Cambodia:
Social Assessment for the Second Health Sector Support Program - Second Additional Financing
February, 2014

Background:

The Cambodia's Second Health Sector Support Program (HSSP2) builds on the previous Health Sector Support Project (HSSP), with extended Program coverage to include the predominantly Indigenous Peoples' inhabited provinces of Mondulkiri and Ratanakiri, which were previously addressed by the Programs of other donors. Due to the extension of coverage to predominantly Indigenous Peoples' inhabited provinces, the World Bank Operational Policy on Indigenous People (OP 4.10) was *triggered* requiring that a process of free, prior, and informed consultation be undertaken with the affected indigenous peoples' communities.

During the HSSP2 Program preparation stage, two activities took place: the preparation of the Indigenous Peoples' Planning Framework (IPPF), and a Social Assessment (SA), with consultations being undertaken in eight villages, across three provinces *(Ratanakiri, Mondulkiri and Kratie)* which aimed to provide data to better inform project designs. The IPPF, based on the health care priorities and constraints in ethnic minority and indigenous peoples' communities identified under SA, set out measures to ensure that target health care improvements to be implemented under HSSP2 are culturally appropriate and inclusive in both gender and intergenerational terms. The measures identified in IPPF to ensure them included a detailed Social Assessment to be implemented in project provinces including free, prior and informed consultations with IP beneficiaries.

Health Poverty Action (HPA) was recruited as short-term consultants in January 2014 to undertake this detailed Social Assessment, including further consultations with Indigenous Peoples' and ethnic minorities, and the development of an Indigenous Peoples Plan. The proposed Indigenous Peoples Plan is based on the findings of this detailed Social Assessment including the results of free, prior and informed consultations with IP beneficiaries, for the purpose of having greater support to and participation from Indigenous Peoples' communities on health service delivery during the implementation of Additional Financing.

Methodology Overview:

Village level Focused Group Discussions (Village FGD) were undertaken with seven indigenous/ ethnic minority groups: Tumpoun, Jaray, Kreong, Kavet, Lao-Khmer (Ratanakiri Province), the Phnong (Mondulkiri Province), and the Cham (Kratie Province). Three villages were selected for each indigenous/ ethnic minority group, resulting in a total of twenty-one (21) villages targeted across the three provinces. The villages selected were weighted towards villages with high concentrations of ethnic populations for each target group, combined with distance from the Health Center (close proximity, remote and middle distance), except for Cham communities (close proximity near river, remote near river and transitional agricultural community away from river; this approach was a targeted approach to adapt to the particular characteristics of the Cham communities). A decision was made to undertake two FGDs in each target village, one comprised of male participants and another comprised of female participants, resulting in a total of forty-two (42) Village FGDs across the three provinces/ seven target groups. The decision to divide FGD participants into gender groups was made in order to help reduce constraints that participants may face if in a mixed gender group. The resulting FGD groups were highly diverse with a variety of participants from a wide range of vulnerable groups including the elderly, disabled and widows.

FGD teams composed of persons from the ethnic target groups were assembled for each of the seven (7) target groups. The teams were composed of two males and two females. Each gender sub-team had a dedicated facilitator and a dedicated documenter who were allocated responsibility for undertaking separate FGDs with the male or female participants, respectively. Many of the FGD staff were staff members of Health Poverty Action (HPA), staff members of

the Indigenous Peoples' Health Improvement Association (local NGO) or were recruited on a short-term basis from known sources. All FGD staff had previous experience in undertaking surveys and FGDs. The seven different FGD teams were assigned a Supervisor, all Supervisors were HPA staff members with considerable experience in working with the relevant target groups and experience in undertaking surveys and FGDs.

The FGD staff and their allocated Supervisors participated in a 2.5 days training. Day one of the training focused on introducing the FGD questions, reporting formats and the selected FGD protocols to ensure a consistent approach was adopted across all twenty one villages. Facilitators were also provided with refresher training to ensure that the FGDs were managed in a manner that reduced any potential interference or intimidation from other participants. Village level FGD practice sessions were conducted on the afternoon of the second day, followed by a review and reflection session at the training hall. On the morning of day three additional training hall based FGD practice and reflection sessions were undertaken. Minor amendments were made to refine the FGD questions based on their translation to the target group's language.

The Village Chiefs in all target villages were contacted and meetings with village level leaders were arranged to seek permission and explain the reason for the Social Assessment. A combination of both Purposive and Random participants were invited to join. Purposive participants were four males and four females: Village Chief (1 x M), Village Elders (1 x M, 1 x F), VHSG Members (1 x M, 1 x F), Traditional Birth Attendant (1 x F), the Commune Council Focal Person for Women and Children (1 x F), Traditional Healer (1 x M). The other participants were selected randomly for the village population with a protocol developed to ensure that all random participants were selected using a standardized methodology. In total 480 persons participated in the village level FGDs across the three provinces/ seven target groups, 246 females and 234 males.

The projects provincial teams also undertook a mixed gender FGD at the provincial level. Eight representatives from the following government departments were invited to attend: the Provincial Health Department, the target Operation District Department, the Provincial Hospital Administration, the Provincial Department of Rural Development, the Provincial Department of Women's Affairs, "Implementation Plan 3" (Provincial Governors Office), the Provincial Planning Department; and also a senior staff member from Action for Health (the HEF administrators). A total of twenty-four (24) persons were invited to participate in the FGD, the actual number of participants was nineteen (19); six (6) females and thirteen (13) males.

The information gathered from the FGDs was translated into English language text and reviewed using a textual analysis approach, wherein the appearance of certain issue or comments where analyzed within the FGD group and then the weight of such statement was judged by the agreement of the group with it, as reflected in the minute reports of the discussions. This information was then quantified and calculated as a percentage of FGD stating or supporting the word or phrase, thus indicating its importance or position through a Levi-Strauss analytical approach.

In addition to the FGDs project staff also undertook Key Informant Interviews. Fifteen invitations were sent to the Provincial Health Department, the target Operation District Department, and three (3) NGOs targeted based on their work on health issues/ work with the target groups – in all three target provinces. Fifteen (15) persons were invited to participate in the Key Informant Interviews; the actual number of participants was thirteen (13); five (5) females and eight (8) males.

The table below details the village level FGDs held during the Social Assessment:

Village	District	Ethnicity	Date of FGD	No./ Gender of Participants		
Ratanakiri Province				**Male**	**Female**	**Total**
La Lai	Veun Sai	Kavet	10/02/2014	19	10	29
Rak	Veun Sai	Kavet	11/02/2014	10	12	22

Kang Nak	Veun Sai	Kavet	12/02/2014	17	10	27
Kaoh Peak	Veun Sai	Kreong	10/02/2014	13	13	26
Khun	Veun Sai	Kreong	11/02/2014	11	10	21
Ka Choun Kraom	Veun Sai	Kreong	12/02/2014	5	10	15
Srae Chhuk	Lumphat	Lao	10/02/2014	7	12	19
Lumphat	Lumphat	Lao	11/02/2014	7	14	21
Thmei	Lumphat	Lao	12/02/2014	9	13	22
Leu Khoun	Bar Kaev	Tumpoun	10/02/2014	10	21	31
Dan	Bar Kaev	Tumpoun	11/02/2014	7	12	19
Pa Ar	Bar Kaev	Tumpoun	12/02/2014	11	11	22
Nhang	Andoung Meas	Jaray	10/02/2014	16	12	28
Tang Se	Andoung Meas	Jaray	11/02/2014	12	11	23
Ta Nga	Andoung Meas	Jaray	12/02/2014	17	11	28
Sub-total				**171**	**182**	**353**
Mondulkiri Province				**Male**	**Female**	**Total**
Pu Tang	Sen Monorom	Phnong	10/02/2014	10	10	20
Chhoul	Kaoh Nheaek	Phnong	12/02/2014	11	14	25
Purapet	Pech Chenda	Phnong	13/02/2014	12	10	22
Sub-total				**33**	**34**	**67**
Kratie Province				**Male**	**Female**	**Total**
Chheu Teal Phluoh	Chhloung	Cham	10/02/2014	10	10	20
Pongro Muoy	Chhloung	Cham	11/02/2014	10	10	20
Balang	Chhloung	Cham	12/02/2014	10	10	20
Sub-total				**30**	**30**	**60**
Total				**234**	**246**	**480**

The below table details the provincial level FGDs held with government staff during the Social Assessment:

Province	Date of FGD	No./ Gender of Participants		
		Male	Female	Total
Ratanakiri	18/02/2014	6	2	8
Mondulkiri	17/02/2014	3	1	4
Kratie	20/02/2014	4	3	7
Total		**13**	**6**	**19**

The below table details the provincial level Key Informant Interviews held with government and NGO representatives during the Social Assessment:

No.	Province	Date of FGD	Type	Gender of Participants	
				Male	Female
1	Ratanakiri	12/02/2014	Govt.	Male	
2	Ratanakiri	12/02/2014	NGO		Female
3	Ratanakiri	12/02/2014	NGO		Female
4	Ratanakiri	14/02/2014	NGO	Male	
5	Mondulkiri	17/10/2012	NGO	Male	
6	Mondulkiri	17/10/2012	Govt.		Female
7	Mondulkiri	18/02/2014	NGO		Female
8	Mondulkiri	18/02/2014	NGO	Male	
9	Mondulkiri	18/02/2014	Govt.	Male	
10	Kratie	20/02/2014	Govt.		Female
11	Kratie	20/02/2014	NGO	Male	
12	Kratie	21/02/2014	NGO	Male	
13	Kratie	21/02/2014	Govt.	Male	
Total				**8**	**5**

Informing Communities about HSSP2 Program Objectives and Goals:

A large proportion of Cambodia's indigenous population is illiterate, and those that do enter the formal education system are commonly restricted to a few years primary level education. Therefore it is difficult to communicate complex information and concepts regarding the HSSP2 Program's objectives and its specific health-related goals to the target villagers. The indigenous staff assembled to undertake the village level FGDs expressed concern regarding confusing participants prior to the commencement of the FGD. To overcome this problem a simplified standard text was drafted for use by the FGD Facilitators at the start of the village level FGDs. The simple text focused on explaining the projects focus on improving health issues related to women, new-born and child health, communicable and non-communicable diseases; and improving the provision of health services, assistance for the poor with the payment of health related costs and improving the availability of heath staff. Minor amendments were made during the staff training session based on difficulties experienced during their translation to the target group's language.

The FGD Facilitators reported that there was some difficulty regarding the explanation of non-communicable diseases, and that village level FGD participants were previously unaware of the project, but hoped that the Program would improve the provision of health services available to them. The FGD Facilitators also reported that the participants were unable to distinguish what health activities were related to government health services/ HSSP2, the activities of NGOs and the activities related to interventions supported by other Development Partners, such as the Global Fund and UNICEF.

Legal and Policy Framework:

Legal Framework

In Cambodia, there are no specific laws or legal instructions articulating the rights of Indigenous Peoples or ethnic minorities. However, it should be noted that Prakas (sub-decrees) related to existing laws are issued to provide clarification or operational guidance but were unavailable for this assessment.

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: "The Kingdom of Cambodia recognizes and respects human rights as stipulated in the United Nations Charter, the Universal Declaration of Human rights and the covenants and conventions related to human rights, women's rights and children's rights. Khmer citizens shall be equal before the law, enjoying the same rights and freedom and obligations regardless of race, color, 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 people and their rights as indigenous people.

In 1997, a special Inter-ministerial Committee was formed to focus on Highland Peoples Development; the Committee developed a **General Policy for Highland Peoples Development**. The general policy was the result of an extensive consultations process, including consultations with local indigenous groups, NGOs, international development agencies and relevant government departments. However, the draft General Policy for Highland Peoples Development has never been enacted.

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."

Related to international law, Cambodia is party to: the International Covenant on Economic Social and Cultural Rights (ICESCR) 1966, the International Covenant on Civil and Political Rights (ICCPR) 1966, the Optional Protocol of the ICCPR, the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) 1965, the International Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) 1979, and the Convention on Biological Diversity (CBD) 1992. These international instruments contain a number of provisions related to the protection of the rights of indigenous peoples. Cambodia also became a signatory to the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) in 2007.

Policy Framework

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

Demographic Overview:

A 2006 study of indigenous populations conducted by the Ministry of Rural Development, National Statistics Institute and Commune Database estimated Cambodia's indigenous population to be 200,156 and that indigenous groups are mainly living in ten provinces of Cambodia. The table below presents statistical data of Indigenous Peoples by provinces[1]:

Statistic Data of Indigenous Peoples in Cambodia (2006)

No	Ethnicity	Rattanak Kiri	Mondol Kiri	Kracheh	Preah Vihear	Kampong Thom	Stung Treng	Odor Meanchey	Kampong Cham	Pursat	Kampong Spue	Banteay Meanchey	Battambang	Sihanouk Ville	Siem Reap	Koh Kong	Total
1	Kuoy			5,939	16,731	13,044	1,644	2,203				1,712	8				41,281
2	Phnong	267	26,866	12,454	24		430	699					3				40,743
3	Tumpoun	31,088	388		5		4	281					16				31,782
4	Chaaraay	20,170	84				12	158					14				20,438
5	Kroeung	18,442	57				278	124									18,901
6	Stieng		648	10,593				27	2,564								13,832
7	Praov	7,968					444										8,412
8	Kaveat	2,379					2,710	18									5,107
9	Kraol		659	3,411				29									4,099
10	Mel			3,172													3,172
11	K'chak	2,887					1	52									2,940
12	Por				1,329					1,207							2,536
13	Kaonh			1,529									433				1,962
14	Chong									774						1,064	1,838
15	Souy										1,833						1,833
16	Thmoon		148	448				5									601
17	Lon	289					251										540
18	S'ouch													106			106
19	Raadear	2						16									18
20	Kek							15									15
21	Ro Ong																0
22	Stung																0
23	L'oeun																0
24	Samrae																0
Total		**83,492**	**28,850**	**37,546**	**18,089**	**13,044**	**5,774**	**3,627**	**2,564**	**1,981**	**1,833**	**1,712**	**474**	**106**	**0**	**1,064**	**200,156**

Source: Department of Indigenous Minority Development

The Cham constitute about half of the ethnic minority population and are widely distributed throughout the country. 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. 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.

[1] Source: Department of Indigenous Minority Development.

Socio-political Overview:

For many indigenous communities in Cambodia their main social unit is the village community. A council of elders, chosen among the wisest and more experienced men and women of the village, helps the community to make decisions and solve disputes to maintain peace and solidarity among members. Many of the communities observe indigenous customary laws that form their traditional legal system; which is not officially recognized by the national legal system. During the period 1979-1992 senior government positions in the provinces with high concentrations of indigenous peoples *(e.g. Stung Treng, Ratanakiri and Mondulkiri)* were largely occupied by members of the indigenous groups. However, since that time senior government positions, specifically the number of deputy-governor post holders, has increased in number and are now predominately occupied by ethnic Khmer people appointed by the central government in Phnom Penh. Considering the D&D administrative decentralization process that has developed in Cambodia over recent years, this change represents a significant loss of decision making authority over issues of importance to indigenous communities.

Livelihood Strategy Overview:

Indigenous Peoples' and ethnic minority groups in Cambodia face particular socio-economic problems related to language skills, low education levels, remoteness, and low population density. The majority of Cambodia's indigenous peoples still live in traditional ways, primarily cultivating rice, using traditional swidden agriculture/ shifting cultivation techniques, wetland rice cultivation, pig and chicken raising, gathering food from the forest, hunting and fishing. Their livelihood strategies are usually augmented by providing their labor to the 'better-off' households, for which they are paid in cash. As a result of Cambodia's irregular climatic conditions, agricultural production can fluctuate significantly from year to year. With the majority of the indigenous/ ethnic minority population engaged in subsistence agriculture, food insecurity is a dominant feature of their poverty and vulnerability. Many communities report insufficient supplies of food for periods between 2-5 months of the year. As a consequence of which, indigenous peoples' are disproportionately affected by high levels of malnutrition and stunting.

Households fall into heavy indebtedness as a result of borrowing from rice/ moneylenders, against current crop production, at very high interest rates, which requires large repayments in rice/ money. In some cases, this practice has evolved from a short-term coping strategy into longer-term coping strategy. Research by Oxfam and the Cambodia Development Research Institute indicate that around half of farmers who had to sell their land did so to pay for health care expenses. Illness and injury are one of the most common reasons for taking out a loan, accounting for thirteen percent of all loans (World Bank, 2006).

In recent years many of Cambodia's indigenous communities are experiencing the loss of land and decreasing access to land that they had lived off of for generations. This is due to their traditional territories being targeted for large-scale plantations, natural resource exploitation (logging, mining, etc.) and the development of hydro-electric power stations. These developments have significant negative implications for their immediate income generation options and their food security needs; also threatening their social cohesions and related negative impacts on their spirituality and health.

Health Overview:

As with the WHO definition, health is considered as being more than the absence of illness. However, typically indigenous peoples' concept of health is wider and more ecological than the WHO definition. For many indigenous peoples' their conceptual understanding of health

also includes the availability of work, access to food and water, and importantly, the collective well-being of other members of their group and linkages with their ecological environment. Great emphasis is placed on being in harmony with the environment and other species, this relates to their traditional spiritual beliefs and its strong connections with the ecological environment within which they live.

The RGC has overseen significant progress in improving Cambodian citizen's health in recent years, as confirmed by a comparison between the data presented in the 2005 Cambodian Demographic Health Survey (CDHS) and the 2010 CDHS. Whilst the progress achieved has been significant, this progress has not been evenly distributed throughout the country and amongst the different social/ ethnic groups. The data presented demonstrates significant disparities between the different province, and the urban and rural areas. This is illustrated below with the comparisons of selected key health and health system indicators, comparing the data presented related to four provinces with high levels of indigenous/ ethnic minority communities *(Mondulkiri/ Ratanakiri and Preah Vihear/ Steung Treng)* against the national averages for rural areas, urban areas and Phnom Penh, the nation's capital.

Additionally, available MoH Health Management Information System (HMIS) data for Ratanakiri and Mondulkiri provinces are referenced to inform upon the progress in the health system for these two primarily indigenous provinces and to give an indication of developments reported since the 2010 CDHS, though with qualified limitations. While progress has continued to be made throughout Cambodia in the period between the 2010 CDHS and the time of this Social Assessment, a review of the 2012 HMIS data for Ratanakiri and Mondulkiri provinces illustrates that these high IP population concentrated areas are still lagging behind other provinces in their progress on key health indicators. It should be noted that the HMIS data represents only those who sought health care within the public health system, unlike the CDHS data, which using randomly selected population survey techniques focuses on ascertaining the overall health status of the population within the province.

Percentage of Deliveries Conducted in a Health Facility:

- According to the data presented in the 2010 CDHS the percentage of deliveries conducted in a health facility in Mondulkiri and Ratanakiri was 30.1%, and for Preah Vihear and Steung Treng 21.2%. This appears weak against national averages in rural areas of 47.8%, urban areas of 85.8%; and Phnom Penh 65.2%. Based on the available HMIS data on Ratanakiri as of 2012, the province had achieved a delivery at health facilities rate of 32.5%, although it should be noted that a proportion of the increase can be associated with the corresponding increase of in-country migration into the province by low-land Khmer peoples with higher health seeking behavior. For Mondulkiri, the rate increased to 27.6% according to the HMIS data as of 2012, up from an estimated 19.9% in 2008 based on the same data source. While progress is being made for both provinces with an estimated 14% and 8% annual increases in rates for Ratanakiri and Mondulkiri respectively, these high IP population provinces still lag behind the rest of the country both in terms of their overall coverage rates as well as progress improvement rates.

Infant Mortality *(death between birth and 1 years of age)*:

- According to the data presented in the 2010 CDHS Preah Vihear and Steung Treng have the highest infant mortality rates in the country with 95 deaths per 1,000 live births. Mondulkiri and Ratanakiri have the second highest infant mortality rates in the country with 82 deaths per 1,000 live births. This is approximately twice the national average of 45 deaths, and is six times higher than Phnom Penh with 13 deaths per 1,000 live births.

Under-five Mortality *(death between birth and 5 years of age)*:

- According to the data presented in the 2010 CDHS Preah Vihear and Steung Treng provinces have the highest under-five mortality rate in the country with 118 deaths per 1,000 live births, compared to Phnom Penh with 18 deaths, and nearly twice the national average of 54 deaths per 1,000 live births.
- Mondulkiri and Ratanakiri has the second highest under-five mortality rate in the country with 106 deaths per 1,000 live births, this is nearly twice the national average of 54 deaths, and is nearly six times higher than Phnom Penh with 18 deaths per 1,000 live births.

No ANC Services:

- In Preah Vihear/ Steung Treng 33.1% of women received no antenatal care services, and in Ratanakiri/ Mondulkiri 37.0% of women received no antenatal care. This is approximately three times higher than the rural average of 11.6% and over 40 times higher than the Phnom Penh rate of 0.9%.

Outpatient Service Demand and HSSP 2 Fund Utilization:

- Based on available HMIS data, Ratanakiri saw a 2% increase in public health facility Out-patient Department service utilization as of 2012 as compared with 2008, once adjusted for population increases. Mondulkiri appears to have made better progress with an increase of 35% from 2008 to 2012, after adjusting for population changes. For both Ratanakiri and Mondulkiri it should be noted the OPD service utilization had declined from 2007-2009 from reported supply side limitations due to funding transitions, and a portion of the increase from 2008 to 2012 was likely a result of the return to the 2007 utilization levels.
- Mondulkiri and Ratanakiri had the lowest and second lowest, respectively, rates of HSSP2 fund usage of all the SOA ODs in Cambodia. From 2010 – 2012 (the period for which data is available) Mondulkiri averaged only 69% spend per year of the allocated HSSP2 funds despite the good facility performance scores reported. Ratanakiri did better with 75% average spend despite having lower performance scores than Mondulkiri. This underspend was a unique quality of the high IP provinces with all other remote regions, such as Samraong OD in Otdar Meanchey Province, averaging in the middle to high 90% range in their utilization of HSSP2 allocated funds. The lack of progress seen in OPD demand and other services/ key health indicators is likely contributed to by the inability of the provincial health systems to effectively utilize the funds made available by HSSP2 in these provinces.

Considering that the indigenous populations of these four provinces combined (160,068) represents approximately 80% of the reported indigenous populations of Cambodia, it can be surmised that Cambodia's indigenous population has not equally benefited from the significant health advances achieved during the period. At present, Indigenous Peoples and Ethnic Minorities are not targeted as special targeted populations under National Disease and Health Sector Strategic Plans and Policies, despite their unique vulnerabilities/ special needs and the provinces in which the reside reporting relatively low achievement of key health indicators as compared to other provinces in Cambodia. Therefore there is a need for the development of specific strategies/ policies and targeted activities to increase the health status of Cambodia's indigenous population.

Findings Consultations:

1. Health Service Delivery and Utilization

1.1. Maternal and Child Health

In terms of maternal health, only 55% of Village FGD groups indicated having received some type of ANC or PNC outreach services within their villages. That said, over 71% of focus groups indicated knowledge of maternal health services available at the Health Center, though it was unclear whether such services were being used, with some participants openly stating their non-use of the services. Child health outreach activities, specifically in the form of vaccinations within the villages, were strong with 100% of villages reporting some type of vaccination outreach activity within the previous year. Reportedly, 80-90% of the children within the villages were covered. However, this was not an estimation derived by the groups themselves, but in all cases a reference to the Commune Council figures. There were also reports of non-coverage of some children due to the short duration of the vaccination drive *(usually no longer than half-a-day per village)* and some families arriving late due to distances or other factors.

1.2. Communicable and Non-communicable Diseases

The results of focus group discussions with forty-two (42) focus groups across twenty-one (21) villages indicated 93% of the focus groups having received some type of outreach education service at their village within the last one-year period. However, the vast majority of the IEC/BCC education coverage (90%) was accomplished in the form of Malaria education under Global Fund activities in the region, with the remaining 3% being non-cross-coverage villages by other disease IEC/BCC activities (TB: 43% of villages received at least 1 education session in the previous year; HIV/AIDS/STI: 67% of villages received at least 1 education session in the previous year). It should be noted that of those TB and HIV/AIDS/STI related IEC/BCC sessions, 50% reported only having received one (1) session during the entire year.

For specific disease perceptions, malaria and dengue remain high as key concerns for the communities, with 90% of Village FGD groups reporting the diseases as being a key concern for them. Another strong trend of concern was seen for Typhoid Fever, which was specified as a key concern for many FGD groups of villages located near waterways, particularly Cham communities in Kratie and indigenous communities located near rivers in Ratanakiri.

While communicable diseases and the disease burden off them featured prominently in the discussions and the dialogue of the targeted communities, there appears to be no significant perception of non-communicable disease burdens/ risks within the target groups. When asked about different diseases and ailments affecting their communities, a wide range of communicable diseases and related ailments were put forth, however, no non-communicable diseases were brought up by any group in the open discussions on diseases.

1.3. IEC and BCC Resources

It was revealed during the Key Informant Interviews that a major barrier has been the availability and provision of IEC and BCC resources to indigenous and ethnic minority communities. Interviews across all three provinces revealed that there were no IEC and/or BCC materials targeted towards or sensitized towards indigenous and ethnic minority specific communication. Moreover, local authorities across all three provinces indicated that even Khmer oriented versions of IEC and BCC materials had not been distributed to these communities under HSSP2 by the local authorities, and that any production and distribution of materials was being done by NGOs through other donor funded projects, although not comprehensively, only in their project's target areas.

2. Health Care Financing

2.1. User Fees

Satisfaction with user fee rates was found to be highly correlated with the presence of a public health provider who spoke their own language or was from their own community. With that in mind, 29% of Village FGD groups reported satisfaction with the current user fee rate for their public health facilities, with most of these groups being concentrated in Kratie and Mondulkiri.

However, the remaining 71% of the Village FGD groups reported user fee costs to be "Too High" with many stating the costs of Health Center fees and charges for children and the elderly being an issue.

The use of user fees can be an appropriate strategy to enhance costs recovery, however, this strategy is primarily relevant to facilities located in high population density, average income areas with limited access constraints. In low income, low population density areas the use of user fees is a significant barrier in the provision of health services to indigenous and ethnic minority communities. Moreover, the low income generated through user fees in facilities located in remote areas does not provide a motivating financial incentive for staff to work in remote facilities and improve the quality of health service provision.

2.2. Health Equity Fund grants to support the poor for accessing health care services

Of the Village FGD groups, 85% indicated knowing about the availability of HEF coverage for themselves and their communities, although it must be noted that even in Village FGD groups where the majority of participants were aware, there was always at least a few individuals without any knowledge of the HEFs. However, only 33% of Village FGD groups indicated that a significant portion (>33%) of the members were able to use HEF services. When delving into the reasons for this non-utilization, many anecdotal barriers were indicated with many individuals across all groups stating difficult in receiving their ID Poor cards/status as well as some poor were excluded from ID-poor selection process while some non-poor were selected. Other barriers included having to pay for services despite having HEF pre-qualification, the non-acceptance of ID Poor status or HEF pre-qualification, and non-coverage of transportation expenses. This trend was consistent across all target groups and provinces.

While a directive of the MoH has advocates for the expansion of HEF coverage down to the Health Center levels, the results of the Key Informant Interviews has shown this effort to be sporadic and incomplete. While HEF is available in the Provincial Referral Hospital of Ratanakiri province, it is currently unavailable at the District Referral Hospital in Borkeo District and is only now being piloted at four (4) Health Centers across the entire province. In Mondulkiri province, the HEF is likewise available at the Provincial Referral Hospital and available at only five (5) Health Centers. In Kratie province, the HEF was available at five (5) Health Centers and was in the process of being expended, according to the local health authorities. In total, while beginning to be expanded, the HEF remains inaccessible across the vast majority of indigenous and ethnic minority serving Health Centers.

3. Human Resources and Sensitization

3.1. Training of community-based health workers to ensure staff speak local languages, and are familiar with local culture.

While no specific trainings for Health Center staff assigned to outreach activities was indicated in any of the FGD discussions, the lack of which was confirmed by interviews conducted with the local health authorities in all three provinces, the Village FGD did reveal the availability of ethnic language speaker within Health Centers. Out of the forty-two (42) Village FGDs, 86% of the groups indicated that there was at least one (1) person who spoke their ethnic language working at their Health Center. However, only 45% of the groups indicated that this person was a health provider (Nurse, midwife, etc.) and not a health support staff member (registrars, volunteer, cleaners, etc.). This distinction between health providers and health support staff appears to be key as it greatly contributed to the communities' perception of the services provided and their ability to raise issues at the Health Center. A cursory analysis of correlations revealed that groups that had health providers who spoke their ethnic language were far more likely to report that they had the ability to voice their concerns/ grievances to the Health Center, that they felt that Health Center services were sensitive to their cultural and ethnic identity, and they were far more likely to report that they were satisfied with the costs of health services that they received.

4. Health system stewardship

4.1. Can beneficiaries voice their views, concerns and preferences freely?

52% of the FGD groups reported that they did not have the ability to voice their concerns to health personnel. As noted earlier, those who did state their ability to be able to voice their concerns or complaints were almost all groups who had a health provider who spoke their ethnic language. Of the 48% who felt that they could not complain or voice concerns, all reported a fear of retribution by health staff and the likelihood that critical health services would be denied if they brought up any type of complaint about services or attitudes. That said, many of the respondents across all groups indicated serious problems with rude and unresponsive staff, and many of those without health providers from their ethnic group in the facilities indicated that they had encountered discrimination in the provision of health services, particularly for the Cham communities.

The reality of continued low quality services, limited opening hours, staff unavailability and financial barriers remain as well as supply shortages at facilities. The major issue of poor professional attitudes among health care providers towards indigenous and ethnic communities continues to threaten the potential impact of demand side improvements.

4.2. Expansion to health system to reach more remote indigenous and ethnic minority populations

Expansions in the number of health facilities has occurred across all the target provinces, with emphasis placed on the upgrading of Health Posts to Health Centers. In Ratanakiri province, one (1) Health Post has been upgraded to a Health Center, as well as the upgrading of Borkeo Health Center to a District Referral Hospital and additional building construction at the Referral Hospital, it was noted that this was done with donor funds outside of HSSP2. Mondulkiri province witnessed the upgrading of four (4) Health Posts to Health Centers during the HSSP2 project period, although again through donor funding not linked to HSSP2. Kratie province saw the five (5) Health Posts upgraded to be Health Centers and the upgrading of a Health Center to a District Hospital in Chlong District using HSSP2 funding.

The lack of adequate integration of the upgraded facilities into the health financing structure of the Cambodian health system resulted in some of the health facilities not being adequately budgeted for in Mondulkiri. While the local health authorities put forth their best efforts to find the equipment and staff to cover these newly upgraded health facilities; many were not able to provide the full MPA required for Health Center status and efforts to staff and stock the new Health Centers have led to resources being spread thinly across other public health facilities in the provinces.

Consultation Mechanisms:

At present there is a lack of formal mechanisms to facilitate consultations and dialogue with indigenous peoples/ ethnic minorities. The HSSP2 Program should consider the establishment and institutionalization of provincial level mechanisms to facilitate the engagement of indigenous/ ethnic groups' community representatives in the design and monitoring of provincial/ district annual health operation plans, and the annual health sector review processes. At present the indigenous peoples/ ethnic minority communities are not integrated into health facility performance reviews. The use of a Community Scorecard mechanism to engage communities in the evaluation and development of their Health Centers was trialed in Cambodia during 2011-12 and could be a beneficial mechanism for working towards this. Key project stakeholders include:

Community: The indigenous and ethnic groups have their own traditional/ social leaders. For the Indigenous Communities there is a Council of Elders, which helps the community to make decisions/ resolve disputes, and for the Cham community the Imam and Village Chiefs are key social leaders. The active engagement of traditional/ social leaders in projects results in significant additional impact and achievement.

Civil Society: All provinces has NGO and CBOs that have worked with the indigenous/ ethnic minority communities for many years and have built-up strong relationships with the communities and their leaders, they can play a useful role in the dissemination of information and facilitating the engagement of the communities into formal mechanisms.

The existence of such consultation mechanisms related to annual health operation planning, facility and the annual health sector review processes would ensure greater awareness of their particular constraints and needs.