

Cambodia Nutrition Project (CPN: P162675)

Indigenous Peoples Planning Framework

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1. Introduction

Emerging from widespread poverty in the 1990s, Cambodia health outcomes have improved rapidly and surpassed several countries which were much better off at this time. Despite progress on many fronts, maternal and child undernutrition remain a significant public health challenge, constraining the foundations of Cambodia's human capital formation. Although child stunting (low height-for-age) declined from 59% in 1996 to 32% in 2014, prevalence remains 'high' according to WHO public health thresholds. Child wasting (9.6 percent) is also considered 'high', particularly given low levels of absolute poverty and food insecurity. Maternal undernutrition contributes to poor pregnancy outcomes for women and their children: fourteen percent of women age 15-49 are underweight. Among women of reproductive age, nearly half (44 percent) suffer from anemia. Poor maternal health and nutrition during pregnancy (including maternal anemia and underweight) contribute to the high burden of children born with low birth weight (11 percent) as well as the in utero origins of stunting (UNICEF 2016).

Inequities in reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) outcomes persist and need priority attention. National averages mask distinct disparities in RMNCAH-N outcomes for Cambodia's rural, remote, indigenous, and socioeconomically challenged families. The wealth gap in child mortality has remained unchanged since 2005 at roughly three times higher for poor and rural children compared to wealthy and urban. Between 2000 and 2014, both absolute and relative inequality gaps in NMR by household wealth and place of residence increased. Stunting prevalence in the poorest wealth quintile (42 percent) is more than double that of the richest (18 percent) with the wealthiest experiencing the most rapid improvements. DPT3 coverage is 91 percent among the wealthiest children but only 61 percent in the poorest. Simultaneously, new challenges are emerging to address the RMNCAH-N needs of vulnerable urban and migrant populations.

The determinants and drivers of malnutrition are multiple, interacting, and multisectoral. Therefore, reducing the burden of child stunting and wasting in Cambodia will require interventions to: i) prevent the in utero origins of growth faltering (through improvements in maternal health and nutritional status); ii) improve the immediate drivers of malnutrition (nutrient intake and disease); and iii) simultaneously address underlying drivers (food insecurity, poor care for women and children, low access to health services, and poor access to water, sanitation, and hygiene).

2. Project Description

The project aims to serve as an anchor for an enhanced and coordinated response to accelerate the country's human capital formation, focusing on facility- and community-based approaches to maternal and child health and nutrition in the early years.

Component 1: Strengthening the Delivery of Identified Priority Health Services

Component 1 leverages the HEF and SDG systems—existing results-based health sector platforms—to improve the supply-side delivery of identified priority interventions. The component will support a shift from plans to implementation and aim to improve the accessibility, affordability, and quality of these identified priority services. The component has two sub-components, one aimed at increasing the availability and quality of services, and the second aimed at stimulating service utilization, primarily for the poor.

Component 1.1 Performance-based Service Delivery Grants (SDGs) to Improve Availability and Quality of Identified Priority Services. Sub-component 1.1 will build on Cambodia's

NQEM processes to accelerate improvements in health service quality across the continuum of care for women and children. A performance-based SDG top-up payment will be provided to health facilities based upon the score from a Maternal and Child Health and Nutrition (MCHN) Scorecard. The MCHN Scorecard will focus on the eleven identified priority services, including reduction of gaps in routine immunization and improvements in integrated outreach.

Component 1.2: Expanding Health Equity Funds (HEFs). This sub-component aims to enhance the equity of priority RMNCAH-N outcomes through an expansion of the scope of coverage for the current HEF system. These expansions of service and population coverage will increase utilization of identified priority RMNCAH-N services among targeted vulnerable populations.

Component 2: Stimulating demand and accountability at the community level

Component 2 will finance community-based interventions in seven priority provinces to stimulate demand, increase utilization of facility-based priority services, and encourage the adoption of improved RMNCAH-N behaviors.

Sub-component 2.1: Commune/Sangkat (C/S) Service Delivery Grants (C/S-SDGs) for Women and Children. Sub-component 2.1 will provide financing for communes to deliver CPWC activities via the performance-based C/S-SDG grant. The grant adapts the successful MOH SDG system and applies the principle to sub-national authorities. The C/S-SDG will provide discretionary support to communes over and above the C/S fund to ensure the delivery of activities in accordance to the CPWC guideline.

Sub-component 2.2: Building Capacities, Monitoring, and Verifying C/S-SDG. This sub-component will support a program of activities necessary to activate and operationalize the C/S-SDG system, including: i) development and roll-out of the C/S-SDG operations manual and implementation guidelines; ii) conduct of six-monthly commune *ex-ante* scoring by district; and iii) capacity building and coaching for sub-national authorities to implement the C/S-SDG program. The C/S-SDG scoring, and verification processes will leverage the CPWC actors and mechanisms to integrate the transparency, community monitoring, and joint annual planning (between the community, commune, and health sector) as outlined in the ISAF.

Sub-component 2.3 Project Management, Monitoring, and Evaluation for NCDD. This sub-component will support provision of technical and operational assistance for the routine administration, procurement, financial management (FM), environmental and social safeguards management, and M&E of Component 2 activities (including financial audits of the project). The sub-component will also support the procurement of a third party entity to conduct *ex-post* independent verification of C/S-SDG scores.

Component 3: Ensuring an Effective, Sustainable Response

This component will finance: i) central level actions needed to enhance the effectiveness and sustainability of project investments; ii) development and delivery of modernized social and behavior change communication (SBCC) campaigns; iii) comprehensive monitoring, evaluation and adaptive learning; and iv) project management.

Sub-component 3.1 Strengthening the functional and technical capacities at national and

sub-national levels. This sub-component will support MOH national centers and departments to: (i) create an enabling environment and (ii) improve supply-side readiness, responsiveness, effectiveness, and delivery of identified priority interventions financed in Components 1 and 2. In addition, a DLI has been added for CARD in order to strengthen the leadership and ownership of the multisectoral nutrition agenda at the national and provincial levels, in alignment with the forthcoming revised National Strategy for Food Security and Nutrition.

Sub-component 3.2: Development of a Comprehensive SBCC Campaign. The sub-component will support the National Maternal and Child Health Center to design and roll out modern, effective SBCC campaigns and associated content. Sub-component 3.2 will be financed on an input basis and will support additional technical assistance and formative research required to prepare content, the development of materials (mass/social media, print, radio, etc.) and support for delivery (the development and roll-out of operational guidelines via training and/or coaching modalities). The priority will be to support relevant programs in the NMCHC to develop a campaign focused on Maternal, Infant, and Young Child Nutrition, for which there has been ongoing strategic and technical support.¹ The component can further support the creation of SBCC materials for HEF promotion and other health promotion activities in collaboration with relevant departments. This component will also be able to finance the procurement and use of technology to improve the quality and reach of SBCC. Mass/social media activities can be implemented with national coverage, while the interpersonal activities will have a phased roll out beginning with the seven priority provinces.

Sub-component 3.3: Monitoring, Evaluation, and Adaptive Learning. The sub-component will support the strengthening of monitoring and evaluation (M&E) systems for RMNCAH-N in Cambodia, including data collection, reporting, and analysis at sub-national and national levels.

Sub-component 3.4: Project Management (MOH). This sub-component will support the provision of technical and operational assistance for the day-to-day coordination, administration, procurement, financial management (FM), environmental and social safeguards management, and M&E and reporting of the project, including the carrying out of financial audits of the whole project. The sub-component will also support capacity strengthening of responsible departments with the MOH to ensure continued ability of relevant departments to support project management and implementation needs and support operational costs of the Project Coordination Unit (PCU) to deliver on the project's cross-sectoral coordination requirements.

3. Potential Issues and Impacts on Indigenous People (IP)

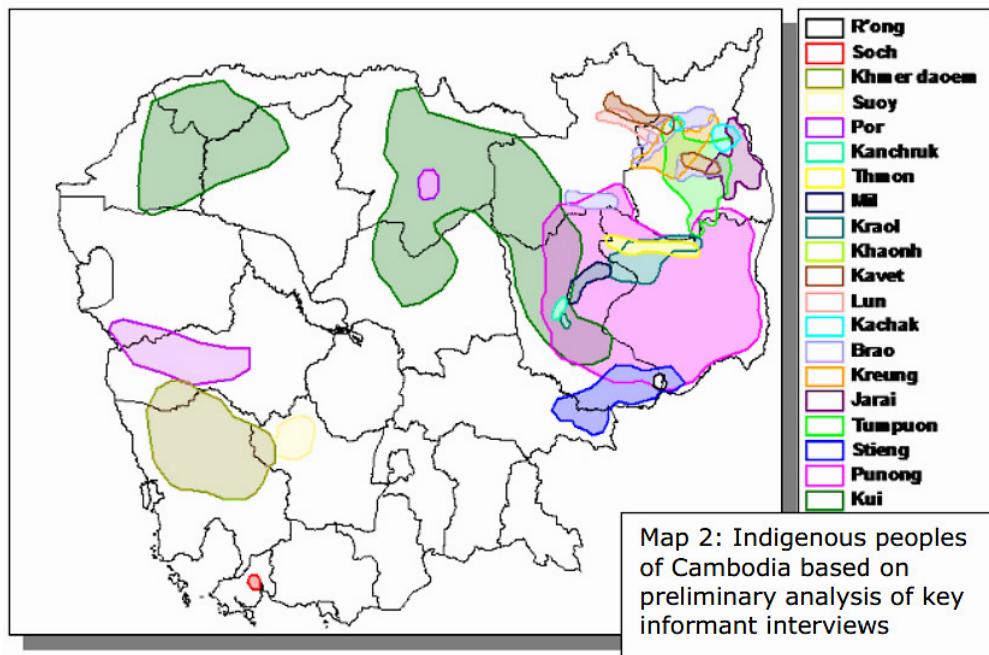
¹ With technical support from UNICEF, Helen Keller International, Alive & Thrive, and the World Bank, the NNP has conducted robust formative research into maternal, infant and young child nutrition behaviors; developed a comprehensive national strategy; and initiated the development of a multi-channel and contextually relevant SBCC campaign. The World Bank WASH and HNP teams have collaborated with MRD and NNP to conduct an implementer assessment to support operationalization of the campaign.

Based upon the window of opportunity to achieve maximum impact on improving nutrition, immunization, and neonatal mortality, the primary beneficiaries will be pregnant and lactating women and children under age 2 in Cambodia, with a priority focus on the poor and underserved. While the project's systems and institutional strengthening activities will take place at the national level, implementation of community and facility level activities will be rolled out in a phased manner, covering sub-national geographies as feasible within the financing envelope. The Investment Case for RMNCAH-N has identified seven priority, high need provinces for intensive support: Mondulkiri, Ratanakiri, Kratie, Steung Treng, Preah Vihear, Kampong Chhnang, and Koh Kong. All districts in these provinces will roll out the MCNH Scorecard and will receive component 2 financing. Table 10 describes the estimated project beneficiaries, including the secondary target population of all community members interacting with first 1,000 days beneficiaries.

Table 1. Project beneficiaries in seven prioritized provinces

Age groups	Male	Female	Total
Infants (0-1)	20,852	20,427	41,278
Children under five (0-5)	101,749	98,541	200,291
Women in reproductive age (15-49)		426,826	
Total population (0-100)	829,107	847,724	1,676,831

The map below gives an overview of the geographical distribution of Indigenous Peoples in Cambodia²



Source: NGO Forum (Cambodia) 2006.

The Cambodian definition of ethnic minorities does not include Vietnamese, Chinese and other groups who are considered 'migrants', despite many living in Cambodia for generations due mainly to the fact that they reside in areas with easier access to public services and most of them are not as poor as people living in remote and mountainous areas. If a wider definition

of ‘ethnic’ groups were to be applied to include Cham, Lao, Vietnamese and Chinese populations, then the non-ethnic Khmer population is estimated to be approximately 6% of Cambodia’s total population. Indigenous Peoples’ groups are dispersed widely across Cambodia, but are mainly concentrated in twelve provinces; 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 Meancheay:	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 Meancheay:	Kuoy.
12 Koh Kong:	Chong.

As a part of the Social Assessment, focus group discussions were facilitated by an NGO, Catholic Relief Services (CRS), in three provinces with high concentration of indigenous people, Mondul Kiri, Ratanak Kiri and Kratie and with different ethnic groups that have large populations, namely Phnong, Tumpoun and Stieng in December 2018². The main findings of the community consultations were:

- The consulted IP participants have a strong desire to engage with the Project’s activities and a willingness to learn more about the Project.
- The consulted IP groups indicated that they felt that their non-Khmer communities would benefit from the Project as designed to the same level as other Khmer communities though they believed the project would strongly benefit women and children more than others.
- IP communities still face challenges in access to health services as a result of financial barriers, their limited understanding of healthcare services, and the quality of services delivery for IP needs at health centers. In particular, all IP focus group indicated that IP communities were encountering issues with the IDPoor system and their understanding of it.
- IP focus groups stated a desire for greater accessibility to health services in the form of greater service provision hours and days at health facilities. In relation to the Project specifically, IP participants asked that Project activities be timed to align with their cultural and schedule needs, such as ceasing of activities in communities during mourning periods and holding events in early morning or late evening.
- IP focus groups indicated that they wished to be involved in the Project and indicated that village-level consultations with their communities to feedback on the Project using neutral third-party entities (such as CSO/NGOs) would be their preferred means of consultative feedback.

² Source: CNP Social Assessment Report 2018 submitted by the Catholic Relief Services

All three focus group discussions focused on possible adverse impacts from the project on their communities. Following this extensive discussion, the only key issue to arise was that of possible negative impacts on community members if they wished to participate in the project. Specifically, participants were concerned that if consultation and outreach to the communities was not done in a manner that was sensitive to their cultural needs (such as not scheduling events in communities during mourning periods) and with consideration to their routine schedules (such as forest gathering periods and when they come back from the field), then either project participation would negatively impact their traditions and livelihoods, or they would be unable to participate and thus be underrepresented. As such, all FGD requested that this risk be mitigated through the designing of consultations in a manner that aligned well with the IP communities' needs.

The consultations with indigenous peoples/ ethnic minorities undertaken during the Social Assessment as well as further analysis of the project design have identified limited, if any, potential adverse effects of the project. The anticipated positive and potentially adverse impacts of each project component and subcomponent are summarized in the table below as well as actions that can be taken to minimize any adverse impacts and ensure that project benefits are equally accessible and culturally appropriate for IP groups in the target project areas.

Project Component	Activities and Potential Impacts	Actions to Mitigate Adverse Impacts and Ensure Culturally Appropriate Benefits
COMPONENT 1: Strengthening the Delivery of Identified Priority Health Services		
Sub-component 1.1: Performance-based Service Delivery Grants (SDGs) to Improve Availability and Quality of Identified Priority Services.	This sub-component aims to accelerate improvements in health service quality across the continuum of care for women and children. A performance-based SDG top-up payment will be provided to health facilities based upon the score from a Maternal and Child Health and Nutrition (MCHN) Scorecard. The MCHN Scorecard will focus on the eleven identified priority services, including counselling for pregnant and lactating women, early breast-feeding, maternal, infant and young child nutrition (MIYCN), growth monitoring and promotion, identification and referral of severe acute malnutrition (SAM), vitamin A supplementation, immunization, and iron folic acid supplementation. It is expected that performance-based grants will translate into improved management, increased service utilization, better provider behaviour, increased community participation (including IP groups) and strengthened health service delivery at facility and community levels.	Use of targeted services by IP groups at HCs and in the communities, particularly in areas with high IP populations, will be monitored and reviewed on an at-least-annual basis to identify changes in HC use and to identify challenges to IP use of services, and to include actions to address such challenges in annual work plans for the respective HCs and ODs. An effort to specifically obtain patient feedback through the formal assessment process for HCs from IP groups should be made in order to better understand their specific service delivery experience.
Sub-component 1.2: Expanding Health Equity Funds	This sub-component aims to enhance the equity of priority reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH-N) outcomes through an expansion of services and population coverage for the current HEF system to increase utilization of identified priority RMNCAH-N services among targeted vulnerable populations. The project will support three areas of HEF benefit	Use of targeted IDPoor/HEF Cards will be monitored and reviewed on an at-least-annual basis to identify changes in HEF use and to identify challenges to IP use of IDPoor/HEF cards and to include actions to address such challenges in annual work plans for the respective HCs and

	<p>expansion including (1) defining standard operating procedures for a well-child visit for children age 0-2; 2; extension of HEF benefits to the children (age 0-2 years) of informal workers, and (3) transport allowances for identified priority services.</p>	<p>ODs. A focus may be needed on encouraging the use of the post-ID Poor identification system available through MOH to ensure that all eligible IPs have the appropriate documentation to receive free services. HEF Promoters should also include representative of IP groups to enable them to better communicate with their respective IP groups.</p>
Component 2: Stimulating Demand and Accountability at the Community Level		
Sub-component 2.1 Commune/Sangkat (C/S) Service Delivery Grants (C/S-SDGs) for Women and Children	<p>Activities under this sub-component 2.1 will be financed through a performance-based grant to incentivise communes (the sub-national authorities/SNA) to enable the scale up of the Commune Program for Women and Children (CPWC)'s community-based health, nutrition, and HEF promotion activities alongside results-based (Component 2.2) and input-based (Component 2.3) investments in the underlying systems and capacities necessary to deliver such activities. Under this sub-component it is expected to have increased utilization of identified priority health and nutrition services by the communities especially the indigenous populations/ethnic minority groups; strengthened the links between SNA, public health providers, and citizens; and improved SNA commitment and accountability to deliver and sustainably finance relevant social service activities linked with the project's identified priority services. Commune performance will be assessed through semi-annual scoring carried out by certified provincial/district assessors using a developed Commune/Sangkat SDG checklist. An independent firm will be recruited to conduct performance verification.</p>	<p>Village Health Support Groups are encouraged to include representatives of all IP groups in their areas in order to ensure that they receive appropriate communications and have appropriate mechanisms for providing feedback on service delivery. IP group representatives should also be engaged as the collectors of commune performance evaluation data for the checklist and/or facilitators of community scorecards and the sharing of information on commune performance (i.e. through the use of Implementation Plan for Social Accountability/ISAF activities). Use of commune-level services by IP groups should also be monitored as part of the data collected to evaluate commune performance to the extent possible.</p>
Sub-component 2.2: Building Capacities, Monitoring, and Verifying C/S-SDG	<p>This sub-component will support a program of activities necessary to activate and operationalize the C/S-SDG system, including: i) development and roll-out of the C/S-SDG operations manual and implementation guidelines; ii) conduct of six-monthly commune <i>ex-ante</i> scoring by district; and iii) capacity building and coaching for sub-national authorities to implement the C/S-SDG program. It will be financed using disbursement linked indicators (DLIs), a set of tracer indicators with annual targets aimed at paying against its performance.</p>	<p>The preparation of these materials and approaches should take into consideration an emphasis on maximizing inclusion of IP groups and other marginalized or vulnerable groups.</p>

Sub-component 2.3 Project Management, Monitoring, and Evaluation for NCDD	Project management will be integrated into the responsible units and departments of NCDD-S. It is expected that the support of this sub-component will contribute to improved provision of technical and operational assistance for the routine administration, procurement, financial management (FM), environmental and social safeguards management, and monitoring and evaluation.	Social safeguards training for NCDDS and subnational authorities should include sessions/modules on the WB policy, OP 4.10 and ensure that NCDDS social risk management policies and procedures align with WB policy to the extent possible. NCDDS strategies on gender and social inclusion should be applied to this project.
COMPONENT 3. Ensuring an Effective and Sustainable Response		
Sub-component 3.1 Strengthening the functional and technical capacities at national and sub-national levels	It is expected that the support of this sub-component to MOH national centers and departments will translate into (i) create an enabling environment and (ii) improved supply-side readiness, responsiveness, effectiveness, and delivery of identified priority interventions financed in Components 1 and 2. In addition, a DLI has been added for Council of Agriculture and Rural Development (CARD) in order to strengthen the leadership and ownership of the multisectoral nutrition agenda at the national and provincial levels, in alignment with the forthcoming revised National Strategy for Food Security and Nutrition.	Social safeguards training for MOH national and subnational levels should include sessions/modules on the WB policy, OP 4.10 and ensure that MOH social risk management policies and procedures align with WB policy to the extent possible.
Sub-component 3.2 Development of a Comprehensive SBCC Campaign	The sub-component will support the National Maternal and Child Health Center to design and roll out modern, effective SBCC campaigns and associated content. It is expected that the new SBCC will contribute to behavior change of pregnant/lactating mothers and especially among the indigenous populations/ethnic minority groups toward appropriate maternal, infant, young child nutrition practices.	All SBCC documents and approaches should be customized for local circumstances to the extent possible, including consideration of culturally appropriate means of communication for various IP communities. This would include the possible use of audio material in local languages, the use of local language facilitators, communicators, coordination of traditional, tribal leaders in the organization and delivery of activities.
Sub-component 3.3: Monitoring, Evaluation, and Adaptive Learning	The sub-component will (1) contribute to strengthened monitoring and evaluation (M&E) systems for RMNCAH-N in Cambodia, including data collection, reporting, and analysis at sub-national and national levels; (2) complement the proposed financing of an impact evaluation external to the project; and (3) support deployment of an adaptive learning, or “learning-by-doing” approach in years 1-2 of the project – a trial period in which all the above described system as well as the component 3 revisions	(1) Dissagregation and analysis of data to identify IP groups is encouraged to the extent possible. This may include supplementing existing systems with addition data collection to collect IP-specific data. (2) Include the study on impact of the project on IP health and nutritional status.

	and training program will be developed, piloted, revised and adapted.	(3) IPs health and nutritional status will improved as resulted from the improved system health system performance.
Sub-Component 3.4 Project Management	The sub-component will support capacity strengthening of responsible departments within the MOH to ensure continued ability of relevant departments to support project management and implementation needs.	Social safeguards training for MOH implementation teams should include sessions/modules on the WB policy, OP 4.10 and ensure that MOH social risk management policies and procedures align with WB policy to the extent possible.

4. Legal, Policy and Regulatory Frameworks

- World Bank Operation Policy, (OP) 4.10, Indigenous Peoples

The World Bank safeguard policy on Indigenous Peoples is triggered as the proposed project is nation-wide in coverage and includes the 12 provinces where indigenous peoples/ ethnic minorities reside and the predominantly indigenous peoples' populated provinces. As required by OP 4.10 a process of free, prior, and informed community consultation was carried out in three provinces with high IP concentration, Mondul Kiri, Ratanak Kiri and Kratie and with the most populous ethnic groups (*Phnong, Tumpoung and Stieng*). Whilst OP 4.10 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. As for health sector, it only emphasized that relevant health institutions should promote hygiene, use of clean water, prevention and treatment of communicable diseases, vaccination for children and pregnant women and nutrition for indigenous people as well as providing free care services to those poor indigenous people.

In relation to health policy, both the Health Strategic Plan 2008-15 and 2016-2020 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. In addition, the MoH Fast Track Roadmap for Improving Nutrition 2014-2020 did not provide any specific intervention to this particular group. 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.”³

5. Implementation and monitoring arrangements

The project will be implemented by two implementing agencies: The Ministry of Health, acting as Executing Agency, and NCDDS of MOI. MOH will implement components 1 and 3 through its technical departments, the national programs, and the PHDs, ODs, RHs, and HCs. The NCDDS of MOI will implement component 2 through its technical departments and the provincial, district/khan, and commune/Sangkat administrations.

Ministry of Health (MOH)

The institutional arrangements are based on the implementation experience of the H-EQIP. As mentioned above, the MOH will be the Executing Agency which oversees the implementation through its technical departments, national programs as well as the PHDs, ODs, referral hospitals and health centers. As such, the Preventive Medicine Department (PMD) of MoH is responsible for overseeing the implementation of this IPPF and any related IPPs. The MoH will strengthen the implementation of the Community Participation activities to enhance community level participation for IPs to better participate in decisions related to improving health services for indigenous persons'/ ethnic minorities, and respond more effectively to their particular concerns in a culturally appropriateness.

Operational Districts (OD)

All Operational Districts in the seven priority provinces 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 integrated packages of health outreach activities, Health Center Management Committee (HCMC) meetings and Village Health Support Group (VHSG) meetings with the participation of its members and especially an IP representative as recommended by the Community Participation Policy of the MOH. In addition, the certified OD assessors will (1) carry out the quality performance assessment regularly using the National Quality Enhancement Monitoring Tools(NQEMT) including the MCHN Scorecard, (2) conduct coaching and training activities to improve MCHN performance indicators; and (3) conduct training for VHSG and CPWC.

Health Centers:

Health Service Provider—frontline primary care services for patients including maternal and child health, nutrition, immunization, communicable and non-communicable diseases. Conduc

³ Source: Report submitted to the 62nd session of the UN Commission on Human Rights.

HCMC meetings and conduct quality assurance for VHSGs. In addition, all health centers located in those seven priority provinces will play a primary role in the implementation of the IPPF and serve as the frontline to provide quality minimum package of services (MPA). They will plan and regularly (1) conduct integrated health outreach activities, particularly for remote and difficult to reach population, following the Integrated Outreach Management Guidelines (*updated February 2013*);

National Committee for Sub-National Democratic Development Secretariat (NCDD-S)/MOI

The NCDD-S will provide policy guidance, authorization and oversee the implementation of the CNP component 2 activities which will be carried out by its provinces/districts, Communes/Sangkats (C/S) administrations according to the Cambodia's Decentralization and Deconcentration reform (D&D). In addition, the NCDD-S will assign social safeguard focal point to oversee the implementation of the IPPF at the Communes/Sangkat levels.

Province/District Administrations

Every six months, certified administrative provincial/district assessors in seven priority provinces will conduct quality performance assessment in their own communes, report the assessment scores to the NCDD-S and also provide training and coaching to build capacity of communes to implement C/S-SDG.

Commune Authorities

Commune Authorities in these seven-priority provinces will integrate planning and budgeting of C/S-SDG into standard Commune Investment Plan (CIP) processes; reporting on C/S-SDG funds; consolidation of C/S-SDG indicators on semi-annual basis; and convene quarterly HCMC meetings.

Commune Committee for Women and Children Focal Point (CCWC-FP)

The CCWC-FP will provide administrative oversight and mentoring for the village assistants; monitoring and supervision of commune and village level CPWC activities; acts as a focal point for C/S-SDG scoring; participate in CIP and C/S-SDG planning; support to commune clerk to ensure allocation of C/S-SDG funds to planned activities.

Village Health Support Groups (VHSG)

The VHSG will conduct activities as per CPWC guidelines, including: community mobilization, health and nutrition education, HEF promotion activities; conduct village social mapping; support VA in gathering village data for C/S-SDG checklist; nominated members participate in HCMC meetings and report back.

MoH and NCDD-S Social Safeguards Focal Points

The assigned MoH and NCDD-S Social Safeguards Focal Points (FPs) will be responsible for:

- (i) Participating in training conducted by the World Bank on social safeguards, sharing information and providing further training to other project stakeholders, as needed.
- (ii) Overseeing the implementing activities as per the IPPF and ensure that indigenous peoples/ ethnic minorities in target areas are receiving culturally appropriate support.
- (iii) Conducting public consultative meetings in indigenous peoples/ ethnic minority communities as part of regular project supervision missions, during the midterm and

- end of project evaluations in order to further identify needs for additional activities to ensure that IP groups benefit from the project, and in cultural appropriate way.
- (iv) Preparing documentation for dissemination to project stakeholders (i.e. activity concept notes) to highlight any issues that limit access to culturally appropriate nutrition-related health services/ health promotion and issues of concern raised by indigenous peoples/ ethnic minorities identified during public consultations and research funded by the program and proposed activities to address these concerns.
 - (v) Identify any potential adverse impacts as result of project implementation, and articulate/ advocate for appropriate program implementation modifications (including coverage of any costs to implement such modifications) during project implementation, but particularly as a part of the preparation of project-specific annual work program and budgets (AWPBs).

The World Bank Role

As part of monitoring project implementation progress, the World Bank will assign a social safeguards specialist to provide technical and operational support for the implementation of the IPPF for both the MOH and NCDD-S. The social safeguards specialist will:

- i. In coordination with the MOH and NCDD-S, conduct site visits to the areas where indigenous peoples reside in order to verify compliance on provisions in IPPF as policy requirements.
- ii. Conduct social safeguard training for relevant staff at central and sub-national levels of MoH, NCDD-S in provinces with high concentrations of indigenous peoples'/ ethnic minorities.
- iii. Provide ongoing support, as needed, to project implementing agencies to design interventions to ensure that IP groups obtain the maximum benefit from the project in culturally appropriate ways.

6. Capacity building measures

The project will focus on capacity building at national levels in functional and technical aspects, work with C/S and HC to sustainably mobilize resources for identified priority interventions, and routinely monitor and improve program performance. The capacity building will take into consideration the culturally appropriateness of the IP communities in the target provinces.

The project's institutional development activities will strengthen capacity for lesson learning across the two agencies, 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 Social Assessment.

Limited understanding and low level of literacy 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 project will ensure that relevant Health Centres/ community groups 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 these are important resources that need to be better used by relevant MoH departments.

Enhanced participation of indigenous peoples'/ ethnic minority communities, CCWC 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 and NCDD-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, CCWC 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 and the NCDD-S are committed to increasing the participation of all sections of society in monitoring services as a means of enhancing public accountability. The project 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 health operational districts and administrative 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.

Capacity Building for MOH and NCDD-S. The mainstreaming of safeguards is necessary to support targeted interventions in the seven priority 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, NCDD-S at the central level and in provinces/ operational and administrative districts with high concentrations of indigenous persons'/ ethnic minority populations
- (ii) Improving the delivery of culturally appropriate health services at the health centre levels targeting information and behavior change communication activities using culturally appropriate health promotion materials, and extended health service provision to community level using the existing community platform namely the VHSG, HCMC, Commune Councils, CCWC-FP and village chiefs.
- (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

A national-level stakeholder consultation meeting on the EMP and IPPF for the Cambodia Nutrition Project (CPN) was led by Department of Preventive Medicine Department (PMD), Ministry of Health (MoH), with technical support from the World Bank safeguard team on 18th October 2018. This consultation meeting was participated by 43 participants including health staff from HCs and referral hospitals, representatives from relevant health departments and national programs, NGOs AND UN agencies.

The consultation meeting revealed strong support to improve the nutritional status of targeted women and children especially for indigenous people in the priority provinces. Key issues for the project to address were identified such as poor complimentary feeding practices among IP communities due to their limited knowledge coupled with cultural/language barriers and the need to provide culturally appropriate and sensitized Information, Education, Communication (IEC) and Behavior Change Communication (BCC) materials (IEC/BCC) materials to promote their health awareness and appropriate practice.

As summarized above in Section 3, as a part of the Social Assessment, community consultations were facilitated by an NGO, Catholic Relief Services, in three provinces with high concentration of indigenous people, Mondul Kiri, Ratanak Kiri and Kratie and with different ethnic groups that have large populations, namely Phnong, Tumpoun and Stieng in December 2018⁴. These consultations have further informed the preparation of this IPPF.

Led by the Social Safeguard Focal Points, both MOH and NCDD-S will engage in ongoing consultation with target communities, specifically targeting IP groups, during the period of implementation. At least semi-annual field visits by each implementing agency will include visits to villages with IP groups to obtain feedback on project implementation and the findings of these consultations will be incorporated into field mission reports as well as formal project reports, including the midterm review and final project reports. Most importantly, the findings of ongoing consultations will be used to inform the preparation of annual Indigenous People Action Plans as described below in Section 8.

The IPPF has been prepared based on these two consultations' findings and recommendations as well as the findings of relevant elements of a Social Assessment and IPPF (last update February 2016) prepared by MOH for the H-EQIP project and it will be disclosed on the Ministry of Health's website and the World Bank's website prior to World Bank appraisal of the project.

8. Annual Indigenous People Action Plans

As many of the specific activities to be implemented each year of the project have yet to be determined due to their community-driven nature (particularly with respect to Component 2), there is a need for annual Indigenous Peoples Action Plans to be incorporated into the Annual Operating Plans (AOPs) prepared by MOH and NCDD-S which are relevant for the project. These AOPs should include a separate section utilizing a simple format (for example, a table with columns for issue identified, proposed action and cost) as well as an attachment with further details, as needed (even if brief), for an annual project Indigenous Peoples Action Plan which describes specific activities to be taken to address the specific needs of IPs to ensure that they benefit from the project to the maximum extent possible, that support is provided in culturally appropriate ways, and that any adverse impacts on IP groups that arise during project implementation are effectively avoided, minimized or mitigated. These annual Action

⁴ Source: CNP Social Assessment Report 2018 submitted by the Catholic Relief Services

plans should include not only brief descriptions of activities to be undertaken within the year, but also any budget required to undertake such activities so that budget resources can be made available, as needed.

While the action plans will be prepared at the national level, in consultation between the two implementing agencies, MOH and the NCDD-S, such actions should also be incorporated into province and district-specific, PHD/OD Annual Operational Plans (AOPs) for the MOH and as well as Commune/Sangkat Investment Plans (CIPs), to the extent possible.

The annual Indigenous Peoples Action Plans for the project will be submitted to the World Bank as part of the Annual Operating Plan (AOP) review and be subject to No Objection to ensure that appropriate attention has been paid to IP issues in the annual plan and that any required budget resources are made available.