Ministry of Health

Health Equity and Quality Improvement Program (H-EQIP), 2016 - 2020

Supplemental Indigenous Peoples' and Ethnic Minority Consultations

Social Assessment

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Executive Summary

The proposed Health Equity and Quality Improvement Program (H-EQIP) builds upon the previous Cambodia Health Sector Support Programs 1 & 2. The Royal Government of Cambodia (RGC) has overseen significant progress in improving Cambodian citizen's health over the past fifteen years. Notably in the past five years Cambodia has witnessed significant improvements related to maternal health outcomes. Health infrastructure has also developed significantly and there has been progress related to the number of health care providers, with a large increase in the number of midwifes and to a less extent an increase in the number of nurses. The RGC has identified quality improvements related to health service delivery and financial protection for the poor as areas of priority for the next health strategic plan. Whilst the progress achieved has been significant, this progress has not been evenly distributed throughout the country and amongst the different social/ ethnic groups. Health outcomes still exhibit distinct urban–rural and rich–poor differentials, which disproportionately affected the provinces in which large concentrations of indigenous peoples'/ ethnic minority groups reside.

Due to the proposed H-EQIP program including provinces where concentrations of indigenous peoples' and ethnic minorities reside the World Bank Operational Policy on Indigenous People (OP 4.10) was triggered requiring that a process of free, prior, and informed consultation be undertaken with the affected indigenous peoples' communities. The consultations were undertaken with nine different indigenous peoples'/ ethnic minority groups across four target provinces, engaging with six hundred and thirty-nine persons. The consultations identified improvements in health services over the past five years, but also several constraints faced by these communities and actions to be undertake to address them, which are explored further in this report.

Introduction

The proposed Health Equity and Quality Improvement Program (H-EQIP) July 1, 2016–June 30, 2021 builds upon the previous Cambodia Health Sector Support Programs 1 & 2. The proposed H-EQIP program will support parts of the larger Cambodia Health Strategic Plan (2016-20), specifically those related to financial protection and improving the quality of health services. The proposed program is nation-wide in coverage and includes provinces where concentrations of indigenous peoples' reside and the predominantly indigenous peoples' inhabited provinces of Mondulkiri and Ratanakiri. Due to program coverage including provinces where concentrations of indigenous peoples' and ethnic minorities reside the World Bank Operational Policy on Indigenous People (OP 4.10) was triggered requiring that a process of free, prior, and informed consultation be undertaken with the affected indigenous peoples' communities. Whilst the World Bank Operational Policy on Indigenous People is primarily aimed at identifying possible adverse effects of the proposed program on indigenous peoples' and ethnic minorities, it also uses the consultation process to identify additional measures that may be required to provide indigenous peoples'/ ethnic minorities with culturally appropriate program benefits and increase their participation during project implementation, monitoring, and evaluation.

Legal Framework

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.

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 (CEDAW), the Convention on Biological Diversity (CBD) 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).

Policy Framework

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

In relation to health policy, the **Health Strategic Plan** 2008-2015 has no specific mention of indigenous peoples' or the identification of measures to address the specific health barriers that they face. Ethnic minorities are mentioned once in relation to cross cutting challenges.
The **Rectangular Strategy** is the guiding policy document in Cambodia and sets-out a broad social protection framework. 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) 2014-18 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)*.

Demographic Overview

The Royal Government of Cambodia has official names for minority groups falling into three categories:

1. The indigenous minorities, also called Khmer-Loeu
2. The Cham, also called Khmer-Islam
3. The foreign residents/ immigrants.

In 1997 an Inter-Ministerial Committee stated that people belonging to ethnic minorities are exclusively the people who are native born in Cambodia for generations. For instance, the Khmer-Loeu (hill tribes) and the Cham are to be called ethnic minorities of the Kingdom. The Cambodian definition of ethnic minorities does not include Vietnamese, Chinese and other groups who are considered 'migrants', despite many living in Cambodia for generations. If a wider definition of 'ethnic' groups were to be applied to include Cham, Lao, Vietnamese and Chinese populations, then the non-ethnic Khmer population is estimated to be approximately 6% of Cambodia's total population.

The Khmer-Loeu (hill-tribes) are estimated to be living in 15 provinces of Cambodia, with a high concentration of Khmer-Loeu peoples' in the north-eastern provinces of Ratanakiri and Mondulkiri where they account for a higher percentage of the population than Khmer peoples'; there are other concentrations of Khmer-Loeu peoples' in the south-west of Cambodia. The Cham constitute about half of the ethnic minority population and are widely distributed throughout the country, with a high concentration of Cham peoples' in the north-eastern province of Kratie.

A 2006 study of indigenous populations conducted by the Ministry of Rural Development and the National Statistics Institute using the commune database estimated Cambodia's indigenous peoples' population to be 200,156 and that indigenous groups were mainly living in ten provinces of Cambodia. The table below presents statistical data of Indigenous Peoples' disaggregated by provinces:

Statistic Data of Indigenous Peoples in Cambodia (2006)

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

Source: Department of Indigenous Minority Development

The data presented is relevant in that it gives a good overview of the geographical areas where indigenous peoples' are concentrated.

The 2008 Cambodian Population Census did not collect/ disaggregate data by ethnicity. However, the census did collect data on Population by Mother Tongue. The 2008 report identified 23 minority mother tongues; with the speakers of minority languages numbering 383,273, representing about three percent of the total population of Cambodia (2008,

estimated at 13,395,682). The highest percentage among the minority language speakers is that of Cham (53.24 percent). These figures should be regarded as conservative as indigenous people do not always feel confident identifying themselves as indigenous and therefore may not be counted as such in the census.

Identifying an exact population number is complicated as no two population surveys give approximately the same figures and internal government data is difficult to access and methodologically questionable. The collection of indigenous/ ethnic minority population statistics are the responsibility of the National Institute of Statistics (NIS), in collaboration of the Ministry of Rural Development and the Ministry of Interior. They communicate through the channel of the National Committee for Decentralization and De-concentration (NCDD) and collaborate with the commune councils in gathering annual population statistics, including for the indigenous population. The NCDD consolidates and aggregates data for the indigenous population at the national level. However, the data on indigenous/ ethnic minority populations is not as yet shown in the commune, district and provincial profiles. Based on Commune Database information (2010) there is 17 different indigenous groups, including Phnong (24 percent of the total), Kouy (21 percent), Tompuonn (15 percent), Charay (11 percent), Kroeung (10 percent), and others (18 percent). These groups live in 15 provinces, 36 districts, 131 communes and 503 villages/ communities, with an estimated 45,280 households and a total population of 219,989 (United National Development Action Framework – CAA, 2014).

The current lack of reliable data, disaggregated by ethnicity, makes the specific problems these communities face invisible to decision makers.

Social-Cultural Overview

Among the numerous ethnic groups included under the umbrella terminology 'indigenous', some display many commonalities, while others are markedly dissimilar, even within small geographical areas. Indigenous languages are mostly distinctly different from each other. For many indigenous communities in Cambodia their main social/ political unit is the community living in the village. While the Village Chief fulfils many government administrative requirements a Council of Elders helps the community to make decisions and solve disputes to maintain peace and solidarity among members.

Traditionally, the village 'headman' is chosen by the Council of Elders and the Elders are selected by the villagers from among the most influential/ skilled men and women in the village. The Council of Elders exercises considerable political and economic power within the village. The Elders are also village level arbitrators for the villagers and decide on issues of social justice and penalties in cases of conflict, they facilitate community level decision making, often with all villagers concentrated in one location. The traditional social and political structures within villages still functions, but their representation outside their village has changed, being undertaken by government recognised Village Chiefs and Commune Council members. However, the Council of Elders are still considered the cultural and social representative of the Khmer-Loeu indigenous groups.

There are no traditional structures that exist above the village level for the different Khmer-Loeu indigenous groups. Most community members continue to observe indigenous practices and customary laws that form their traditional governance system. Many indigenous peoples' lack access to education in their mother tongue as well as in Khmer and as a result has low levels of education that limit their access to employment opportunities. Indigenous people often live in remote areas and lack easy access to basic social services, including health and education.

The Cham peoples are different from the Khmer-Loeu, their Village Chiefs and Imam's are largely considered to be their representatives, politically, socially and culturally. Cham communities are organised differently and they have social structures above the village level that represents the interests of their peoples.

The majority of Cambodia's indigenous peoples' still live in traditional ways, primarily cultivating rice, using traditional swidden agriculture/ shifting cultivation techniques, wetland rice cultivation, animal husbandry, hunting, fishing and weaving. Many have a close relationship with forests, collecting food and non-timber forest products from (e.g. chopping rattan, plucking vine and tapping resin). Their livelihood strategies are usually augmented by providing their labor to *'better-off'* households, for which they are paid in cash.

As a result of Cambodia's irregular climatic conditions, agricultural production can fluctuate significantly from year to year. With the majority of the indigenous/ ethnic minority population engaged in subsistence agriculture, food insecurity is a dominant feature of their poverty and vulnerability. Many communities report insufficient supplies of food for periods between 2-5 months of the year. As a consequence of which, indigenous peoples' are disproportionately affected by high levels of malnutrition and stunting.

Poor households who are dependent on subsistence farming regularly fall into heavy indebtedness as a result of borrowing from rice/ money lenders, against current crop production, at very high interest rates, which requires large repayments in rice/ money. In some cases, this practice has evolved from a short-term copings strategy into longer-term coping strategy. Research conducted by Oxfam and the Cambodia Development Research Institute indicated that around half of farmers who had to sell their land did so to pay for health care expenses. Illness and injury are one of the most common reasons for taking out a loan, accounting for thirteen percent of all loans (World Bank, 2006). Whilst no recent studies have been undertaken it can be assumed that the expansion of the Health Equity Fund at the Health Centre level over the last two years in the consultation's target provinces would have had a positive impact on reducing health associated indebtedness.

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

Political Participation

There are two prevailing views about minority representation in Cambodia. The first is that ethnic minorities have been effectively integrated into mainstream Khmer communities and issues or concerns they may have are no different to those of the general Khmer population. The second is that minorities face significant challenges distinct from those of the rest of the population.

Indigenous peoples' and ethnic minorities face challenges in being elected to the National Assembly or the Senate. There are no specific quotas for indigenous peoples' or ethnic minority's representation in Cambodia's legislative bodies. However current levels of indigenous/ ethnic minority representation in the National Assembly approximately reflect the proportion of indigenous/ ethnic minority people living in the country. The election of ethnic minorities and indigenous peoples' depends primarily on the country's main political parties, when political parties place minority representatives at the top of their candidate lists they are more likely be elected. Reportedly, there is pressure on these MPs to identify more with their Cambodian (Khmer) nationality than their ethnicity.

The relatively small population size in the geographical areas where minorities are concentrated means that there are fewer seats to which minority MPs and Senators can be elected. To be eligible to run for election a candidate must speak Khmer, despite many minorities speaking only their indigenous/ ethnic language. The requirement to speak and

read Khmer excludes many indigenous people from participating, especially women who have a lower literacy rate. The majority of the minorities represented in the National Assembly belong to the Cham; a group which is largely regarded by many as well organised and mostly integrated into Khmer society.

During the period 1979-1992 senior sub-national government positions in the provinces with high concentrations of indigenous peoples' were largely occupied by members of the indigenous/ ethnic minority groups. However, since that time senior government positions, specifically the number of deputy-governor post holders, has increased in number and are now predominately occupied by ethnic Khmer people appointed by the central government. Considering the Decentralization and De-concentration (D&D) program that has been implemented in Cambodia over recent years in an attempt to devolve more decision making power to the sub-national/ local levels, this change represents a significant loss of decision making authority over issues of importance to indigenous/ ethnic minority communities.

Under the D&D program some government decision making and planning was devolved down to local level government with the creation of Commune Councils. Indigenous/ ethnic minority people are well represented in Commune Councils located in areas where their populations are concentrated. The consultation found that in the indigenous/ ethnic communities visited, the majority of commune councillors were indigenous peoples'/ ethnic minorities. However many have low levels of education and insufficient capacity to implement their assigned responsibilities and oversee local development. While responsibility for local development has been transferred to the Commune Councils it has been without the corresponding financial resources, capacity or authority. A study of the 2012 Commune Council Elections found that language barriers and a lack of education resulted in many indigenous people being unable to vote or otherwise participate in the electoral process (COMFREL, 2012).

Indigenous peoples' and ethnic minorities have their own traditional village based decision making structures and social-cultural leaders that remain important to members of their groups. These traditional structures are different from the new village, commune, district and provincial level authority structures established since the late 1990's that are recognised by wider Khmer society. For the indigenous communities a village level Council of Elders helps the community to make decisions and resolve disputes, they facilitate community level decision making, often with all villagers concentrated in one location. For Cham communities the Imam and Village Chiefs are key social leaders. Many of the indigenous/ ethnic minority communities observe customary laws that form their traditional legal system; which is not officially recognized by the national government/ legal systems.

During the consultation process several key informant interview respondents commented on the difficulties of getting the sub-national and national level decision makers to understand the unique livelihood and cultural circumstances of indigenous peoples' and their needs.

Health Overview

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

The first comprehensive Health Strategic Plan (HSP1) was implemented in 2002–2007. The second Health Strategic Plan (HSP2) 2008-15 is currently being implemented and focuses on

three priority areas: maternal and child health, communicable diseases and non-communicable diseases. It also identifies the need for improvement in health-service delivery, health financing, human resources for health, health information systems and health-system governance. The 2011 mid-term review of the HSP2 stated that further progress on outcome indicators would require more focus on governance, management and regulation; and increased community involvement, especially at district and provincial levels. The MoH is currently finalizing the third Health Strategic Plan (HSP3) 2016–2020.

The RGC has overseen significant progress in improving Cambodian citizen's health over the past fifteen years, as confirmed by a review of the data presented in the Cambodian Demographic and Health Survey (CDHS). The CDHS has been conducted every five years since 2000 to collect regional and national data on demography, health care and health status *(with a representative sample down to the provincial level)*. Demographic and Health Surveys are internationally recognised as sources of reliable information. Whilst the progress achieved has been significant, this progress has not been evenly distributed throughout the country and amongst the different social/ ethnic groups. Health outcomes still exhibit distinct urban–rural and rich–poor differentials and are poor in comparison with global and regional averages.

To explore the urban–rural differentials in relation to geographical areas with large concentrations of indigenous peoples'/ ethnic minorities the consultation included a review of the data presented in the 2014 CDHS. The indicators selected relate to priority areas of HSP2:

	ANC from a Skilled Provider (%)	No ANC Received (%)
Ratanakiri/ Mondulkiri	76	23.7
Preah Vihear/ Stung Treng	85.5	14.2
Kratie	72.8	26.6
Rural Average	94.8	5
Urban Average	98.6	1.4
National Average	95	5

Number of ANC Visits	Urban	Rural	Total
None	1.4	5	4.5
1	1.4	3.1	2.9
2-3	11.5	17.6	16.7
4+	85.4	73.9	75.6
Don't Know/ missing	0.3	0.3	0.3

Delivery by Skilled Provider and Place of Delivery

	Delivery by Skilled Provider (%)	Health Facility Delivery (%)	Public Health Facility (%)	Private Health Facility (%)	Home Delivery (%)
Ratanakiri/ Mondulkiri	53.6	51.2	39.3	11.9	48.1
Preah Vihear/ Stung Treng	54.6	51.1	49.3	1.8	48.8
Kratie	51.9	46.2	40.3	5.9	53.7
Rural Average	87.6	81	69.4	11.6	18.7
Urban Average	97.8	96	65.8	30.2	3.9
National Average	89	-	-	-	-

Timing of First Postnatal Check-up After Delivery

	Less Than 4hrs (%)	4-23hrs (%)	1–2 Days (%)	No Postnatal Check-up (%)
Ratanakiri/ Mondulkiri	37.6	1.6	0	60.8
Preah Vihear/ Stung Treng	57	2.4	8.8	31.1
Kratie	74.1	1.5	16.1	8.2
Rural Average	76.6	7.9	4.5	9.7
Urban Average	72.9	22	3.1	1.3
National Average	76	14	90	9

Childhood Mortality Rates - per 1,000 live births

	Neonatal Mortality	Post-natal Mortality	Infant Mortality	Under-5 Mortality
Ratanakiri/ Mondulkiri	36	36	72	80
Preah Vihear/ Stung Treng	25	45	70	79
Kratie	30	31	61	80
Rural Average	23	20	42	52
Urban Average	10	14	13	18

Vaccinations

	All Basic Vaccinations	No Vaccinations
Ratanakiri/ Mondulkiri	43.9	10.6
Preah Vihear/ Stung Treng	55.6	1.2
Kratie	65.1	7.7
Rural Average	71.2	2.7
Urban Average	86.4	0.5

Percentage of ill or injured population who sought first treatment

	Urban – First Treatment (%)	Rural – First Treatment (%)
Public Sector	14.9	23.5
Private Sector	78.1	64,7
	40.6	12.7
Non-medical Sector	1	5.3
Traditional Healer	0.3	0.9

Overall the CHDS indicates that both economic development and the ageing of the population are leading to a shift of morbidity and mortality away from communicable diseases to NCDs and injuries. The data presented demonstrates significant health inequalities between the provinces with concentrated indigenous/ ethnic minority populations, urban and rural averages.

Consultation Findings

During the consultation process FGDs and KIIs were used to understand the views of government health manager, stakeholders and user's in relation to areas that would receive financial support from World Bank coordinated pool funding under the proposed H-EQIP program. The information below provides an overview of the views expressed by respondents in relation to the areas of support as detailed in the terms of reference.

1. Health Service Delivery and Utilization

1.1. Maternal and Child Health

In an effort to better capture actual utilization of maternal and child health services, the current Social Assessment elected to shift from a focus on utilization of Health Centre MNCH services as opposed to simply looking at ANC/ PNC outreach, as done with the previous Social Assessment. Based on the responses of the FGDs, an average of 57% of FGDs reported birthing or ANC services as the primary use of Health Centres for participants. This utilization category was higher in provinces with large indigenous persons'/ ethnic minority populations (61%) as compared to provinces with smaller indigenous persons'/ ethnic minority populations (53%). That said, the CDHS 2014 put the number of births by skilled attendants at 53.6%, 54.6% and 51.9% for Ratanakiri/ Mondulkiri, Preah Vihear/ Stung Treng and Kratie, respectively; the three lowest rates for the country. While Health Centre utilization for birthing appears to be improving, the gap between provinces with concentrations of indigenous persons'/ ethnic minority populations and the rest of the country still remains significant.

In terms of child health, while previous commune reports have placed child vaccination rates between 80-90% in target areas, the CDHS 2014 placed Ratanakiri/ Mondulkiri as the lowest complete basic vaccination rate in the country at 43.9% with Preah Vihear/Stung Treng being the second lowest at 55.6%. Kratie appears comparatively better with a rate of 64.5%; however, this came in as the 5th lowest rate in the country. Again, while progress seems to have been made (compared to the 2010 CDHS), the gap between provinces with concentrations of indigenous persons'/ ethnic minority populations and the rest of the country remains high.

1.1. Communicable/ Non-communicable Diseases and service provision at the community through health outreach activities

FGD results indicated that that 100% of FGDs received outreach from Health Centre or health authority staff, though the frequency varied significantly. Overall, the number of visits per year averaged 4.6 times per year with a standard deviation of 3.9 times (meaning most ranged from 1 visit per year to 8 depending on village). For provinces with large indigenous persons'/ ethnic minority populations, the frequency of visits was significantly lower on average than provinces with smaller indigenous persons'/ ethnic minority populations, with 3.2 visits per year (standard deviation of 2.3) as compared to 5.8 visits (with a standard deviation of 4.5). This appears to indicate significantly lower health outreach visits in the regions with large indigenous persons'/ ethnic minority populations villages get on average between 1 visits and 5 visits a year. This may be somewhat accounted for due to the remote aspects and long distances from Health Centres in those provinces. Overall, significant gains were seen with the number of FGDs reporting only one visit in the year having decreased from 50% in the previous to Social Assessment to only 10% under the current Social Assessment.

In terms of content, the vast majority of health outreach activities appear to be concentrated on vaccination activities with 93% of village FGDs having reported outreach related to child and pregnant women vaccinations. However, only 38% of FGD reported having received any type of ANC, PNC, maternal or child health outreach activities aside from vaccinations and/ or deworming, and 23% having received any health outreach relating to infectious diseases (e.g. TB, Malaria, HIV/AIDS, dengue, etc.) other than general commodity distribution (i.e. bed nets without instruction). As such, while the number of visits has increased, the content of such visits has substantial room for improvement and focus. Moreover, the targeting of the vaccination visits should be questioned in terms of approach and effectiveness given the CDHS 2014 data on vaccination completion rates.

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

Responses to KII questions related to health out-reach activities differed greatly between government and non-government respondents. However, it was noted by all respondents that in areas where NGOs supported health out-reach staff were very active and provided more outreach services, the reason given was that MoH external payment rates are higher than MoH internal payment rates, due to insufficient budgets available to cover the expenses incurred whilst undertaking out-reach activities, such as transport costs. It was noted during interviews that many Health Centres lacked sufficient staff numbers to provide staff for both Health Centre service provision and regular health out-reach activities, and the number of staff able to speak relevant community languages was also low.

1.2. Use of VHSGs for assisting health service delivery at the community and reporting health issues from the community to the Health Centres

During the FGDs respondents were asked about the activities of VHSGs, 100% of FGDs reported having VHSGs, and 85% reported them as being active, with the majority providing basic health advice and referring people to health facilities. It was noted that participants had problems distinguishing between VHSGs and other community health workers such as Global Fund supported VMWs. In contrast many KII respondents commented on VHSGs becoming less active in the target areas over the past two years, unless supported by NGOs through other donor projects. The reason given was the reduced budget available and reduced payment amounts. It was noted by several KII respondents that MoH external payment rates are higher than MoH internal payment rates. In areas with high concentrations of indigenous persons'/ ethnic minorities, with low utilization of public health services, one of the main ways to increase utilization is active health promotion to improve health seeking behavior.

1.3. IEC/BCC materials designed to take account of specific needs of IP and ethnic minority communities.

As with the previous Social Assessment, much anecdotal evidence could be seen concerning the general lack of IEC and BCC materials in the target communities. That said, 38% of FGDs reported having experienced indigenous/ ethnic minority targeted IEC/ BCC materials (specifically either messaged in an IP language or representing IP relevant images) though this was heavily skewed to provinces with large indigenous persons'/ ethnic minority populations (59% reporting having seen such materials) compared to provinces with small indigenous persons'/ ethnic minority populations (23%). Based on the reports of the FGD and KII, as well as the variations with large indigenous persons'/ ethnic minority populations between villages within the same Health Centre catchment, it appears highly likely that the adapted materials were provided through NGO outreach as opposed to standard government supported Health Centre outreach activities.

It was identified during the KIIs that a major barrier for health promotion/ awareness raising has been the availability and provision of IEC and BCC resources for indigenous and ethnic minority communities. Interviews across all four provinces revealed that there were no government provided IEC and/ or BCC materials targeted towards or sensitized towards indigenous and ethnic minority specific communication. Moreover, local authorities across all four provinces indicated that even Khmer oriented versions of IEC and BCC materials had not been distributed to these communities in recent years, and that any production and distribution of materials was being done by UNICEF/ NGOs through other donor funded projects *(mainly Global Fund)*, although not comprehensively across the province; only in their project's target areas.

2. Health Care Financing

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

Awareness of HEFs remained constant under this Social Assessment as compared with the one conducted in 2014, with 86% of FGD participants reporting a knowledge of HEFs although some were not completely aware of HEF availability at the Health Centre level. In terms of actual utilization, there appeared to be distinctions between provinces with small populations of indigenous persons/ ethnic minorities relative to the total population (Preah Vihear and Kratie) and those with larger indigenous persons' populations (Ratanakiri and Mondulkiri).

In Preah Vihear provinces, which have smaller indigenous persons'/ ethnic minority populations, 23% of the FGDs had no participants who had been able to access HEF funds, while 50% of the FGDs had a only minority of participants (40% or fewer of participants) who

had accessed HEFs, and 27% of the FGDs conducted had a larger number of FGD participants (over 40% of participants) who had accessed HEF support. In contrast, Ratanakiri and Mondulkiri (which have larger IP populations) had a lower percentage of total FGDs conducted that contained no FGD participants that had had used HEFs (9%). These provinces also had fewer FGDs that had a large number of participants who had accessed HEFs (21%).

This seems to indicate that progress has been made in HEF utilization, likely a result of the recent expansion of HEF at the Health Centre level, and that overall there appears to be an increase in utilization across the indigenous peoples' villages. That said, for densely populated indigenous persons' regions and still for the majority of villages in smaller indigenous persons'/ ethnic minorities populated areas utilization within the communities appears to be fragile with a limited number of the population being able to utilize the services. As is discussed below, this limitation may be a result of the HEF identification criteria, and it appears that now that uptake at the village level is now being achieved, focus may need to be placed on maximizing utilization by directly targeting households and populations within villages who are not accessing HEF.

While many individuals were aware of HEF, with few having ID Poor status for pre-identification, there were various self-initiated statements from FGD participants of having gone through the post-identification processes at health facilities only to be rejected and burdened with treatment costs. This risk of financial liabilities for treatment costs (not to mention indirect costs such as transportation to reach the health facility and post-identification point) appears to be a significant limiter on users' willingness to try and access the HEF and as such use said health facilities. Given these risks, it is also a possibility that those who use the HEF post-identification already had a willingness/ ability to pay the health facility costs, thus the willingness to incur the risk of post-identification rejection, which would indicate some targeting issues of the post-identification process as those accessing it may not be those actually targeted; thus increasing the likelihood of leakages in targeting and non-access by poor who lack the money to risk rejection.

KIIs revealed that HEF coverage is available at the all target hospitals and has expanded significantly over the last two years to cover all Health Centres. However, interviews conducted with relevant HEF providers did raise some issues of concern. The HEF providers are implementing their activities using the same model for implementing in Khmer provinces as they have for implementing in provinces where the majority of the population are non-Khmer. Across the four target provinces there was only one HEF provider staff member that speaks any indigenous languages *(Ratanakiri)*. There is no specific strategy in place for indigenous peoples'/ ethnic minorities or any recognition amongst HEF provider staff of how the needs of indigenous peoples'/ ethnic minorities differ from the dominant Khmer population. The only IEC material used was a picture of the ID Poor Card. Staff reported undertaking outreach/ awareness raising activities, securing a translator at the village visited, but noted that this outreach had reduced significantly in the past two years due to budget cuts.

Issues were raised related to problems experienced with the HEF pre-identification approach and its reliance on the ID Poor process – this is an identifiable problem due to the large percentage of HEF eligible patients that go through the post-identification screening process, in some areas it is nearly 50/50, which clearly indicates that the ID Poor associated pre-identification system is problematic. This is an issue also identified by senior government officials and incorporated into the NSDP 2014-18 with a focus on strengthening the existing national targeting mechanism, enhancing targeting efficiency and reducing inclusion/ exclusion errors, particularly for ethnic minorities.

<u>User Fees</u>

As was noted in the previous Social Assessment, there appeared to be a correlation between satisfaction with user fee rates and the presence of an indigenous/ ethnic minority health provider at health facilities. The current Social Assessment has revealed a significant increase in the number of indigenous/ ethnic minority health providers in public facilities (a 51% increase average against the previous Social Assessment with a 74% increase in Ratanakiri & Mondulkiri specifically). This in turn correlates to a 102% increase in satisfaction with health facility user fees by FGD participants with 58% of FGDs reporting satisfaction with the current user fee costs as compared to 29% in the previous Social Assessment. As such, it does appear, assuming that costs have not changed in the interim which there is no indication of, that the willingness to pay of indigenous/ ethnic minority users has increased since the previous assessment. This shift in perception of the value of services also seems to have been reflected in the desired changes in health service provision and systems by the FGD participants with only 6% of FGDs reporting cost reduction as a primary change they wished to see happen.

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

3. Human Resources and Sensitization

3.1. Ensure community-based health workers from all ethnic minority areas understand local languages and/ or are familiar with local culture.

A significant increase in indigenous health providers was observed across all areas that were covered by the previous Social Assessment, with a 51% increase in the number of indigenous/ ethnic minority health providers overall and a 74% increase in Mondulkiri & Ratanakiri. That said, these gains remain somewhat limited with 58% of FGDs reporting that the health facilities had two or less indigenous/ ethnic minority clinical staff, meaning that it was not possible for an indigenous/ ethnic minority clinical staff member to be present during all work shifts; it was noted that 20% of health facilities did have three or more indigenous staff which theoretically would allow all shifts to be covered.

Despite this progress, discrimination against indigenous peoples'/ ethnic minorities in health service provision remains a significant issue, specifically for provinces with large indigenous peoples' populations. While only 7% of FGDs in provinces with small indigenous peoples'/ ethnic minority populations had participants who reported having experienced ethnic discrimination, 52% of FGDs in large indigenous peoples' population provinces (Mondulkiri & Ratanakiri) had participants who reported having experienced ethnic discrimination in health facilities while seeking services.

The KIIs revealed that the recruitment of indigenous peoples'/ ethnic minority health providers has increased over the past two years. However, it was noted that most were low level clinical staff, primary-level midwifes/ nurses who receive one year of technical training, who were immediately despatched to work in remote Health Centres/ Health Posts without skills assessments or gaining practical experience at the hospitals prior to assignment. Concerns were raised that these staff were undertaking consultations and providing services/ medication for health related issues for which they had received little training, without adequate skills and technical supervision. This resulted in many patients being directly referred to the hospital for treatment and many patients now choosing to completely by-pass Health Centres and seeking services directly from the hospitals. Language remained a significant barrier at the hospitals

due to the very limited number of staff that can speak minority languages, with many patients having to bring their children for translation or asking local NGOs/ CSOs to help them access services. It was noted in the KIIs that none of the four target provinces provided any type of language or cultural training to health workers prior to deploying them to work in Health Centres with high concentrations of indigenous persons'/ ethnic minorities residing within their catchment areas.

3.2. HCMCs in monitoring health service delivery.

According to the KIIs conducted Health Centre Management Committees (HCMCs) continue to meet on a quarterly basis, but mostly without the full attendance of members. During the meetings members only reviewed the Health Centre reports as there are no other monitoring activities available to them. Indigenous peoples'/ ethnic minorities are members of the HCMCs but they are mainly Health Centre staff or Commune Council government staff, there are no non-government community/ CSO members. However, it should be noted that in most HCMCs there is the involvement of two Village Health Support Groups members from the catchment areas – this is only a very small percentage of total VHSGs. There was no information provided on the VHSG-HCMC participant selection criteria. It is possible that their independence is compromised due to conflicting dual roles as village level community health worker under the management of Health Centre staff and their governance/ monitoring role as members of the HCMC. Whilst conducting the KIIs many respondents noted that OD/PHD staff is not very active in monitoring the HCMC meetings.

3.3. Can they voice their views, concerns and preferences related to health care services freely?

While substantial progress has been seen across most areas, community members' willingness and perceived ability to voice their concerns to health staff and leadership seems to have reduced. While in the previous Social Assessment 52% of participants reported not having the ability to raise concerns to health staff or management, this has now increased to 62%; a 20% comparative increase. This inhibition appeared to be more prominent in provinces with larger indigenous peoples'/ ethnic minority populations than in provinces with small indigenous peoples' ethnic minority populations with 67% reporting being unable to voice their concerns in Ratanakiri and Mondulkiri as opposed to 57% in Kratie and Preah Vihear. Most importantly, in provinces with large indigenous peoples'/ ethnic minority populations, many participants reported direct fear of reprisals and the withholding of health services as the reason why they would not speak up about issues or concerns.

This issue of voice appears to directly connect to the predominant changes FGD participants would wish to have with their health services and provision. When asked about what would be the first change the FGD participants would like to have to their health services or system, 53% of the FGD conducted named changes in HC Staff behavior and attitudes as the key change they wished to have; for provinces with larger indigenous peoples'/ ethnic minority populations this was slightly higher at 61% of the FGDs conducted. A further 23% of the FGDs conducted named increased opening hours and having staff present in the Health Centre for more hours as the first change they wished and a separate 13% wished for more indigenous peoples'/ ethnic minority staff to be employed in health facilities.

Most importantly, 69% of FGDs, without initiation by the survey, reported that they wished to have indigenous peoples'/ ethnic minority representatives either as members of the HCMCs or in senior management positions at the Health Centres/ hospitals. This was a consistent and strong request across all regions representing 57% of FGDs conducted in provinces with larger indigenous peoples'/ ethnic minority populations and 79% of FGDs conducted in provinces with smaller populations.

3.4. *Construction/ renovation of health infrastructure in currently underserved areas, which are mainly rural and areas with high ethnic minority and IP populations.*

Expansions in the number of health facilities has occurred across all target provinces during the World Bank funded HSSP2 program period, with emphasis placed on the upgrading of facilities. In Ratanakiri one Health Centre was upgraded from a Health Post, as well as the upgrading of Borkeo Health Centre to a District Hospital and the construction of a maternity ward at the referral hospital, an additional upgraded Health Centre is due to be finalised in February 2016. It was noted that this was done with funding from donors outside of HSSP2. In Mondulkiri four Health Posts were upgraded to Health Centres and there is a plan to upgrade a Health Centre to a District Hospital, but the schedule/ donor is not confirmed. It was noted that this was done with funding from donors outside of HSSP2. In Kratie there are a large number of health facilities when compared to neighbouring Ratanakiri and Mondulkiri. The assigned government health official was not certain about numbers and donors, but it is likely that eight Health Centres were upgraded/ constructed utilising HSSP2/ Japan Embassy Funding. In addition to this the District Hospital in Chlong District was upgraded from a Health Centre in 2013, again the PHD official allocated for interview did not know the donor. In Preah Vihear ten new Health Centres were constructed and two Health Posts were upgraded to Health Centres during the period under review, also four new Health Centres are due for completion in early 2016. The majority of the new Health Centres were financed by HSSP2, but at least three were financed with funding from donors outside of HSSP2. All new and upgraded Health Centres were reported to offer the full Minimum Package of Activities required for Health Centre status

Health Facility Overview:

Health Facilities	**Kratie**	**Preah Vihear**	**Ratanakiri**	**Mondulkiri**
Health Centres	29	23	14	11
Health Posts	12	16	15	13
Hospitals	3	1	2	1
Total	**44**	**40**	**31**	**25**

The table below gives an overview of the constraints and recommendations that were identified during the consultation process.

Constraints Identified	**Proposed Actions to Address Constraints**	**Responsible Entities**
Limited HEF Access: • No HEF strategies to target indigenous peoples/ ethnic minorities. • HEF services recently expanded to new Health Centres. HEF Provider has inadequate physical/ human resources to respond to expansion. • Severe lack of HEF staff that speak indigenous/ ethnic minority languages.	To improve access Health Equity Fund (HEF) provider, through themselves or contracted CSO/ NGOs, to be contractually required to: 1. Develop detailed strategies specifically targeting indigenous peoples/ ethnic minorities, clearly demonstrating an understanding of language and cultural barriers as they differ from Khmer populated areas. 2. Continue improvements to HEF services recently expanded to new Health Centres (HCs) to ensure greater community level awareness and access. 3. Increase numbers of sub-national level staff with proficiency in relevant minority languages. 4. Submit reports detailing specific activities undertaken and achievements related to increasing the utilization of HEF by indigenous peoples/ ethnic minorities.	MoH/ HEF Provider. HEF Provider. HEF Provider. HEF Provider.

	5. Collaborate with relevant sub-national government departments to enhance targeting efficiency and reduced inclusion and exclusion errors, particularly for indigenous/ ethnic minority groups. • Reassessment of HEF provider physical/ human resources requirements to ensure efficient functioning of newly expanded HEF services. • The Payment Certification Agency (PCA) contract will include requirements and targets specifically related to indigenous peoples/ ethnic minorities for HEF. • The PCA to undertake client surveys with indigenous peoples/ ethnic minorities to better understand user and non-user experiences with the HEF.	HEF Provider/ Provincial Department of Planning (MoI). PCA/ HEF Provider. MoH/ PCA/ WB. PCA.
Limited access to health facilities/ services: • Some provinces have low numbers of rural health facilities. • Irregular health outreach activities undertaken by health facility staff, with limited services provided. • Lack of transportation options in remote areas resulting in high costs.	• Targeted construction of new facilities in remote non-ethnic Khmer population areas (Mondulkiri/ Ratanakiri) – advance recruitment/ training of additional staff for new facilities, costs for new facilities integrated into annual health planning/ budgeting. • Use of SDGs to incentivize regular health outreach activities and expansion of current limited package of health outreach activities in remote and difficult to access areas in adherence to the Health Outreach Guidelines (2013). • Amendment of service delivery performance contracts for all HCs, ODs and SOAs. • Continue improvements to HEF services recently expanded to new HCs to ensure greater awareness and access, including reimbursement of transport costs for eligible persons.	MoH/ PHD. HCs/ ODs. HCs/ ODs. WB/ MoH. WB/ MoH/ SOAs. HEF Provider.
Technical competency of many health providers at the Health Centre level is limited. • New staff predominately primary level staff with limited training/ technical capacity. • Lack of skills building prior to deployment in rural Health Centres.	• Development of strategies to improve the technical competency of health staff working at the HC level in areas with high concentrations of non-khmer populations. • Training and the provision of on-the-job training support targeted in HCs with concentrations of indigenous/ ethnic minority groups within their catchment areas. • Identify existing indigenous/ ethnic minority health workers in relevant HCs to undergo competency training at CPA hospitals/ Regional Training Centers. • Training arrangements coordinated with staff from relevant OD/ PHD departments and the regional Training Centre in Stung Treng. • Annual quality of care assessments conducted, including sections examining the cultural appropriateness of services.	MoH/ PHDs. PHDs/ HCs. PHDs/ HCs. PHDs/ ODs/ HCs. MoH/ PCA.
Lack of culturally relevant health services. • Service delivery approaches largely the same as for Khmer populated areas. • Lack of operational guidance on permissible deviations from national guidelines to facilitate the provision of culturally appropriate services.	• SDGs used to incentivize improvements in the quality and cultural appropriateness of care available at hospitals, HCs/ HPs, including the promotion of and increased utilization of services by HEF beneficiaries. • SDG HC supervision checklist to include sections on service delivery related to indigenous peoples/ ethnic minorities. • HC staff will be required to report on activities undertaken specifically to address the health needs of indigenous peoples/ ethnic minorities as a priority group. The PCA will review the reports and achievements prior to making relevant SDG payments.	HCs/ PCA. MoH/ PCA.

• Discrimination against indigenous peoples'/ ethnic minorities by health providers.	• Selected hospital SDG payments linked to annual progress and outcome indicators related to increasing the quality of service provision for indigenous peoples/ ethnic minorities. This will include indicators related to staff with relevant language skills and the inclusion of indigenous peoples/ ethnic minorities community representatives in annual planning and hospital management decision making forums. • MoH review to examine the need for additional operational guidelines for culturally appropriate health service delivery. • Provision of training on medical staff code of ethics. • Provision of targeted training on the government Client Rights and Health Provider Rights Policy. • Development of health care provider behavioral change strategy and training module/ materials. • CSO/NGO support of sensitization of materials and approaches specifically targeted for IP populations as well as training of health staff in client oriented services and IP sensitivities.	Hospitals/ PCA. MoH. ODs/ PHDs ODs/ PHDs MoH/ PHDs/ contracted CSOs/ NGOs.
Health workers are not from IP/ ethnic minority communities. • The majority of HC staff are Khmer from low-land Cambodia provinces. • Absence of cultural awareness training for staff members assigned to work in the remote facilities. • Lack of operational policy/ guidance on the provision of culturally appropriate health care provision. Staff strict adherence to national protocols.	• MoH review to examine the need for additional operational guidelines to guide health providers on culturally appropriate health service delivery. • Increase the number of IP/ ethnic minority medical staff through the introduction of training grants for professional medical training, targeted at both IP/ ethnic minority communities and existing IP/ ethnic minority low level health care professionals, with associated training bonds. • Collaboration with relevant local CSOs/ NGOs to develop cultural awareness training modules in collaboration with indigenous/ ethnic community leaders. • Arrangement for local NGO provision of annual training using the cultural awareness training modules, targeted at facilities in ODs with high non-ethnic Khmer populations.	MoH. MoH/ PHDs PHDs/ contracted CSOs/ NGOs. PHDs/ contracted CSOs/ NGOs.
Health workers absent from facilities. • Staff absenteeism. • Many Health Centers/ Posts are open and staffed for limited hours per day. • Lack of functioning monitoring mechanism. • Lack of functioning disciplinary mechanism.	• Strategy to improve staff attendance at health facilities, balancing service delivery in remote and difficult to access communities and health facilities 24 hours opening –with considerations of minority language needs. • Introduction of Performance Management and Accountability System for monitoring staff performance and linking staff attendance to SDG performance incentives. • Introduction of community dialogue mechanism via facility community score card mechanism - with performance linkages to staff incentive scheme. • Strengthening accountability of SOA management to ensure performance monitoring, including spot checks to health facilities, and linking staff attendance to SDG performance incentives. • Ensure feedback on health facility opening and staff attendance through SDG incentive monitoring system. • Introduction of transparent facility based complaints mechanism, with functional Operational District follow-up plan.	MoH/ PHDs. MoH/ PHDs/ PCA. MoH/ PHDs. MoH/ PCA. PHDs/ PCA. MoH/ ODs.

Limited community level health promotion and awareness raising activities. • VHSG members partially functional, due to lack of budget – unless supported by NGOs. • Sever lack of health promotion IEC materials, including culturally appropriate materials. • Available IEC materials using indigenous imagery/ languages not formally recognized by the National Center for Health Promotion. • Lack of training for community health workers. • Lack of monitoring of community health workers	• National Centre for Health Promotion to facilitate consultations with relevant CSOs/ NGOs in target provinces to source existing health promotion related IEC materials that are culturally suitable for indigenous persons' and ethnic minorities, and field tested. • Allocation of budget to NCHP to develop and disseminate health education materials targeted at indigenous and ethnic minority groups. • Allocation of adequate budget to support VHSG training, the provision of culturally appropriate health education IEC/ BCC materials and monitoring. • Allocation of adequate budget to support VHSG community level work and facility reporting. • Provision of training to government approved community health workers (VHSGs) to fulfil the role expected of them in the CPP. • Strengthening accountability of SOA managers to ensure accurate performance monitoring and reporting related to health promotion activities and the performance of VHSGs.	NCHP. MoH. PHDs/ ODs/ HCs. PHDs/ ODs/ HCs. PHDs. MoH/ PCA.
Limited ethnic minority community representative participation in health facility management and planning process. • Lack of non-government indigenous/ ethnic minority community representatives in Health Centre management. • Lack of mechanisms for community dialogue and indigenous/ ethnic minority community leaders' engagement in health planning and facility management.	• MoH review to examine the need for additional operational guidelines for non-government community level representation in CPP related forums such as the HCMCs, and increasing the participation of non-government community level indigenous persons'/ ethnic minority representatives in multi-level annual health planning and reviews. • Allocation of adequate funds to ensure regular Health Centre Management Committee meetings with high rate of participation from members, particularly members from remote and difficult to access communities. • Relevant ODs and PHDs to adopt scorecards measuring key supervisory processes and health system outputs, including sections detailing specific supervisory activities undertaken to increase the utilization of public health services by indigenous peoples/ ethnic minorities and achievements. • Introduction of Community Scorecard mechanism to facilitate dialogue and community participation in health facility performance reviews. Initial targeting at facilities located in areas with high non-ethnic Khmer populations.	MoH. PHDs/ ODs/ HCs. PCA/ PHDs/ ODs. MoH/ PHDs/ HCs.
Lack of IP/ ethnic minority targeting. Indigenous peoples'/ ethnic minorities not targeted as vulnerable/ special needs groups under current national health policies and strategies.	• Inclusion of indigenous peoples and ethnic minorities as special targeted populations under national disease and health sector strategic plans and policies.	RGC/ MoH/ donors.
Persistent inequalities in health outcomes. Inequalities in health outcomes disproportionately affecting provinces with high	• Development of strategy to reduce provincial health inequalities, with a focus on provinces with lowest health outcome indicators. • Targeted construction of new facilities in remote non-ethnic Khmer population areas (Mondulkiri/ Ratanakiri). • Strengthening accountability of SOA managers to ensure accurate performance monitoring, including PCA	RGC/ MoH/ donors. MoH/ PHDs. MoH/ PCA.

concentrations of indigenous persons/ ethnic minorities.	spot checks in health facilities and community level verification of reported health outreach activities.	

Methodology:

As prescribed in the consultation Terms of Reference village level Focused Group Discussions (FGDs) were undertaken with nine indigenous/ ethnic minority groups across four provinces: Tumpoun, Jaray, Kreong *(Ratanakiri)*, Phnong *(Mondulkiri)*, Stieng, Kraol and Cham *(Kratie)* and Kuoy, Poar *(Preah Vihear)*. Three villages were selected for each indigenous/ ethnic minority group, resulting in a total of twenty-seven villages targeted across the four provinces. The villages selected were weighted towards villages with high concentrations of ethnic populations for each target group, combined with distance from the Health Centre (close proximity, remote and middle distance), except for Cham communities (close proximity near river, remote near river and transitional agricultural community away from river). A decision was made to undertake two FGDs in each target village, one comprised of male participants and another comprised of female participants, resulting in a total of fifty-four FGDs being undertaken. The decision to divide FGD participants into gender groups was made in order to help reduce constraints that participants may face if in a mixed gender group.

FGD teams composed of persons from the ethnic target groups were assembled for each of the nine target groups. The teams were composed of two males and two females. Each gender sub-team had a dedicated facilitator and a dedicated documenter and were assigned a supervisor. All FGD staff had previous experience in undertaking surveys and FGDs in the target provinces and working with the relevant target groups. The FGD staff and their allocated supervisors participated in the three day training. The training focused on introducing the FGD questions, reporting formats and the selected FGD protocols to ensure a consistent approach was adopted across all twenty-seven villages. Facilitators were also provided with refresher training to ensure that the FGDs were managed in a manner that reduced any potential interference or intimidation from other participants. Minor amendments were made to refine the FGD questions based on their translation to the target group's language.

The Village Chiefs in all target villages were contacted and meetings with village level leaders were arranged to seek permission and explain the reason for the Social Assessment. It was agreed that two village FGDs (M/F) would be conducted in each target village, 16th–18th November. A combination of both Purposive and Random participants were invited to join. Purposive participants were four males and four females: Village Chief (1 x M), Village Elders (1 x M, 1 x F), VHSG Members (1 x M, 1 x F), Traditional Birth Attendant (1 x F), the Commune Council Focal Person for Women and Children (1 x F), Traditional Healer (1 x M). The other participants (M/F) were selected randomly on the day of the FGD using a skip protocol developed to ensure that all random participants were selected using a standardized methodology. In total five hundred and ninety two (592) persons participated in the village level FGDs, two hundred and ninety two (292) females and three hundred (300) males.

The consultation's provincial Team Leaders also undertook a mixed gender FGD at the provincial level (19th-20th November) with representatives from eight relevant government departments. A total of thirty-two persons were invited to participate in the provincial level FGDs, the actual number of participants was twenty-six (26), nine (9) females and seventeen (17) males.

The information gathered from the FGDs was translated into English language text and reviewed using a textual analysis approach, wherein the appearance of certain issue or comments were analysed within the FGD group and then the weight of such statement was judged by the agreement of the group with it, as reflected in the minute reports of the discussions. This information was then quantified and calculated as a percentage of FGD

groups stating or supporting the word or phrase, thus indicating its importance or position through a Levi-Strauss analytical approach.

In addition to the FGDs the consultation undertook Key Informant Interviews. Six invitations were sent to the Provincial Health Department, the target Operation District Department, the HEF provider, a senior minority community leader and two relevant NGOs targeted based on their work on health issues/ work with the target groups – in each of the target provinces. Twenty-four persons were invited to participate in the Key Informant Interviews; the actual number of participants was twenty-one (21); six (6) females and fifteen (15) males.

Informing Communities About Program Objectives and Goals

A significant proportion of Cambodia's indigenous population is illiterate, and those that do enter the formal education system are commonly restricted to a few years primary level education. Therefore it is difficult to communicate complex information and concepts regarding the program's objectives and its specific health-related goals to the target villagers. Indigenous staff participating in the consultation expressed concerns regarding confusing participants prior to the commencement of the FGD. A simplified standard text was drafted for use by facilitators at the start of the village FGDs. The simple text focused on explaining the projects focus on improving the provision and quality of public health services, providing assistance for the poor with the payment of health related costs and improving the availability of heath staff, participants were also encouraged to express their needs and concerns. Adjustments were made to the draft text during the training sessions based on difficulties experienced related to translation to the target indigenous/ ethnic minority languages. Towards the end of the FGD participants were asked to present recommendations on ideas that they would like the program to address and make recommendations on ways to increase the participation of indigenous/ ethnic communities.

At the end of the village level FGDs participants were asked to express their thoughts about the proposed health project, if they believe that the project would be positive or negative. The consulted indigenous peoples'/ ethnic minorities did not express any concerns about possible negative impacts of the proposed program due to its focus on improving access to quality health services and increasing protection against health related impoverishment through increased utilization of the Health Equity Fund. Participants overwhelmingly expressed support for the program if it would result in positive improvements to the health of their communities and the cultural appropriateness of services available at the hospital and Health Centres. Some participants expressed frustration at not being able to access free health services despite being very poor and hoped that the program would help them. Generally participants were unable to comment on the cultural appropriateness of program design as they had not heard about the proposed program before and did not have enough information to have a view, but commented that the health staff are Khmer and sometimes have difficulties understanding their health needs and language, hence the need to improve the cultural appropriateness of services available at the hospital and Health Centres.

Consultation Mechanisms

Aside from the consultation contractual requirements of the World Bank Operational Policy on Indigenous People (OP 4.10) there continues to be a lack of formalised mechanisms to facilitate ongoing consultations and dialogue with indigenous peoples'/ ethnic minorities about their health needs, and activities specifically designed to ensure their engagement in designing and monitoring health development plans. Indigenous peoples'/ ethnic minority community representatives are not integrated into facility performance reviews, government health sector monitoring, evaluations, or the annual health planning review/ processes. This non-involvement is also experienced in provinces in which indigenous peoples' constitute the majority of the population (e.g. Ratanakiri and Mondulkiri). Information regarding the activities undertaken during the implementation of the HSSP2 program appears to confirm that no

activities were designed to explicitly focus on addressing the specific health needs and the particular constraints experienced by indigenous peoples' and ethnic minority communities.

The existence of mechanisms to ensure ongoing consultations and the engagement of indigenous peoples'/ ethnic minority communities into health planning and health facility performance reviews would have ensured a greater awareness of their particular needs and potentially the adoption of specific activities during the annual health planning processes.

The current lack of reliable data, disaggregated by ethnicity, makes the specific problems these communities face invisible to decision makers. The fast changing demographic situation in areas with high concentrations of indigenous/ ethnic minority peoples' means the indigenous voice in decision making will likely receive less attention; unless authentic consultative mechanisms are established with non-government community recognised representatives.

The fact that the traditional governance/ decision making structures of the indigenous Khmer Loeu are village based and traditional pan-village structures do not exist presents some complications to be overcome when integrating them into district and provincial level planning/ reviews. However, in Mondulkiri unofficial provincial level indigenous representative groups exist and have recently been organised to represent indigenous peoples with some provincial level government departments, which started with representation in education planning, however as yet this has not been extended to health planning/ reviews. The Cham are well organised and therefore it is much easier to identify community representatives for engagement in health planning and reviews. In Preah Vihear and Kratie indigenous peoples' are concentrated in distinct geographical locations which makes engaging with them easier than in Ratanakiri where various groups are distributed throughout the province. The establishment of community representatives to engage in health planning and reviews in Ratanakiri will likely have to engage relevant CSOs/ NGOs to start the process, ideally a consortium of them so they need to negotiate and the process cannot be dominated by one group. Through their work they will know potential candidates that have abilities/ education, they can agree on a list and then representatives can be selected on a district basis, in those districts elders councils can be consulted on candidates prior to selection/ election.

Ministry of Health

Health Equity and Quality Improvement Program (H-EQIP), 2016 - 2020

Supplemental Indigenous Peoples' and Ethnic Minority Consultations

Consultation Overview

Annex 1

Date: December 2015

Introduction:

The proposed Health Equity and Quality Improvement Program (H-EQIP) July 1, 2016 – June 30, 2021 builds upon the previous Cambodia Health Sector Support Programs 1 & 2. The proposed H-EQIP program will support parts of the larger Cambodia Health Strategic Plan (2016-20), specifically those related to financial protection and improving the quality of health services. The proposed program is nation-wide in coverage and includes provinces where concentrations of indigenous peoples' reside and the predominantly indigenous peoples' inhabited provinces of Mondulkiri and Ratanakiri. Due to program coverage including provinces where concentrations of indigenous peoples' and ethnic minorities reside the World Bank Operational Policy on Indigenous People (OP 4.10) was triggered requiring that a process of free, prior, and informed consultation be undertaken with the affected indigenous peoples' communities.

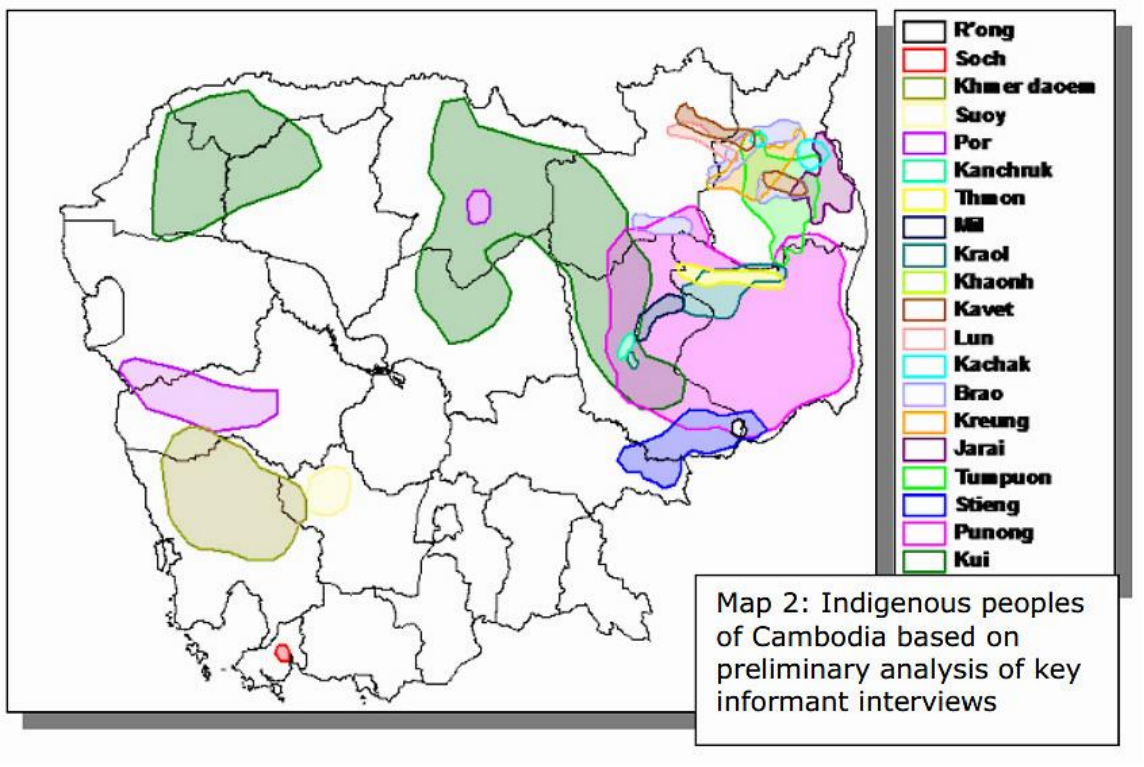
Geographical Overview:

The proposed H-EQIP program is nation-wide in coverage and includes provinces where concentrations of indigenous peoples'/ ethnic minorities reside and the predominantly indigenous peoples' inhabited provinces of Mondulkiri and Ratanakiri.

Map of Cambodia

Geographical Locations of Indigenous Peoples'/ Ethnic Minorities:

The map below gives an overview of the geographical distribution of Indigenous Peoples' in Cambodia:[1]



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

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

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

[1] Source: NGO Forum (Cambodia) 2006.

The proposed H-EQIP program's consultation with affected indigenous peoples'/ ethnic minority communities focused on nine different indigenous peoples'/ ethnic minority groups across four provinces:

Province	Indigenous Peoples'/ Ethnic Minority Groups
Mondulkiri Province	Phnong
Ratanakiri Province	Tampoeun, Jarai and Kreung
Kratie Province	Stieng, Kraol, Cham (Muslim) minority group
Preah Vihear Province	Kuoy and Poar

Consultation Methodology:

The consultation gathered relevant information using four different approaches:

1. Desk review of relevant data, research studies and analytical papers
2. Village level Focus Group Discussions
3. Provincial level Focus Group Discussions with relevant government departments
4. Key Informant Interviews with selected government, NGO and community stakeholders.

As prescribed in the Terms of Reference (ToR) the consultation undertook focused group discussion (FGDs) to explore respondent's views on specific issues as detailed in the ToR:

The main health interventions and target groups of the Program, such as the poor, women, new-born and child health, and communicable and non-communicable diseases. The seven strategic areas are health service delivery, health infrastructure, health system financing, heath workforce development, essential support services, health information system, and health system governance.

A basic summary of how the Program addresses social issues through:

- Service provision at health facility and at the community through health outreach activities
- Health Equity Fund grants to support the poor for accessing health care services
- Use of VHSGs for assisting health service delivery at the community and reporting health issues from the community to the Health Centres
- HCMCs in monitoring health service delivery;
- Construction/renovation of health infrastructure in currently underserved areas, which are mainly rural and areas with high ethnic minority and IP populations;
- Increase utilization of health equity funds that exclusively benefit the poor (e.g., IP and ethnic minorities);
- IEC/BCC materials designed to take account of specific needs of IP and ethnic minority communities.
- Ensure community-based health workers from all ethnic minority areas understand local languages and/or are familiar with local culture.

Village Selection:

Three villages were selected for each indigenous/ ethnic minority group, resulting in a total of twenty-seven (27) villages targeted across the four provinces. The villages selected were weighted towards villages with high concentrations of ethnic populations for each target group, combined with distance from the Health Centre *(close proximity, remote and middle distance)*, except for Cham communities *(close proximity near river, remote near river and transitional agricultural community away from river)*.

A decision was made to undertake two FGDs in each target village, one comprised of male participants and another comprised of female participants, resulting in a total of fifty-four (54) FGDs being undertaken. The decision to divide FGD participants into gender groups was made in order to help reduce constraints that participants may face if in a mixed gender group.

The Village Chiefs in all target villages were contacted and meetings with village level leaders were arranged to seek permission and explain the reason for the Social Assessment. It was agreed that two village FGDs (M/F) would be conducted in each target village, 16th–18th November. As detailed in the ToR a combination of both Purposive and Random participants were invited to join. Purposive participants were four males and four females: Village Chief (1 x M), Village Elders (1 x M, 1 x F), VHSG Members (1 x M, 1 x F), Traditional Birth Attendant (1 x F), the Commune Council Focal Person for Women and Children (1 x F), Traditional Healer (1 x M). The other participants (M/F) were selected randomly on the day of the FGD using a skip protocol developed to ensure that all random participants were selected using a standardized methodology. Please see annex 1.2 below for an English language version of the skip protocol – please note that this protocol was translated into Khmer for the training and for use by the teams in the target villages.

FGD Team Composition and Training:

FGD teams composed of persons from the ethnic target groups were assembled for each of the nine target groups. The teams were composed of two males and two females. Each gender sub-team had a dedicated facilitator and a dedicated documenter and were assigned a supervisor. All FGD staff had previous experience in undertaking surveys and FGDs in the target provinces and working with the relevant target groups. The FGD teams undertook the consultations in seven relevant indigenous/ ethnic group languages, with the exception of the Poar and the Kuoy in Preah Vihear province. The use of the Poar language has significantly reduced in recent years and many no longer use/ know the language. Both the Poar and the Kuoy are fluent Khmer speakers, so a decision was made to conduct the FGDs for those two target groups in Khmer.

The FGD staff and their allocated supervisors participated in the three day training (November 12th - 14th) in Ratanakiri province. The training focused on introducing the FGD questions, reporting formats and the selected FGD protocols to ensure that a consistent approach was adopted across all twenty-seven villages. Facilitators were also provided with refresher training to ensure that the FGDs were managed in a manner that reduced any potential interference or intimidation from other participants. All training participants undertook practical exercises to refine the implementation approach and provide team members with feedback to improve the quality of the FGD implementation.

Please see annex 1.1 below for an English language version of the FGD questionnaire – please note that this protocol was translated into Khmer for the training and during the training the questions were translated again into the relevant indigenous/ ethnic group languages for use by the teams in the target villages. Minor amendments were made to refine the FGD questions based on their translation to the target group's language.

Village Level FGDs:

The village level FGDs were implemented in the twenty-seven (27) target villages, 16th – 18th November. Two FGDs (one Male and one Female) were conducted in each target village, resulting in a total of fifty-four (54) FGDs being implemented in the three day period. In total six hundred and ten (610) persons participated in the village level FGDs, three hundred and twenty-one (321) females and two hundred and eighty-nine (289) males. Please see Annex 1.3 below for selected photographs of the village level FGD implementation. The table below details the number of village level FGD participants, disaggregated by province, village, district, ethnicity and gender:

Village	District	Ethnicity	Date of FGD	No./ Gender of Participants		
Ratanakiri Province				**Male**	**Female**	**Total**
Kaoh Peak	Veun Sai	Kreong	16-Nov-2015	10	11	21
Khon	Veun Sai	Kreong	17-Nov-2015	6	12	18
KaChoun Kraom	Veun Sai	Kreong	18-Nov-2015	5	13	18
LeuKhoun	Bar Kaev	Tumpoun	16-Nov-2015	12	10	22
Dan	Bar Kaev	Tumpoun	18-Nov-2015	11	10	21
Pa Ar	Bar Kaev	Tumpoun	17-Nov-2015	10	10	20
Nhang	Andoung Meas	Jaray	16-Nov-2015	10	12	22
Thmey	Andoung Meas	Jaray	18-Nov-2015	12	11	23
Ket	Andoung Meas	Jaray	17-Nov-2015	12	11	23
Ket	Andoung Meas	Jaray	17-Nov-2015	12	11	23
			Sub-total	**100**	**111**	**211**
Mondulkiri Province				**Male**	**Female**	**Total**
Pu Tang	Sen Monorom	Phnong	16-Nov-2015	10	18	28
Chhoul	Kaoh Nheaek	Phnong	18-Nov-2015	13	14	27
Purapet	Pech Chenda	Phnong	17-Nov-2015	8	8	16
			Sub-total	**31**	**40**	**71**
Kratie Province				**Male**	**Female**	**Total**
Chheuteal Phlos	Chhloung	Cham	16-Nov-2015	11	13	24
Srae Phorl	Chhloung	Cham	17-Nov-2015	12	12	24
Balang	Chhloung	Cham	18-Nov-2015	10	11	21
Rovieng	Sambor	Kraol	17-Nov-2015	10	10	20
Srea Chis	Sambor	Kraol	16-Nov-2015	10	10	20
Phnom Pir	Sambor	Kraol	18-Nov-2015	10	10	20
Kbalsnoul	Snoul	Steang	16-Nov-2015	9	15	24
krong	Snoul	Steang	18-Nov-2015	9	14	23
Thpong	Snoul	Steang	17-Nov-2015	11	11	22
			Sub-total	**92**	**116**	**208**
PreahVihear Province				**Male**	**Female**	**Total**
Peal	Rovieng	Poar	16-Nov-2015	10	12	22
OvLoek	Rovieng	Poar	17-Nov-2015	10	9	19
Kauk Ampil	Rovieng	Poar	18-Nov-2015	10	10	20
Palhal	Tbeng Meanchey	Kuoy	16-Nov-2015	11	8	19
Prame	Tbeng Meanchey	Kuoy	17-Nov-2015	13	7	20
Anlong Svay	Tbeng Meanchey	Kuoy	18-Nov-2015	12	8	20
			Sub-total	**66**	**54**	**120**
			Combined Total	**289**	**321**	**610**

Provincial Level FGDs:

The consultation's provincial Team Leaders also undertook a mixed gender FGD at the provincial level (19th - 20th November) with representatives from eight relevant government departments. Representatives from the following government departments/ agencies were invited to participate in the FGD:

1. Senior member of staff from the Provincial Health Department.
2. Senior member of staff from the relevant health Operational District Department
3. Senior member of staff from the Hospital Administration

4. Senior member of staff from the Provincial Department of Rural Development – *(preferably the Deputy with responsibility for Ethnic Communities Development).*
5. Senior member of staff from the Provincial Department for Women's Affairs *(preferably with IP knowledge, possibly the Deputy of the PDWA)*.
6. Senior member of staff from Action For Health - the HEF Administrators
7. Senior member of staff from the Provincial Governors Office *(from the group previously known as EX-COM, but now called "Implementation Plan 3").*
8. Senior member of staff from the Provincial Planning Department *(preferably a person connected with ID Poor identification/ roll-out)*.

A total of thirty-two persons were invited to participate in the provincial level FGDs, the actual number of participants was twenty-six (26), nine (9) females and seventeen (17) males.

Province	**Male Participants**	**Female Participants**	**Combined Participants**
Mondulkiri Province	5	1	6
Ratanakiri Province	4	2	6
Kratie Province	2	4	6
Preah Vihear Province	6	2	8
Total Participants	**17**	**9**	**26**

Key Informant Interviews:

In addition to the FGDs the consultation undertook Key Informant Interviews (KIIs). Six invitations were sent to the Provincial Health Department, the target Operation District Department, the HEF provider, a senior minority community leader and two relevant NGOs targeted based on their work on health issues/ work with the target groups – in each of the target provinces. The KIIs were undertaken to gather additional information that could not be gathered from FGD participants *(i.e. number of health facilities/ donors)* and also to gain a better understanding of the provinces health context from different perspectives *(health managers, clients and stakeholders)*. All KII participants were informed that the information gathered would be confidential to encourage more *honesty* in providing information related to the questions asked. A total of twenty-four (24) persons were invited to participate in the Key Informant Interviews; the actual number of participants was twenty-one (21); six (6) females and fifteen (15) males.

Province	**Male Participants**	**Female Participants**	**Combined Participants**
Mondulkiri Province	4	1	5
Ratanakiri Province	4	1	5
Kratie Province	4	2	6
Preah Vihear Province	3	2	5
Total Participants	**15**	**6**	**21**

Data Processing:

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

Annex 1.1

FGD Questionnaire
(English language version)

WORLD BANK 2015 IP CONSULTANCY

Focus Group Discussion (FGD) Questionnaire for Village Level

I. Identification:

Questionnaire ID: _____

Team Leader: _____

Name of FGD Facilitator: _____

Name of FGD Recorder: _____

Gender of FGD Group: ◯ Male ◯ Female *(please tick one)*.

Date: _____ Start time: _____ End time: _____

II. Location:

Province: _____ District: _____ Commune: _____

Village: _____ Village ID: _____

III. FGD Questions:

No.	Question	Answer
1.	What are the main types of health services that you visit the Health Centre for?	Types of Health Services 1. 2. 3. 4. 5. *(comments):*

2.	Do you think that Health Centres are EQUALLY accessible to all? *(Equally accessible for both Khmer and Indigenous Peoples).*	*(comments):*
3.	**3a)** When you access the Health Centres for services do they have staff available that can speak **<u>your</u>** indigenous language? **3b) If yes**, what position do they have, nurse/ midwife/ other support staff. **3c)** If the Health Centre has health care providers that speak **<u>your</u>** indigenous language would you use the Health Centre more?	**3a)** *(comments):* **3b)** *(please tick one only - group answer)* ◯ Nurse ◯ Midwife ◯ Other - Clinical staff ◯ Other non-clinical support staff. **3c)** *Comments:*
4.	What types of health services do you access alternative health providers for **(NOT the Health Centre or hospital staff)**? What are the reasons why you do **NOT** seek these services at the Health Centre?	<u>Types of Health Services</u> 1. 2. 3. 4. 5. <u>Reasons Why</u> 1. 2. 3.

		4. *(comments):*
5.	How many hours per day is your local Health Centre open and actively providing services?	*(comments):*
6.	What are the main reasons for NOT using the Health Centre or hospital for health services?	<u>Reasons</u>: 1. 2. 3. 4. 5. *(comments)*
7.	**7a)** When a family member is injured **where do you go first for treatment**? **7b)** Why **do you** or **don't you** use health centre services to get treatment for injuries? *(The use of the word **do** or **don't** for this questions is based on their answer to questions **7a**).*	**7a)***:* ◯ Hospital ◯ Health Centre ◯ Private Health Provider ◯ Traditional Healer ◯ Pharmacist **<u>7b</u>** **<u>Do Use</u>:** 1. 2. 3. 4. **<u>Do Not Use</u>:** 1. 2. 3. 4.

8.	**8a)** How many times has staff from the Health Centre come to your village to provide health services over the past 1 year? **8b)** What type of services do they provided during their visits? *(<u>at the village level</u>)*	**8a)** *(comments):* **8b)** 1. 2. 3. 4. 5. 6.
9.	List services available from government health staff **<u>for pregnant women</u>**, ***both*** at the **health centre** level and during health staff **out-reach services in your village**.	<u>Health Centre</u> 1. 2. 3. 4. 5. <u>Village Out-reach</u> 1. 2. 3. 4. 5. *(comments):*
10.	List *(<u>and rank</u>)* the reasons or types of services that you take your child to the Health Centres for.	1. 2. 3. 4. 5.

11.	**11a)** Has there been any immunization out-reach services in your village <u>in the past 1 year?</u>	**11a)** ◯ Yes ◯ No *(comments):*
12.	**12a)** Do you have Community Health Workers (VHSGs) / volunteers in your village? **12b) IF YES**, what services do they provide? 12c) **IF YES**, are they active in assisting people to access health services?	**12a)** ◯ Yes ◯ No **12b)***:* 1. 2. 3. 4. 5. **12c)** *(comments):*
13.	Do you have TB C-Dots Workers/ Village Malaria Workers in the village? **IF Yes**, **how many times have you received health education on Malaria and TB over the past 1 year**? *(Number of times received health education <u>on Malaria/ TB</u> over the past 12 months <u>at the village level</u>)*.	<u>Malaria</u> *(comments):* <u>TB</u> *(comments):*

14.	When you receive health education do facilitators use materials with Indigenous community pictures or images?	**14)** *(comments):*
15.	How do you feel about the costs of accessing government health facilities for treatment? *(Multiple choice answer – tick **<u>one</u> only**: too high, ok, too low)*.	◯ Too high ◯ OK ◯ Too low *(comments):*
16.	**16a)** Are you aware of the Health Equity Fund, which allows access to health services **<u>without</u>** payment. **16b)** Are you aware of what is required to access the Health Equity Fund for free health services? **16c)** How many of you have accessed services for free under the HEF system? *(e.g. 3/10)*	**16a)** *(comments):* **16b)** *(comments):* **16c)** *(comments):*
17.	**17a)** Do you feel that you can voice your views and concerns freely to government health staff? **17b) <u>IF NO</u>**, what do you think should be done to improve this?	**17a)** *(comments):* **17b)** 1. 2.

		3. 4. *(comments):*
18.	Do you feel that Indigenous Peoples have any opportunities to influence Health Centre Management?	**18)** *(comments):*
19.	What changes could be made to increase community participation in the provision and management of health services? <u>Describe proposed changes **clearly**</u>.	**19)** 1. 2. 3. 4. *(comments):*
20.	Please list *(<u>and rank in order of priority</u>)* **four changes** that you would like to see to improve health services?	1. 2. 3. 4. *(Comments):*

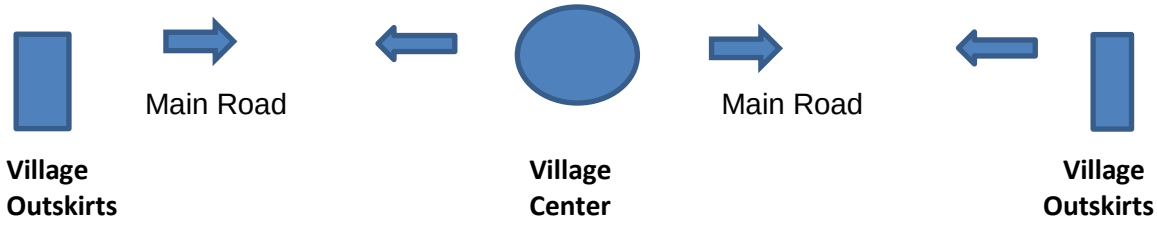
<u>Please Note</u>:

The above FGD questionnaire was translated into Khmer for the training and during the training the questions were translated again into the relevant indigenous/ ethnic group languages for use by the teams in the target villages. Minor amendments were made to refine the FGD questions based on their translation to the target group's language.

Annex 1.2

Protocol for Selection of Random FGD Participants
(English language version)

- For each village there will be 2 Focus Group Discussions – one male and one female.
- Each Focus Group Discussion will have 10 participants, 4 will be pre-selected purposive participants and 6 will be random participants.
- We need to ensure that the same approach is used when selecting the random participants in all 54 FGDs to ensure that they are truly random.
- When the team arrives at a target village they **need to agree a point that is the physical center of the village and two points that will be the outskirts of the village.**



- The team will divide into two groups.
- Starting at the **designated village center**, one group will travel in one direction away from the village center towards the village outskirts; the other group will travel in the opposite direction away from the village center towards the village outskirts.
- Each team will walk on one side of the street, and count houses until they get to house number 3 – approach the house, introduce yourself to the people and explain that you are holding an FGD and ask for a Female participant for the FGD.
- If the household are unable to provide a Female participant move to the house next door – continue this until you have secured a Female participant.
- Once you have secured a Female participant cross the street to the other side of the road, and count houses until they get to house number 3 – approach the house, introduce yourself to the people and explain that you are holding an FGD and ask for a Male participant for the FGD.
- If the household are unable to provide a Male participant move to the house next door – continue this until you have secured a Male participant.
- Once you have secured a Male participant cross the street to the other side of the road, and count houses until they get to house number 3 – approach the house, introduce yourself to the people and explain that you are holding an FGD and ask for a Female participant for the FGD.
- If the household are unable to provide a Female participant move to the house next door – continue this until you have secured a Female participant.
- After this process each of the two teams would have secured 3 participants (2 female and one male).
- The teams will then move to their **designated village outskirt point** and start walking towards the village center.

- Each team will walk on one side of the street, and count houses until they get to house number 3 – approach the house, introduce yourself to the people and explain that you are holding an FGD and ask for a Male participant for the FGD.
- If the household are unable to provide a Male participant move to the house next door – continue this until you have secured a Male participant.
- Once you have secured a Male participant cross the street to the other side of the road, and count houses until they get to house number 3 – approach the house, introduce yourself to the people and explain that you are holding an FGD and ask for a Female participant for the FGD.
- If the household are unable to provide a Female participant move to the house next door – continue this until you have secured a Female participant.
- Once you have secured a Female participant cross the street to the other side of the road, and count houses until they get to house number 3 – approach the house, introduce yourself to the people and explain that you are holding an FGD and ask for a Male participant for the FGD.
- If the household are unable to provide a Male participant move to the house next door – continue this until you have secured a Male participant.
- After this process each of the two teams would have secured another 3 participants *(2 male and one female)*. After the two processes are complete we would have identified 12 random FGD participants, 6 male and 6 female.

FGD Participant Desired Characteristics:

- Adult Males and Adult Females, aged 18 – 60 - if possible it would be good to get a variety of age groups represented in the FGD, **but only if this is possible from the people that are present in your randomly selected households**.

Please Note:

This protocol was translated into Khmer for the training and for use by the teams in the target villages.

Annex 1.3

Selected FGD Implementation Photographs

FGD Implementation in Kratie Province:

FGD-Srae Phorl - Cham Women's Group, 17th Nov. 2015.

FGD - Thporng - Stieng Men's Group, 17th Nov. 2015.

FGD - Srae Phorl – Cham Men's Group, 17th Nov. 2015.

FGD – Rivieng – Kraol Women's Group, 16th Nov. 2015.

FGD Implementation in Ratanakiri Province:

FGD – Kachunkrom – Kreong Women's Group, 18th Nov. 2015.

FGD – Lekhun – Tumpoun Men's Group, 16th Nov. 2015.

FGD – Kaoh Peak – Kreong Men's Group, 16th Nov. 2015.

FGD – Lekhun – Tumpoun Women's Group, 16th Nov. 2015.

FGD Implementation in Mondulkiri Province:

FGD – Pu Tang – Phnong Women's Group, 16th Nov. 2015.

FGD – Chhoul – Phnong Men's Group, 18th Nov. 2015.

FGD – Purapet – Phnong Men's Group, 17th Nov. 2015.

FGD – Chhoul – Phnong Women's Group, 18th Nov. 2015.

FGD Implementation in Preah Vihear Province:

FGD – Kauk Ampill – Poar Women's Group, 18th Nov. 2015.

FGD – Ovloek – Poar Men's Group, 17th Nov. 2015.

FGD – Preal – Poar Men's Group, 16th Nov. 2015.

FGD – Preal – Poar Women's Group, 16th Nov. 2015.