm review in order to further identify needs for additional sub-projects to ensure the cultural appropriateness of program funded activities
- (iii) Preparing documentation for dissemination with project stakeholders to highlight any issues that limit access to culturally appropriate health services/ health promotion and issues of concern raised by indigenous peoples/ ethnic minorities identified during public consultations, social assessments and research funded by the program.

- (iv) Identify any potential adverse impacts as result of sub-project implementation, and articulate/ advocate for appropriate program implementation modifications.

The World Bank Role

As part of the regular implementation support missions The World Bank will assign as a senior social safeguards specialist to provide operational support for the implementation of the IPPF. The social safeguards specialist can:

- i. In coordination with the MOH conduct site visits to the areas that the indigenous peoples resides in order to verify IPPF progress of implementation; this in compliance with the policy requirements.
- ii. Conduct social safeguard training for relevant central level MoH staff and provincial level MoH staff in provinces with high concentrations of indigenous peoples'/ ethnic minorities.

6. Capacity building measures

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 indigenous persons'/ ethnic minorities residing within provinces receiving support from the program. Integrated into the institutional development and capacity building activities of the program will be measures to enhance attention to culturally relevant service quality improvements and enhanced equitable access related to indigenous peoples'/ ethnic minority concerns as identified in the program's Social Assessment.

Language related issues remain significant barriers to health care access and health promotion for indigenous peoples'/ ethnic minorities. The lack of available culturally appropriate IEC and BCC materials for community level health promotion specifically designed for use with indigenous peoples'/ ethnic minorities is a major constraint to health promotion and behavior change communication (BCC) initiatives. The program will, through its support for key national programs, ensure that relevant Health Centres/ community health workers are provided with culturally appropriate IEC and BCC materials for use in community level health promotion activities and BCC strategies. This will require an increased understanding of the health beliefs that influence indigenous peoples'/ ethnic minorities in order to design appropriate materials. NGOs and UN agencies are already using a range of BCC approaches and materials in their work with indigenous peoples'/ ethnic minorities, and this is an important resource that needs to be better used by relevant MoH departments.

Enhanced participation of indigenous peoples'/ ethnic minority communities will be facilitated through the development of more participatory planning and monitoring processes at facility, district and provincial levels. The program will support the MoH's efforts to strengthen the planning process to be more responsive and participatory. This will include strengthening the participation of indigenous peoples'/ ethnic minority community representatives, and undertaking an analysis of the health situation and needs of the catchment population at the local level. The presence of NGOs in provinces with low health outcomes that are working with indigenous peoples'/ ethnic minority groups, is also a resource for provincial/ district health managers.

The MoH is committed to increasing the participation of all sections of society in monitoring services as a means of enhancing public accountability. The program will support this

objective by undertaking operational research to inform the design of culturally appropriate participatory mechanisms in consultation with target indigenous peoples'/ ethnic minority groups; and monitoring the effectiveness of different approaches to enhance indigenous peoples'/ ethnic minority populations community level participation. In operational districts with high concentrations of indigenous peoples'/ ethnic minority populations participatory approaches are likely to take different forms than in the rest of the country where indigenous peoples'/ ethnic minority populations are not concentrated. To raise the profile of indigenous peoples'/ ethnic minority community involvement in health planning and monitoring processes, the planning and monitoring frameworks will include specific sections related to indigenous peoples'/ ethnic minorities for use in relevant provinces. Operational guidelines will be developed on permissible deviations from approaches used in Khmer populated provinces to give operational guidance to health planners/ Health Centre Chiefs and training will be provided to relevant sub-national health managers to promote the inclusion of indigenous peoples'/ ethnic minority community representatives in health planning and reviews.

Capacity Building for MOH. The mainstreaming of safeguards is necessary to support targeted interventions in provinces with high concentrations of indigenous persons/ ethnic minority populations to redress the disparities in health outcome indicators as detailed in the CDHS 2014. Pathways for mainstreaming are:

- (i) Strengthening the social assessment and screening capacity of the MoH at the central level and in provinces/ operational districts with high concentrations of indigenous persons'/ ethnic minority populations
- (ii) Improving the delivery of culturally appropriate health services at the Health Centre level targeting information and behaviour change communication activities using culturally appropriate health promotion materials
- (iii) Enhanced local indigenous persons'/ ethnic minority participation in designing and monitoring local health development plans
- (iv) Monitoring, evaluation and the annual sector review process; including a focus on activities implemented to address the concerns of indigenous peoples'/ ethnic minorities as identified in the program's Social Assessment
- (v) Human resource development – including a focus on increasing the number of clinically qualified indigenous/ ethnic minority health providers and the technical skills of existing indigenous/ ethnic minority staff to improve the quality of care available at Health Centres and hospitals.

7. Public Consultation and Disclosure:

The social assessment, including the consultations with indigenous peoples/ethnic minorities, for preparing the Indigenous People Planning Framework (IPPF) was conducted by the MOH from November 10-20, 2015 in four most densely populated indigenous people/ethnic minority provinces with the objectives to obtain information on the particular needs and challenges facing IP groups, ascertain broad community support and flag any potential areas where additional support and/or different kinds of support may be required. Key relevant findings received during the consultations included the strong support of indigenous peoples/ ethnic minorities to the proposed project due to its focus on improving access to quality

health services and increasing protection against health related impoverishment through increased utilization of the HEF; the need to have expanded health outreach activities conducted regularly in order to provide all basic health care services to indigenous people/ethnic minority in the communities; the need to have IEC/BBC materials targeted toward or sensitizing indigenous peoples/ethnic minorities communication; and the need to increase representation of indigenous peoples/ethnic minorities in planning and reviewing processes of health sector at the sub-national level. The IPPF has been prepared based on findings and recommendations from the social assessment and will be disclosed at MOH website, the Bank's InfoShop prior to appraisal, and to all NGOs working in the health sector through an umbrella NGO (MEDICAM).

8. Outline of an IPP:

The MoH is committed to improving the quality of health care available to all of the citizens of Cambodia and reducing the current inequalities in health outcomes between urban and rural populations. The MoH is particularly concerned that provinces containing concentrations of indigenous peoples'/ ethnic minorities populations display the lowest health outcome indicators in the country, markedly lower than rural averages and significantly lower than urban averages. Through focusing attention on these provinces and the indigenous peoples'/ ethnic minorities that reside within these provinces, through the implementation of culturally specific initiatives, the MoH expects a significant impact on reducing the overall disparities in health outcomes between urban and rural populations.

Potential initiatives for inclusion in program Indigenous People Plans (IPPs) will be prepared in a flexible and operational manner; and could include the activities included in table 1 that resulted from the consultations. The IPP will be discussed with relevant government departments during the implementation of the Project. The IPPs will focus on both of the main objectives of the program: (1) health quality improvements related to strengthening health service deliver, and (2) health equity improvements. The goal of the IPPs will be to ensure that indigenous peoples'/ ethnic minorities are provided with culturally appropriate program benefits and increased opportunities for participation during program implementation, monitoring, and evaluation.

The IPP will include the following elements as needed: (a) summary of the social assessment; (b) summary of the main recommendations resulted from the consultation process; (c) a framework for ensuring free prior and informed consultation with the affected indigenous peoples communities; (d) an action plan of measures to enhance the capacity of MOH at the national and subnational levels; (e) cost for financing the IPP; accessible procedures for the project to address grievances by the indigenous peoples; and (c) appropriate mechanisms for monitoring the IPP.

During the early stages of project implementation the MoH will facilitate community level participation with free prior and informed consultation in Operational Districts with high concentrations of indigenous persons/ ethnic minorities. The consultation will be aimed at reviewing the need for additional operational guidelines for Provincial Health Departments, Operational Districts and Health Centres to deliver culturally appropriate services for indigenous persons/ ethnic minorities. The consultation will examine the need for additional operational guidelines for Health Centre service delivery, non-government community level representation in CPP related forums such as the HCMCs, and increasing the participation of

non-government community level of indigenous persons/ ethnic minority representatives in multi-level annual health planning and reviews.

The table 1 below presents a preliminary overview of potential IPP related activities to address key constraints identified in the program’s Social Assessment. The approach will likely differ in different locations reflecting the particular needs and challenges facing the different ethnic groups (as determined, in part, through the participatory stock-taking exercise to be undertaken in the first year of implementation after the completion of the community level participatory operational research).

Program Component	Potential IPP Related Activities
<p>Component 1: Strengthening Health Service Delivery.</p> <p>Sub-component 1.1: Service Delivery Grants: Health Centres.</p> <p>Sub-component 1.2: Service Delivery Grants: Hospitals.</p>	<p>The payment of SDGs will be based on the utilization of services, related to both the quantity and the quality of services provided. The MoH will review the appropriateness of this approach in relation to facilities located in low population density areas with concentrations of indigenous and ethnic minority communities. The review may potentially amend the focus of SDG payment requirements away from the quantity of services provided to focus more on the improvement of quality services and the introduction of culturally appropriate services related to indigenous/ ethnic minority groups within their catchment areas.</p> <p>Eligible categories of expenditure include, but not limited to, health outreach service provision, community participation activities and the establishment of new health services. Operational District/ Health Centre planning will focus on improving the cultural appropriateness of service provision and increasing the diversity of community representatives in HCMCs as ways to strengthen health service delivery at the Health Centre and community levels in areas with high concentrations of indigenous/ ethnic minority groups.</p> <p>SDGs will be used to incentivize improvements in the quality and cultural appropriateness of care available at Health Centres/ Health Posts and referral hospitals, including the promotion of and increased utilization of services by HEF beneficiaries.</p> <p>SDG Health Centre and referral hospital supervision checklists will include sections on service delivery related to indigenous peoples/ ethnic minorities. Health Centre staff will be required to report on activities undertaken specifically to address the health needs of indigenous peoples/ ethnic minorities as a priority group. The Payment Certification Agency will review the reports and achievements prior to making SDG payments.</p> <p>Training and the provision of on-the-job training support will be targeted in Health Facilities with concentrations of indigenous/ ethnic minority groups within their catchment areas. Training arrangements will be coordinated with staff from relevant PHD departments and the regional training centre in Stung Treng.</p>

<p>S</p> <p>ub-component 1.3: Service Delivery Grants: PHDs and ODs.</p>	<p>The program will introduce a specific performance based financing approach to improve the cultural appropriateness of targeted services in relevant hospitals. This will specifically relate to the language barriers and the inclusion of indigenous peoples/ ethnic minorities community representatives in annual planning and hospital management decision making forums as identified in the program’s Social Assessment.</p> <p>SDGs for PHDs/ ODs will be used to incentivize improvements in participatory planning and monitoring processes at facility, district and provincial levels - focused on strengthening the participation of indigenous peoples’/ ethnic minority community representatives in annual health planning and review processes. Action Plans will be developed to ensure that the health needs of indigenous peoples/ ethnic minorities receive appropriate consideration and attention. The Action Plans will include clear targets and designated responsibilities for activity implementation. Operational Districts will hold open annual meetings where they will present participants with an overview of implementation progress related to the activities stated in the Action Plans and submit quarterly reports related to progress achieved.</p> <p>For relevant ODs and PHDs the scorecard measuring key supervisory processes and health system outputs will include sections related to improving service delivery for indigenous peoples/ ethnic minorities. This will detail specific supervisory activities undertaken to increase the utilization of public health services by indigenous peoples/ ethnic minorities and achievements.</p>
<p>Component 2: Improving Financial Protection and Equity.</p>	<p>This component of the program builds upon previous achievements related to the HEF system, aiming to improve the quality of HEF services and increase their utilization by the ethnic minority and indigenous populations. To achieve this goal HEF providers, through themselves or contracted CSO/NGOs, will be contractually required to:</p> <ol style="list-style-type: none"> 1. Develop detailed strategies specifically targeting indigenous peoples/ ethnic minorities, clearly demonstrating an understanding of language and cultural barriers as they differ from Khmer populated areas. 2. Increase sub-national level staff with high levels of proficiency in relevant minority languages and submit reports detailing specific activities undertaken and achievements related to increasing the utilization of HEF by indigenous peoples/ ethnic minorities. 3. Collaborate with relevant sub-national government departments to enhance targeting efficiency and reduced inclusion and exclusion errors, particularly for indigenous/ ethnic minority groups.
<p>Component 3: Ensuring Sustainable and Responsive Health Systems.</p>	<p>This component aims to strengthen institutional performance, specifically to support the establishment of new institutional structures to provide third party verification of HEFs and SDGs.</p>

<p>Sub-component 3.1: Health System Strengthening.</p> <p>Sub-component 3.2: Health Infrastructure Improvements</p> <p>Sub-component 3.3: Project Management, Monitoring and Evaluation.</p>	<p>The Payment Certification Agency (PCA) contract will include requirements and targets specifically related to indigenous peoples/ ethnic minorities for both SDGs and HEF.</p> <p>The PCA will undertake client surveys with indigenous peoples/ ethnic minorities to better understand user and non-user experiences with the health system.</p> <p>Activities under sub-component 3.1 will focus on the development and implementation of strategies to:</p> <ol style="list-style-type: none"> 1. Improve access to primary care for indigenous peoples/ ethnic minority communities. 2. Identify existing indigenous/ ethnic minority health workers posted in relevant Health Centers to undergo competency training at CPA hospitals/ Regional Training Centers. <p>Activities under sub-component 3.2 will be civil works as per priorities identified by MOH in their civil works plan 2016-2020. Prioritization will be based on access issues, attention to remote areas, concerns around patient safety and improving maternal and neonatal survival. The expected type of investments will include maternity wards and other infrastructure for emergency maternity and neonatal services, HCs and hospitals.</p> <p>Activities under sub-component 3.3 will focus on securing qualified consultants to collaborate with relevant MoH officials to undertake the proposed indigenous/ ethnic minority specific activities as detailed in the IPPF and subsequent IPPs.</p>
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Potential Indicators for Consideration:

Project Level Indicator:

- Reduced inequalities of health outcomes between provinces with high concentrations of indigenous peoples/ ethnic minorities and rural averages (*source of verification CDHS 2014-2019*).

Sub-component 1.1: Service Delivery Grants: Health Centers

- Health Centres annually report the number of clinically qualified staff able to speak minority languages, disaggregated by position/ qualification/ languages spoken and level of language competency (i.e. basic, intermediate, fluent).
- Health Centre quality assurance reviews undertaken during Project mid-term and end of Project reviewa, with a section dedicated to cultural appropriateness of service provision to catchment population.

Sub-component 1.2: Service Delivery Grants: Hospitals

- Number of clinically qualified staff fluent in relevant minority languages disaggregated by position/ qualification.
- Indigenous peoples/ ethnic minorities Action Plans in place and annual public meetings held to report progress and achievements.

Sub-component 1.3: Service Delivery Grants: PHDs and ODs

- Quarterly OD/ PHD checklist reported the detailed actions undertaken to increase the utilization of public health services by indigenous peoples/ ethnic minorities and achievements.

Component 2: Improving Financial Protection and Equity

- HEF: Existence of detailed strategy specifically targeting indigenous peoples/ ethnic minorities.
- Number of sub-national level HEF staff with high proficiency in relevant minority languages, disaggregated by position/ responsibilities/ languages spoken.
- Payment Certification Agency contract includes requirements and targets specifically related to indigenous peoples/ ethnic minorities for both SDGs and HEF.

Sub-component 3.1: Health System Strengthening

- Improved access to primary care for indigenous peoples/ ethnic minority communities.
- Number of indigenous peoples/ ethnic minority health workers posted in Health Centers undergoing competency training at CPA hospitals/ Regional Training Centers.