

**Ministry of Health**  
**Health Equity and Quality Improvement Project (H-EQIP) (P157291)**  
Supplemental Indigenous Peoples' and Ethnic Minority Consultations

**Indigenous Peoples Planning Framework**

**Date: December 5, 2015**

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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.

The Royal Government of Cambodia has requested an IDA credit of US\$30 million. Australia, Germany, and Korea have pledged an amount of approximately US\$50 million equivalent to a World Bank managed multi-donor trust fund (MDTF). Government financing for the Program will be discussed during preparation and informed by the negotiated 2016 budget and three-year rolling annual operational plan. The proportion of financing from Government and Development Partners will be agreed prior to negotiations with an expectation that donors would contribute no more than sixty percent and that this portion would decrease over time. The Government will also begin to finance management costs of the HEFs in addition to direct benefits.

## 2. Project Description

The H-EQIP will build on the innovations introduced in HSSP2, particularly HEFs and SDGs, and aims to ensure sustainability of these programs by integrating them into the RGC's health sector program. 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 target health system strengthening, particularly in the areas of improving provider knowledge, improved availability of critical infrastructure in health facilities, and strengthening Public Financial Management (PFM) using disbursement linked indicators (DLIs), a mechanism to disburse against targets achieved. Another key strategic shift is to transfer the responsibility of third party verification from an internationally recruited firm to establishment of an independent Government agency, and extending this responsibility to also verify SDG results.

## **Project Component Descriptions**

### **Component 1: Financial Protection and Equity**

This Component will rebuild the SDGs as 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 SDGs to complement the RGC's proposed lump sum grants to health facilities, particularly by streamlining the funds flow and reporting arrangements envisaged for the same. These new lump-sum grants are intended as an advance for health facility operating costs and complement to the operational budget as defined in their Annual Operational Plans.

#### **Sub-component 1.1: Service Delivery Grants: Health Centers**

The Project will provide SDGs to health centers to help finance the MPA for health centers, which is currently being revised and expected to be finalized by the end of 2015. Grants will be based on the utilization (i.e., quantity) of services provided and quality of services. Initially, the OD, with its health centers will be considered as one unit and ODs (in due course, this responsibility may shift to Councils) will implement the Prakas issued by the MOH specifying services to be provided, the financing linked to these and how an aggregate performance score will be derived based on the quantity and quality of services delivered by its health centers. The quantity and quality of service delivery including utilization by the poor and indigenous population will be systematically determined by the respective OD/ Council through a standardized supervision checklist. As mentioned above, results would be cross-checked and verified by the same independent Government Agency proposed for HEFs as described below. Once verified, the MOH will inform the Ministry of Economy and Finance (MEF) to make the payment. SDGs eligible categories of expenditure would include health facility minor renovations and repairs, equipment, and operational costs such as maintenance and repair, outreach, community participation activities, establishment of new health services (e.g., healthy living style, NCD screening, among others), other quality-enhancement measures and performance bonus for health workers.

#### **Sub-component 1.2: Service Delivery Grants: Referral Hospital CPA-1, CPA-2, CPA-3**

To incentivize improvements in quality of care at the secondary level, performance in capacity building activities for in-service as well as pre-service candidates, and for their promotion of utilization of services by HEF beneficiaries, the Project will introduce a specific performance based financing approach to improve quality of the targeted services at CPA-1, CPA-2, and CPA-3 hospitals, and introducing a system for the CPA level to improve pre-service practical training to university students and to provide on-the-job training support for improving technical quality of the health center staff. Using a standardized supervisory checklist, hospitals will be measured 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 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. SDGs eligible categories of expenditure would include small civil works, equipment, operational costs, e.g., maintenance and repair, establishment of new health care services such as NCD, outreach and other quality-enhancement measures, and performance bonus for health workers.

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

These SDGs aim to strengthen the management functions integral to the delivery of efficient high quality primary and secondary health services. Performance of ODs and PHDs will be measured quarterly against their self-reported activities on a score card measuring key supervisory processes and health system outputs. These include: timely completion of quality checklists for health facilities in their jurisdiction, contribution to capacity building activities for in-service and pre-service training, drug stock outs in health facilities, human resources availability, Health Management Information Systems (HMIS) reports submitted, quarterly review meetings and system functionality, etc. Similar to the other grants, the proposed PCA would verify the performance.

### **Component 2: Quality of Health Service Delivery**

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. 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: Sustainable and Responsive Health System**

The objective of this component is to further strengthen the MOH's systems and support the management of the project. This component would be closely coordinated with other technical assistance programs of DPs and ensure that there is no duplication of any activity already being undertaken. This component includes a mix of regular investment lending approaches and results-based financing using Disbursement Linked Indicators (DLIs).

#### Sub-component 3.1: Health System Strengthening

This sub-component will support the carrying out of a program of activities designed to improve supply side readiness and strengthen the institutions that will be implementing project activities. On the supply side, these will address some of the key bottlenecks for improving the quality of services in the country- through improvements in the knowledge and practical skills of health providers, both at the pre-service and in-service level, as well as through strengthening the health facilities to meet minimum standards for selected priority health interventions such as emergency obstetric care, neonatal care and availability of drugs and commodities. The component also aims to strengthen institutional performance, specifically the PFM support to the RGC's health system and to support establishment of new institutional structures for HEFs and SDGs, all essential for ensuring the successful implementation of the project activities under components 1 and 2.

#### Sub-component 3.2: Project Management and Technical Assistance

Project management will be integrated into the responsible departments of the MOH. The needs for technical assistance (TA) will be identified following assessment of other donors and request from the MOH. TA costs can be funded from this sub-component where essential for

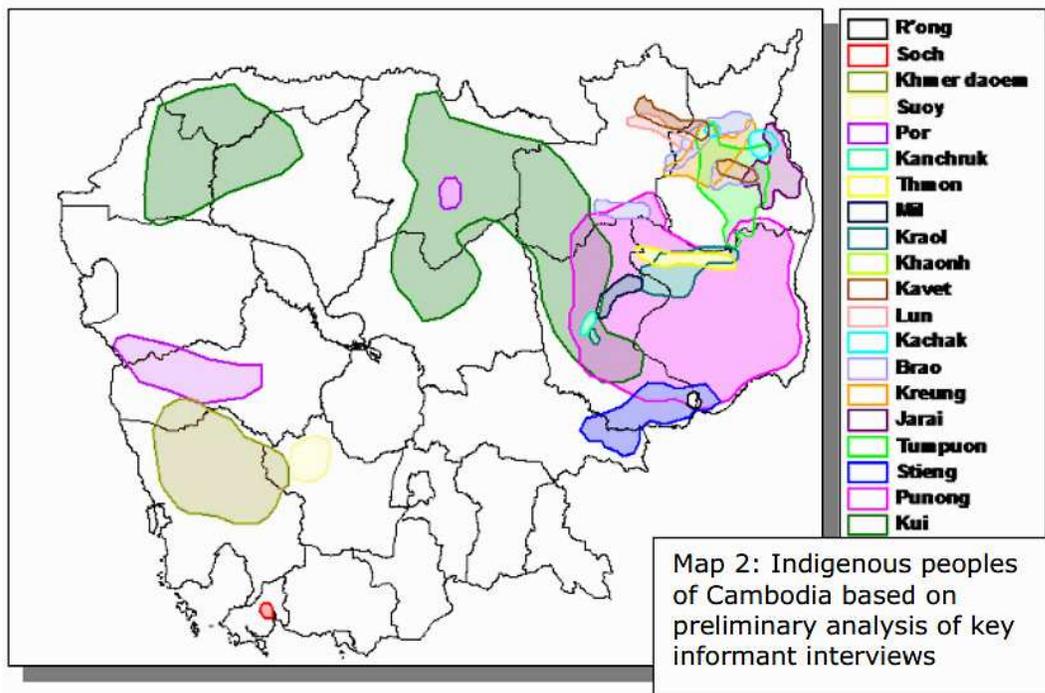
the attainment of project objectives and not being financed or envisaged by any other development partner in the country.

**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 Cambodia<sup>1</sup>:



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

<sup>1</sup> Source: NGO Forum (Cambodia) 2006.

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 program. The consulted indigenous peoples/ ethnic minorities did not express any concerns about possible negative impacts of the proposed program 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 program 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     |
|---|---|----------------------|
| <b>Component 1:</b><br>Strengthening Health Service Delivery. | The program will provide performance-based financing to primary and secondary health facilities based on the actual achievement of results. 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. | Positive:<br>Medium. |
| <b>Sub-component 1.1:</b> Service                             | Eligible categories of expenditure include: health outreach service provision, community participation activities, the establishment of new health services and performance based bonuses for health  |                      |

|  |   |                          |
|--|---|--------------------------|
| <p>Delivery Grants: Health Centres.</p> <p><b>Sub-component 1.2:</b> Service Delivery Grants: Hospitals.</p> <p><b>Sub-component 1.3:</b> Service Delivery Grants: PHDs and ODs.</p>                                       | <p>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 hospitals, 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 Centre staff. The program will also introduce a specific performance based financing approach to improve the quality of targeted services.</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><b>Component 2:</b> Improving Financial Protection and Equity.</p>  | <p>This component of the program 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><b>Component 3:</b> Ensuring Sustainable and Responsive Health Systems.</p> <p><b>Sub-component 3.1:</b> Health System Strengthening.</p> <p><b>Sub-component 3.2:</b> Program Management and Technical Assistance.</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.</p> <p>It is expected that this support will translate into improved access to primary care in marginalized communities, competency based</p> | <p>Positive: Medium.</p> |

|   |  |                      |
|---|--|----------------------|
|   | training for health workers posted in Health Centres and the linking the payment of SDGs to health service performance and quality improvements.   |                      |
| <b>Component 4:</b><br>Contingent<br>Emergency<br>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:<br>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 Mondulakiri 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 countries 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.”<sup>2</sup>

## 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:

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,

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

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 reside 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; (a) 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 program 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   |
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| <p><b>Component 1:</b><br/>Strengthening Health Service Delivery.</p> <p><b>Sub-component 1.1:</b> Service Delivery Grants: Health Centres.</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: 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, including the promotion of and increased utilization of services by HEF beneficiaries.</p> <p>SDG Health Centre supervision checklist 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><b>Sub-component 1.2:</b> Service Delivery Grants: Hospitals.</p> <p><b>Sub-component 1.3:</b> Service</p>                                   | <p>Training and the provision of on-the-job training support will be targeted in Health Centres 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>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>  |

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| <p>Delivery Grants:<br/>PHDs and ODs.</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><b>Component 2:</b><br/>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"> <li>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.</li> <li>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.</li> <li>3. Collaborate with relevant sub-national government departments to enhance targeting efficiency and reduced inclusion and exclusion errors, particularly for indigenous/ ethnic minority groups.</li> </ol>  |
| <p><b>Component 3:</b><br/>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>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>  |

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| <p><b>Sub-component 3.1:</b><br/>Health System Strengthening.</p> | <p>Activities under component 3.1 will focus on the development and implementation of strategies to:</p> <ol style="list-style-type: none"> <li>1. Improve access to primary care for indigenous peoples/ ethnic minority communities.</li> <li>2. Identify existing indigenous/ ethnic minority health workers posted in relevant Health Centers to undergo competency training at CPA hospitals/ Regional Training Centers.</li> </ol> <p>Activities under component 3.2 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.