KINGDOM OF CAMBODIA
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National Committee for Sub-National Democratic Development Secretariat (NCDD-S)

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Cambodia Nutrition Project - II P177370

Indigenous Peoples Planning Framework (IPPF)

Date: December 2021
Prepared by the Ministry of Health and NCDDS

Introduction

This Indigenous Peoples Planning Framework (IPPF) builds on the IPPF prepared under the CNP-I and accommodates required additional measures an inclusion perspectives of Indigenous Peoples/Ethnic Minority communities of new provinces, including Pursat and Banteay Meanchey that the CNP II is targeting. Given that there are Indigenous Peoples where the project will take place, this IPPF has been developed to screen the presence of Indigenous Peoples in line with the World Bank's Environment and Social Standard 7 on Indigenous Peoples (ESS 7). Following ESS7, to be considered as Indigenous Peoples by this project, groups need to possess the following characteristics in varying degrees:

a. Self-identification as members of a distinct indigenous social and cultural group and recognition of this identity by others
b. Collective attachment to geographically distinct habitats, ancestral territories, or areas of seasonal use or occupation, as well as to the natural resources in these areas and
c. Customary cultural, economic, social, or political institutions that are distinct or separate from those of the mainstream society or culture; and
d. A distinct language or dialect, often different from the official language or languages of the country or region in which they reside.

This ESS also applies to communities or groups of Indigenous Peoples who, during the lifetime of members of the community or group, have lost collective attachment to distinct habitats or ancestral territories in the project area, because of forced severance, conflict, government resettlement programs, dispossession of their land, natural disasters, or incorporation of such territories into an urban area. ESS7 also applies to forest dwellers, hunter-gatherers, pastoralists or other nomadic groups, subject to satisfaction of the criteria above.

This IPPF also provides a general overview of Indigenous Peoples in Cambodia and the seven project provinces, the legislative framework in Cambodia and gaps with the World Bank's ESS7 and the process for grievance redress. As CNP-II will include additional provinces, additional assessments of the characteristics and vulnerability of Indigenous Peoples will be undertaken following determination of these provinces during CNP-II implementation.

1. Project Description

The Cambodia Nutrition Project (or hereafter CNP) – II will provide additional resources to scale up activities implemented by the National Committee for Subnational Democratic Development Secretariat (NCDDS) under the CNP-I (P162675). CNP-I was approved in April 2019 and includes financing amounting to US$53 million. The project development objective (PDO) of CNP-I is to improve utilization and quality of priority maternal and child health and nutrition services for targeted groups in Cambodia. The CNP-I aims to improve utilization and quality of priority Maternal and Child Health Nutrition (MCHN) services in the first 1,000 days of life in seven provinces with lagging health and nutrition outcomes. In addition to increasing the access of poor households to health services, the project is designed to stimulate community demand and accountability by providing performance-based financing to local governments to implement a package of community-based MCHN services.

CNP-I includes three components, including Component 1: Strengthening the Delivery of Priority Health Services (US$24 million), Component 2: Stimulating Demand and Accountability at the Community Level (US$10.8 million), and Component 3: Ensuring an Effective and Sustainable Response (US$18.2 million). The project is implemented by two implementing agencies, including the Ministry of Health (MOH) for Components 1 and 3 and the National Committee for Subnational Democratic Development-Secretariat (NCDDS) for Component 2.

DRAFT FOR CONSULTATIONS

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.

The CNP-I was approved under the Safeguards Policies and is no longer eligible for additional financing for scale-up. The CNP-II is being prepared under the ESF as a separate operation and will provide more robust support for implementing and monitoring of the environmental and social commitments.

The PDO under CNP-II remains the same. The proposed CNP-II project will finance identified priority MCNH services, a subset of interventions drawn from the Investment Case for reproductive, maternal, neonatal, child and adolescent health and nutrition (RMNCAH-N) in Cambodia. These priority services are aimed at reducing neonatal mortality, improving maternal and child nutrition, and improving routine immunization coverage. The priority services were defined in accordance with the expectation of the Royal Government of Cambodia (or hereafter RGC) to converge on interventions with known effectiveness to increase sustainability and efficiency of RMNCAH-N financing. CNP-II will finance community-based promotion elements of these services, rather than direct service provision through health facilities. Specifically, CNP-II will be implemented across two components to mirror the activities supported by CNP-I services, the project is designed to stimulate community demand and accountability by providing performance-based financing to local governments to implement a package of community-based MCHN services.

Targeted groups include pregnant and lactating women and children in the first 1,000 days of life in the targeted provinces: seven provinces already covered by CNP-I plus additional two new provinces. The original seven provinces were prioritized in the RMNCAH-N Investment Case due to their high burden (in absolute and relative terms) of lagging health outcomes, their relatively high deprivation using multidimensional poverty indicators, and their gaps in supply-side service readiness. CNP-II activities will be implemented across the original seven and new (2-3) target provinces. selection criteria for additional provinces include those used in CNP-I focused on burden of health and nutrition issues and gaps in the supply side response; the MOH and NCDDS have also requested to prioritize provinces with urgent needs due to the COVID-19 crisis and where they can capitalize on the accelerated rollout of Cambodia's Decentralization and Deconcentration Process. The MOH and NCDDS will jointly agree on the selected provinces. CNP-II is organized along the following components:

a. **Component 1: Commune/Sangkat (C/S) Service Delivery Grants (C/S-SDGs) for Women and Children (US$8.5 million).** The component will finance the implementation of activities defined under Component 2.1 of CNP-I in the original seven provinces plus the additional 2-3 upon full disbursement of funds allocated under Component 2.1 of CNP-I in these provinces. This is anticipated for the calendar years 2023-2025. The aim of the component is to reduce fragmentation and increase the sustainability of community health and nutrition activities by operationalizing a Commune Program for Women and Children (CPWC) to serve as the community-based health and nutrition platform (with formal links between the SNA and health sector actors).

b. **Component 2: Project Management, Monitoring, and Evaluation for the NCDDS (US$1.0 million).** Component 2 will finance activities otherwise eligible under subcomponent 2.3 of CNP-I, quickly disbursing to adapt to the COVID-19 context. This subcomponent will support provision of technical and operational assistance for routine administration as well as the procurement of additional goods (uniforms, equipment, and supplies for CPWC implementation) and services (C/S-SDG independent verification) and strengthened multisectoral coordination. The component may also support enhanced digital and communications equipment to assist with the implementation of C/S-SDG activities in the COVID-19 context.

The implementing agency for CNP-II will be the NCDDS under the of the Ministry of Interior (MOI), which is one of the two implementing agencies for the CNP-I. NCDDS has the capacity

DRAFT FOR CONSULTATIONS

to provide national-level management and leadership as well as to support sub-national implementation. NCDDS has a strong track record of harnessing existing systems which emphasize the role of decentralization, to coordinate with administrative districts, commune councils, and health centers at the selected locations.

2. Indigenous Peoples Planning Framework

3.1 Objective and Scope

The World Bank's ESS7 on Indigenous Peoples is applicable for this project. CNP-II will be implemented in the seven original provinces mostly concentrated with Indigenous Peoples and two to three new target provinces. Across these provinces, Indigenous Peoples will likely be affected as direct beneficiaries of project activities. This IPPF has been developed to ensure the engagement of indigenous Communities provide opportunities for meaningful consultations and allow Indigenous Peoples to obtain project benefits through socially and culturally acceptable approaches, to promote inclusive participation of commune-level activities and access to benefits, and also is in line with the World Bank's ESS7 on Indigenous Peoples.

The IPPF is applicable for activities financed by CNP-II, which builds on Sub-component 2.1 of the CNP-I. Such activities will support C/S SGDs delivery for women and children across the original seven provinces and two new provinces will be added upon full disbursement of funds allocated under Component 2.1 of the CNP-I in these provinces. NCDDS will be responsible to implement the IPPF in coordination with MOH for the implementation of activities under CNP-II. While CNP-II is being processed as a separate project from CNP-I instead of an Additional Financing for the latter, both CNP-I and CNP-II are technically inter-related and hence, the IPPF is also expected to be implemented across activities where there is a substantial interface across these two projects, particularly for the delivery of C/S SDGs which is being supported by both CNP-I and CNP-II.

3.2 Analysis of Issues and Enhancement Opportunities

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 nine priorities, high need provinces for intensive support: Mondulkiri, Ratanakiri, Kratie, Steung Treng, Preah Vihear, Kampong Chhnang, Koh Kong, Banteay Meanchey, and Pursat. 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.

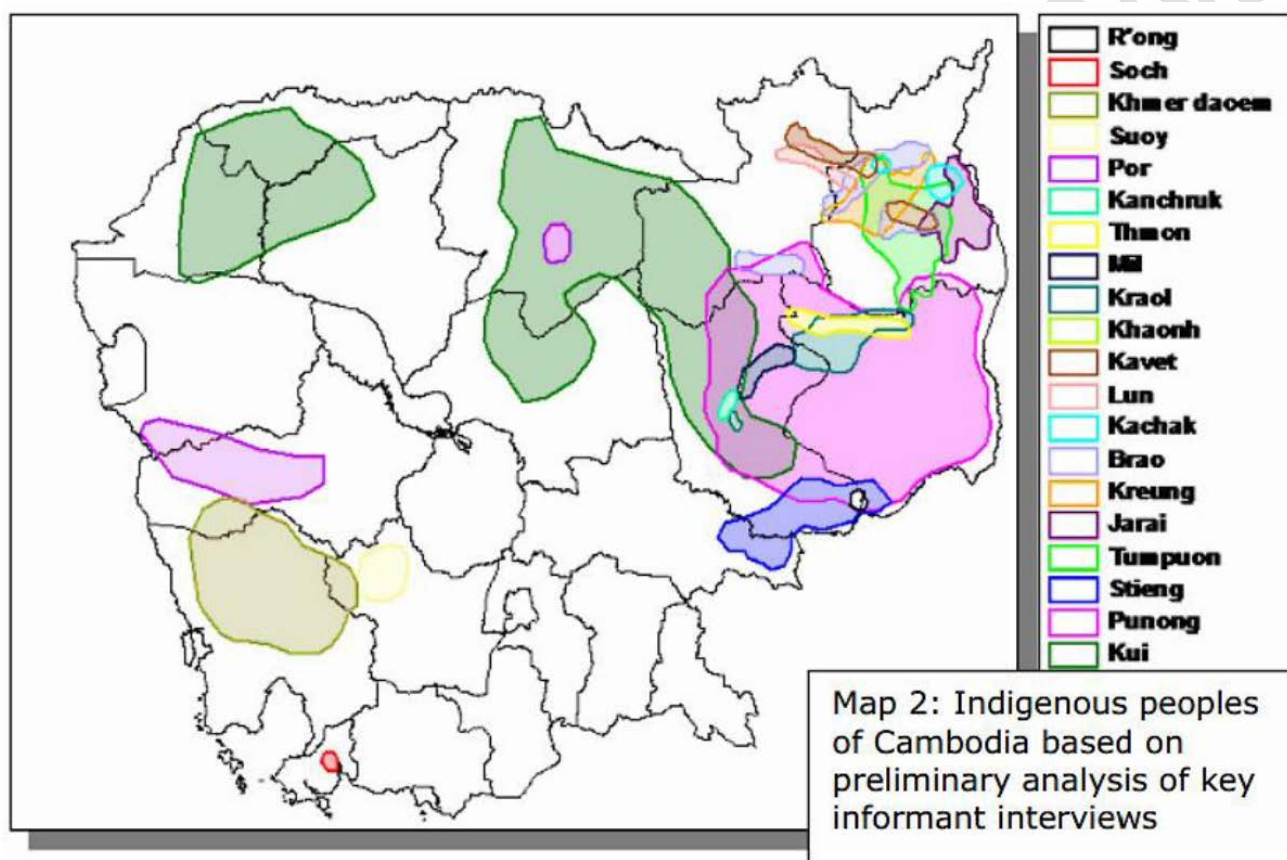
As this project still focuses on seven original provinces mostly concentrated with Indigenous Peoples and new two target provinces, indigenous communities will likely be affected as direct beneficiaries of project activities. To this end, the engagement process provides opportunities for meaningful consultations and allow Indigenous Peoples to obtain project benefits through culturally appropriate manner. The approach is informed by a social assessment focusing on the unique barriers of Indigenous Peoples communities including how best the traditional health care/medicinal practices could be supported and used to interface with modern practices and in particular, women and children, to benefit from nutrition and immunization services. In addition, the preparation the Environmental and Social Management Plan (ESMP) and Stakeholder

DRAFT FOR CONSULTATIONS

Engagement Plan (SEP) and project consultations will be conducted in accordance with the ESS7 and the cultural needs of these groups.

	Original			Revised		
Age groups	Male	Female	Total	Male	Female	Total
Infants under one (0-1)	20,852	20,427	41,278	30,076	29,064	59,139
Children under five (0-5)	101,749	98,541	200,291	165,248	157,244	322,493
Women in reproductive age (15-49)		426,826			759,712	
Total population	829,107	847,724	1,676,831	1,461,224	1,497,442	2,958,666

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



Map 2: Indigenous peoples of Cambodia based on preliminary analysis of key informant interviews

Source: NGO Forum (Cambodia) 2006.

The 2017 Cambodia Socio-Economic Survey finds that the population of Cambodia is 15.8 million, of which 97 percent are of Khmer ethnicity. The remaining 3 percent is composed of Cham and Chinese ethnicities and approximately 1.25 percent are divided between twenty-two indigenous ethnic minority groups also called “Khmer Loeu” or “hill tribes” who are ethnically non-Khmer. These groups are estimated to comprise around 184,000 persons and constitute about 1.25 percent of the Cambodian total population.

The twenty-two small minority groups which range from under 100 to 19,000 members include Phnong, Kuoy, Mil, Kroal, Thmorn, Khaonh, Tumpuon, Charay, Kroeung, Kavet, Saauch, Lun, Kachok, Proav, Souy (Sa’ong), Stieng, and Kavet, and are further detailed in Table 1.

Table 1: Number of indigenous minority people by ethnic groups in Cambodia

Number of indigenous minority people by ethnic groups				
Ethnic minority group		**2008**	**2013**	**Change**
1	Phnong	37,507	47,296	9,789
2	Tumpuon	31,013	51,947	20,934
3	Kuoy	28,612	13,530	-15,082
4	Charay	26,335	13,326	-13,009
5	Kroeung	19,988	22,385	2,397
6	Brao	9,025	13,902	4,877
7	Stieng	6,541	1,279	-5,262
8	Kavet	6,218	5,618	-600
9	Kraol	4,202	7,413	3,211
10	Ja'ong	1,831	266	-1,565
11	Prov	1,827	215	-1,612
12	Mil	1,697	1,905	208
13	L'moon	865	763	-102
14	Suoy (Sa'ong)	857	0	-857
15	Khaonh	743	270	-473
16	Kleung	702	208	-494
17	Saauch	445	837	392
18	Kajrouk	408	731	323
19	Lun	327	436	109
20	Radae	21	1,003	982
21	Mon/Thmor	19	174	155
22	Kachak	10	328	318

Source: Final Draft Report of Census of Indigenous Peoples in Cambodia, Ministry of Planning, 2018

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 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.

As a part of the Social Assessment for CNP-I, 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 2018.[1] In addition, a rapid social assessment was undertaken in October 2021 for Banteay Meanchey and Pursat for the preparation of CNP-II. The main findings of the community consultations were:

[1] Source: CNP Social Assessment Report 2018 submitted by the Catholic Relief Services

- The consulted Indigenous Peoples participants have a strong desire to engage with the Project's activities and a willingness to learn more about the Project.
- The consulted Indigenous Peoples 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.
- Indigenous Peoples 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 Indigenous Peoples needs at health centers. In particular, the Focus Group Discussions (FGDs) indicated that their communities were encountering issues with the IDPoor system and their understanding of it.
- The participants 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, the 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.
- The participants 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.
- Disparities in MCHN outcomes exist in the Indigenous Peoples communities within the two additional provinces, Banteay Meanchey and Pursat. Indeed, the percentage of stunting in children less than five years old is 29 percent and 39 percent in Banteay Meanchey and Pursat, respectively, compared to the national average of 32.4 percent.

All three FGDs 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 Indigenous Peoples' needs, including addressing language barriers.

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 Indigenous Peoples groups in the target project areas.

Under CNP-II, enhancement measures were identified, building on lessons learnt from CNP-I. These includes:

a. Ensuring key Village Health Support Groups are encouraged to include representatives of all IP groups in their areas in order to ensure that they receive appropriate information and have appropriate mechanisms for providing feedback on service delivery.
b. Ensuring that Indigenous Peoples group representatives should also be engaged as the collectors of commune performance evaluation data for the checklist and/or

DRAFT FOR CONSULTATIONS

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).

c. Use of commune- level services by Indigenous Peoples groups should also be monitored as part of the data collected to evaluate commune performance to the extent possible.

d. Use of targeted services by IP groups at health centers (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 Indigenous Peoples' use of services, and to include actions to address such challenges in annual work plans for the respective health centers and Operational Health Districts (ODs). An effort to specifically obtain patient feedback through the formal assessment process for HCs from Indigenous Peoples groups should be made in order to better understand their specific service delivery experience.

e. Use of targeted IDPoor/Health Equity Fund (HEF) Cards will be monitored and reviewed on an at-least-annual basis to identify changes in HEF use and to identify challenges to Indigenous Peoples' use of IDPoor/HEF cards and to include actions to address such challenges in annual work plans for the respective HCs and 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 Indigenous Peoples have the appropriate documentation to receive free services. HEF Promoters should also include representative of Indigenous Peoples groups to enable them to better communicate with their respective Indigenous Peoples groups.

f. All Social and Behavioral Chance Communication (SBCC) documents and approaches should be customized for local circumstances to the extent possible, including consideration of culturally appropriate means of communication for various Indigenous Peoples 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.

g. Disaggregation and analysis of data to identify Indigenous Peoples groups is encouraged to the extent possible. This may include supplementing existing systems with addition data collection to collect Indigenous Peoples-specific data. Focus on Indigenous Peoples health and nutritional status in the impact evaluation study.

h. Social safeguards training for project implementing agencies at the national and subnational levels should include sessions/modules on the World Bank policy, ESS7 and ensure that NCDDS social risk management policies and procedures align with World Bank policy to the extent possible.

4. Legal, Policy and Regulatory Frameworks

The World Bank's ESS7 recognizes that Indigenous Peoples (IPs) have identities and aspirations that are distinct from mainstream groups in national societies and often are disadvantaged by traditional models of development. Specific objectives of the ESS7 include:

a. To ensure that the development process fosters full respect for the human rights, dignity, aspirations, identity, culture, and natural resource-based livelihoods of Indigenous Peoples.

b. To avoid adverse impacts of projects on Indigenous Peoples or, when avoidance is not possible, to minimize, mitigate and/or compensate for such impacts.

DRAFT FOR CONSULTATIONS

c. To promote sustainable development benefits and opportunities for Indigenous Peoples in a manner that is accessible, culturally appropriate and inclusive.

d. To improve project design and promote local support by establishing and maintaining an ongoing relationship based on meaningful consultation with the Indigenous Peoples affected by a project throughout the project's life cycle.

e. To recognize, respect and preserve the culture, knowledge, and practices of Indigenous Peoples, and to provide them with an opportunity to adapt to changing conditions in a manner and in a time- frame acceptable to them.

As this project focuses on seven original provinces mostly concentrated with Indigenous Peoples and new two to three target provinces, indigenous communities will likely be affected as direct beneficiaries of project activities. To this end this IPPF has been to include an engagement process that provide opportunities for meaningful consultations and allow Indigenous Peoples to obtain project benefits through culturally appropriate manner. In addition, the preparation and updating of the ESMP, preparation of the SEP and project consultations will be conducted in accordance with the ESS7 and the cultural needs of the people.

Community consultations were carried out in three provinces with high Indigenous Peoples concentration, Mondul Kiri, Ratanak Kiri and Kratie and with the most populous ethnic groups (*Phnong, Tumpoung and Stieng*). The consultation process is utilized 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.

4.1 Cambodia's Country System

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, color, sex, language, religious belief, political tendency, national origin, social status, wealth or other status. However, the Constitution does not include specific reference to the country's indigenous peoples or ethnic minorities.

In 2009 the Royal Government of Cambodia (RGC) issued the National Policy on Indigenous Peoples 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 Peoples 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. The Working Principle for Equity broadly require provisions for Removing socio-cultural, geographical, financial and bureaucratic barriers in access to and utilization of quality health services, especially by poor and vulnerable people, including persons with disability, ethnic minorities and elderly. 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

DRAFT FOR CONSULTATIONS

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).*

4.2 Ratification of International Agreements

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 favor 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."[2]

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

DRAFT FOR CONSULTATIONS

5. Implementation and monitoring arrangements

The implementing agency for CNP-II will be the NCDDS in the Ministry of Interior (MOI), which is one of the two implementing agencies for the CNP-I (the other being the MOH). NCDDS has the capacity to provide national-level management and leadership as well as to support sub-national implementation. NCDDS has a strong track record of harnessing existing systems which emphasize the role of decentralization, to coordinate with administrative districts, commune councils, and health centers at the selected locations. Given the strong track record of NCDDS under the CNP-I and the aim of the new operation to build upon and expand core CNP-I activities, the same implementation arrangements for NCDDS under the CNP-I will be used for CNPII.

Currently under CNP-I, NCDDS implements Component 2 through its technical departments and the provincial, DM, and C/S administrations. NCDDS has appointed a project director and a project manager to oversee Component 2 activities, and NCDDS' procurement and fiduciary departments are being used for project implementation. CNP-I includes provisions to strengthen NCDDS's departments capacities and skills through additional consultants and technical assistance to enhance departmental/program functions (rather than working only for specific project activities).

The NCDDS will provide policy guidance, authorization and oversee the implementation of the CNP-II activities which will be carried out by provinces, districts, and Communes/Sangkats (C/S) administrations. In addition, the NCDD-S will assign a social safeguard focal point to oversee the implementation of the IPPF at the Communes/Sangkat levels. Specific responsibilities include:

a. Participating in training conducted by the World Bank on IPPF implementation, sharing information and providing further training to other project stakeholders, as needed.

b. Overseeing the implementing activities as per the IPPF and ensure that indigenous peoples/ ethnic minorities in target areas are receiving culturally appropriate support.

c. 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.

d. 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.

e. 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).

In addition to NCDDS, the following entities will also be responsible for certain activities which may be required as part of IPPF implementation. These include

a. Province/District Administrations

Every six months, certified administrative provincial/district assessors in nine 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.

b. Commune Authorities

DRAFT FOR CONSULTATIONS

Commune Authorities in these nine 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.

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

The CCWC-FC 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.

d. 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.

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 priority interventions, and routinely monitor and improve program performance. The capacity building will take into consideration the culturally appropriateness of the Indigenous Peoples 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 Centers/ 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 implementing agencies.

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 NCDDS 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.

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The project will implement project activities in a culturally appropriate manner through participatory approaches 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.

As part of the IPPF, the following capacity building measures are considered critical to ensure that project planning and implementation consider the needs and constrains faced by Indigenous Peoples/ethnic minority groups in target provinces:

a. Strengthening the environmental and social assessment and screening capacity of the NCDD-S at the central level and other implementing agencies in the provinces/ operational and administrative districts with high concentrations of Indigenous Peoples/ ethnic minority populations.
b. Improving the delivery of culturally appropriate health services at the health center 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, Health Centre Management Committee (HCMC), Commune Councils, Commune/Sangkat Committee for Women and Children (CCWC-FP) and village chiefs.
c. Enhanced Indigenous Peoples/ ethnic minority participation in designing and monitoring local health development plans.
d. Measures to respect traditional health care/medicinal practices, which may be supported and used to interface with modern practices and in particular, women and children, to benefit from nutrition and immunization services.
e. Monitoring, evaluation, and the annual sector review process; including a focus on activities implemented to address the concerns of Indigenous Peoples/ ethnic minorities
f. 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 Centers and hospitals.

7. Consultation and Engagement

The project's SEP outlines relevant engagement and consultations with community representatives, including relevant NGOs/CSOs representing Indigenous Peoples. A series of consultations with community representatives in areas with high concentration of Indigenous Peoples were undertaken under CNP-I. These include community consultations with community groups in Mondul Kiri, Ratanak Kiri and Kratie and with different ethnic groups that have large Indigenous Peoples populations, namely Phnong, Tumpoun and Stieng in December 2018. In addition, a rapid social assessment was carried out in October 2018 for Banteay Meanchey and Pursat. A public consultation workshop on IPPF was held on 14th October 2020 with involvement of MOH-NCDDS, WB (STC), and representatives of HC, VHSG, PHD, OD, village chief, and IP from Ratanakkiri, Mondulkiri, Preah Vihear, and Koh Kong with a total of 58 participants. These consultations have further informed the preparation of this IPPF. A national consultation of the existing IPPF under CNP-I was previously organized on 18th October 2018, involving 43 participants including health staff from HCs and referral hospitals, representatives from relevant health departments and national programs, NGOs and UN agencies. Another round of consultations is being organized under CNP-II.

DRAFT FOR CONSULTATIONS

Such consultations indicate strong government support to improve the nutritional status of targeted women and children especially for Indigenous Peoples 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.

The IPPF acknowledges that access barriers remain high for Indigenous Peoples/ethnic minorities to receive relevant information, participate and benefit from project activities. Hence, strengthening NCDDS' capacity for community outreach, by capitalizing upon the existing sub-national and community networks will be pursued under CNP-II. The main social risk is that vulnerable and disadvantaged households and groups, including potentially indigenous communities encountering obstacles to access facilities and services provided by the project activities. Although the project will have broader social benefits because it supports the provision of the essential package of health and nutrition services to the targeted population in selected provinces, there are risks of not being able to reach the most needed groups namely mothers, newborns, and children to implement the project. Also, the project requires to adopt a robust and inclusive social mapping of eligible households; targeted health and nutrition SBCC through door-to-door home visits, community groups, and mobilization for community-based growth monitoring and promotion (GMP); health equity fund (HEF) promotion to increase service utilization among the poor; and community mobilization. These are critical aspects that require careful planning and implementation not allowing gaps and exclusion of most needy categories of households. Therefore, CNP-II focuses on Indigenous Peoples through the Stakeholder engagement to ensure an inclusive and participatory approach.

Inclusion of vulnerable and disadvantaged groups is a key part of stakeholder consultation process. The strategy includes methods to involve poor, vulnerable households including IP communities as they are the direct beneficiaries of the project, hence ensuring that the project benefits will be distributed in a fair and accountable manner is key to project success. This will be done through: (a) conducting an orientation workshop in the new locations to sensitize beneficiaries to the project and its proposed activities, (b) continuing to use beneficiary feedback mechanisms designed for C/S-SDG systems, and (c) supporting robust communications and awareness campaigns to further sensitize the public.

This is mainly to ensure that the updated IPPF has an engagement process that provide opportunities for meaningful consultations and allow Indigenous Peoples to obtain project benefits through culturally appropriate manner. The preparation of this instrument was informed by a social assessment focusing on the unique barriers of Indigenous Peoples communities including how best the traditional health care/medicinal practices could be supported and used to interface with modern practices and in particular, women and children, to benefit from nutrition and immunization services. In addition, the preparation and updating of the ESMP, preparation of the SEP and project consultations will be conducted in accordance with the ESS7 and the cultural needs of the people. As relevant and necessary, adaptations to activities and language will also be undertaken to address the needs in indigenous communities where the project operates.

DRAFT FOR CONSULTATIONS

8. Indigenous Peoples Plans

Since CNP-II is expected to benefit Indigenous Peoples/ethnic minority groups through enhanced access to maternal and child nutrition services, a standalone Indigenous Peoples Plan (IPP) is not required under the project. Key elements of the IPPF are integrated into the project's SEP and ESMP, and specific actions will be integrated into the project's Annual Operating Plans (AOPs). These include aspects related to capacity building on socially and culturally engagement approaches, consultations, and recruitment of local project workers.

These AOPs should include clear actions to address the IPPF's requirements and will need to be reported as part of the project's progress report. The project's progress report shall also describe specific activities to be taken to address the specific needs of Indigenous Peoples 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 Indigenous Peoples groups that arise during project implementation are effectively avoided, minimized or mitigated. These AOPs should include not only brief descriptions of activities to be undertaken within the year, but also any funds required to undertake such activities so that budget resources can be made available, as needed. Such actions shall also be incorporated into province and district specific PHD/OD AOPs as well as Commune/Sangkat planning documents as relevant.

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

9. Grievance Redress Mechanism

The project's Feedback Grievance Redress Mechanism (FGRM) is set out in the project's SEP, and build on the existing systems under the CNP-I. The FGRM is to ensure that:

a. The basic rights and interests of Indigenous Peoples are protected
b. The concerns of Indigenous Peoples arising from the project implementation process are adequately addressed
c. Entitlements or livelihood support for Indigenous Peoples, if required, are provided on time and accordance with the above stated government and World Bank's ESF, and
d. Indigenous Peoples are aware of their rights to access grievance procedures free of charge for the above purposes.

Based on the SEP, the project's GRM is as follows:

a. Receiving complaints from the citizens feedback mechanism:

- When one or more citizens are not satisfied and are willing to provide feedback on related performance of Village Health Support Groups (VHSGs) and or health centre and/or C/S administrative services deliveries, they can provide their feedback or grievance to service providers: VHSG, village team, and/or direct service providers. The citizen can inform other stakeholders as needed.
- The messages that citizens can deliver to the service providers can be via verbal messages, complaints or feedback forms, telephone calls, or other means such as social media.
- All complaints that C/S receive must be reported and recorded.

b. Citizen feedbacks and accountabilities mechanism

- The C/S chief is the first actor to review and respond to all citizen feedback and complaints, especially feedback related to the Commune Program for Women and Children (CPWC) activity implementation. After receiving feedback or complaints from citizens, the C/S chief shall respond accordingly and in a timely manner (within 20 business days) through interventions or actions of C/S administration and/or HC. The C/S chief shall inform the VHSG to report to the community or respective individual accordingly. In the event that complaints are received by the VHSGs, they will inform and dispatch the complaints to relevant stakeholders, including the C/S chief and/or other agencies, depending on the nature and sensitivity of the issues. These first point contacts shall provide measures to protect complainants, especially across sensitive issues such as fraud and corruption.

DRAFT FOR CONSULTATIONS

- If the C/S chief cannot take action to respond to the complaints or feedbacks, the C/S chief shall submit those complaints or feedbacks to Health Care Management Committee (HCMC) meeting for further actions. At the HCMC meeting, the committee can decide if any actions or resolutions are possible.
- If the HCMC cannot come to a solution, the C/S chief shall refer the case to the DMA governor for further action. After receiving the cases, the District Management Authority (DMA) governor shall take action immediately through their DMA action or OD. The DMA governor shall inform the results of resolutions to C/S chief, who can then inform the citizens.
- If the case cannot be solved at the DMA level, the DMA governor shall send the cases to the PA governor. The PA governor can take action through Provincial Administrations (PA) or PHD. PA governor shall inform to DMA governor the results of interventions. The PA governor shall inform the results and resolutions to DMA governor who can inform the citizens.
- If the case cannot be solved by provincial level, the PA governor shall send the cases to NCDDS or NCHP based on the nature of case.
- The NCDDS and the National Centre for Health promotion (NCHP) are the last mechanism to solve and respond to the citizen feedback or complaints related to CPWC activities implementation. The Chairman of NCDDS and/or Chairwoman of NCHP shall inform the results of resolutions to PA governor who can inform the citizens.
- All feedback and responses shall be recorded. At the community level, the VHSGs will record any complaint directed to them and report to village chiefs on a weekly basis, then village chiefs with assistance from village assistants will consolidate all complaints into monthly reports to submit to C/S. Next, the C/S consolidate all complaints for submitting to DMA, and then to PA.

In addition to the formal process above, complainants can also elevate the complaint within the system if they are not satisfied with a response or proposed resolution. The NCDDS will track complaint settlement processes and duly inform the complainants accordingly.

Figure 1: Grievance Redress Mechanism

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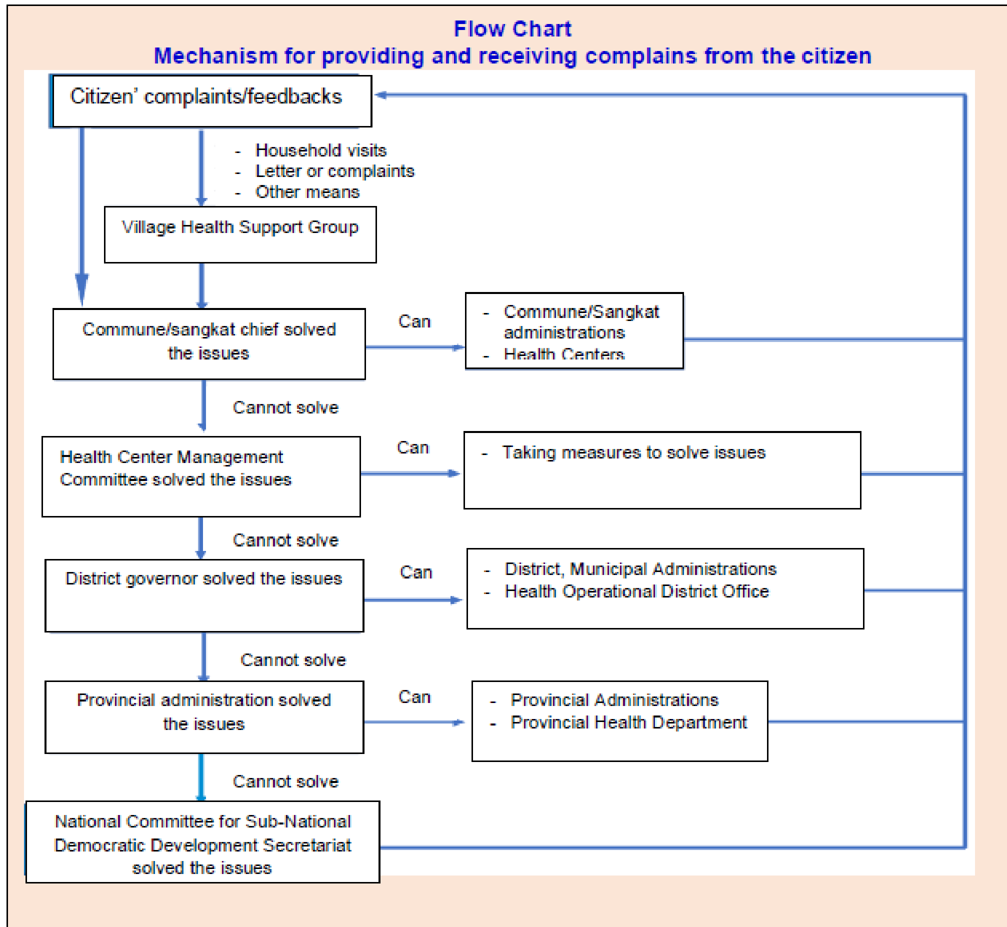

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Figure 6: VHSG Weekly Report Template

Kingdom of Cambodia
Nation Religion King

Province: ……………….
District: …………………
Commune: ……………...
Village: …………………

VHSG Weekly Report
(Cambodia Nutrition Project)
Period: from……………………to………………

1. CPWC Activity Implementation

No.	Activities	Output		Beneficiaries				RS	
		P	A	HH	PW	M/G	CU2	GA	NGOs
1									
2									
3									
4									
5									

Note: P: Plan, A: Actual, HH: Household, PW: Pregnant Women, M/G: Mother/Guardian, CU2: Children under 2 years, RS: Relevant Stakeholder, GA: Government Agency, NGOs: Non-government Organization,

2. Citizen Feedback Collection

No.	Description	Date	Quantity		MoC
			Citizen	CSO	

Note: CSO: Civil Society Organization, MoC: Mean of Communication, please share all Citizen Feedback Form (Form 04)

3. Other activities

No.	Description	Quantity	Remark

4. Issues and Challenges

No.	Description	DoH	Status		Suggestion
			S	P	

Note: DoH: Date of Happening, S: Solved and P: Pending

Date……………………………………

Signature: ……………………………
(Name), VHSGs

8.2.1.2 Village Monthly Report

The village chief with the assistance of the village team shall review the VHSG weekly reports and consolidate these reports into the village monthly report by using form below and then submit this monthly report to C/S chief at the end of each month.

Figure 7: Monthly Village Progress Report Template

Kingdom of Cambodia
Nation Religion King

Province: ………………
District: …………………
Commune: ……………..
Village: …………………

Monthly Village Progress Report
(Cambodia Nutrition Project)
Period: from……………………to………………

1. CPWC Activity Implementation

No.	Activities	Output		Beneficiaries				RS	
		P	A	HH	PW	M/G	CU2	GA	NGOs
1									
2									
3									
4									
5									

Note: P: Plan, A: Actual, HH: Household, PW: Pregnant Women, M/G: Mother/Guardian, CU2: Children under 2 years, RS: Relevant Stakeholder, GA: Government Agency, NGOs: Non-government Organization,

2. Citizen Feedback Collection

No.	Description	Quantity		MoC	Date of Resolved	Date of Forwarded
		Citizen	CSO			

Note: CSO: Civil Society Organization and MoC: Mean of Communication, please share all Citizen Feedback Form (Form 04)

3. Other Activities

No.	Description	Quantity	Remark

4. Issues and Challenges

No.	Description	DoH	Status		Suggestion
			S	P	

Note: DoH: Date of Happening, S: Solved and P: Pending

Date…………………………………

Signature: ……………………………
(Name), Chief of Village