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Stakeholder Engagement Plan
for Cambodia Nutrition Project II P 177370

National Committee for Subnational Democratic Development-Secretariat

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List of Abbreviations

CNP-I	Cambodia Nutrition Project
CNP-II	Cambodia Nutrition Project II
CPWC	Commune Program for Women and Children
C/S	Communes/Sangkats
ESF	Environmental and Social Framework
ESMF	Environmental and Social Management Framework
GRM	Grievance Redress Mechanism
HEF	Health Equity Fund
IP	Indigenous Peoples
MOH	Ministry of Health
MOI	Ministry of Interior
NCDDS	National Committee for Subnational Democratic Development-Secretariat
RMNCAH-N	Reproductive, maternal, newborn, child, and adolescent health and nutrition
SNA	Sub-National Administration
SDG	Service Delivery Grant
SEP	Stakeholder Engagement Plan
VHSG	Village Health Support Group
WB	World Bank
WHO	World Health Organization

A. Introduction and the Background

1. Project Background

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

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

The PDO under CNP-II remains the same. The proposed CNP-ll will finance the delivery of the C/S SDG with the aim to strengthen capacities of local authorities/CPWC to promote citizens' behavioral changes; and to stimulate demand for and increase utilization of facility-based priority services, and encourage the adoption of improved Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH-N) behaviors. These priority services are aimed at reducing neonatal mortality, improving maternal and child nutrition, and improving routine immunization coverage. The priority services were defined in accordance with the expectation of the Royal Government of Cambodia (or hereafter RGC) to converge on interventions with known effectiveness to increase sustainability and efficiency of RMNCAH-N financing. CNP-II will finance community-based promotion elements of these services, rather than direct service provision through health facilities.

Specifically, CNP-II will be implemented across two components to mirror the activities supported by CNP-I Components 2.1 and 2.3. The additional resources will be directed to: (a) support an extended time period for implementation; (b) expand geographic coverage of CNP's community-based health and nutrition activities from the original seven priority provinces to additional new provinces; and (c) select project management costs and new goods and services procurements to accommodate the COVID-19 context.

The Cambodia Nutrition Project II comprises the following components:

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

[1] The name CPWC has been used to align with the mandate of the CCWC which extends beyond health and nutrition. If it is successful and feasible, it may be possible to expand the scope of CPWC activities beyond those proposed in the project.

the CPWC has been piloted as a community platform for health and nutrition promotion in the seven priority provinces. Under CNP-I Component 3, the MOH has developed the package of activities for VHSGs to support this program. The package includes: (a) social mapping for first 1,000-day households; (b) targeted health and nutrition social behavior change communication (SBCC) through door-to-door home visits, community groups, and mobilization for community-based GMP; (c) HEF promotion to increase service utilization among the poor; (d) community mobilization, including for SAM screening; and (e) health center management committee (HCMC) meetings. Under the CNP-I restructuring, CPWC activities will be adapted to respond to COVID-19 infection prevention and control measures and to include provision of information on COVID-19 prevention, treatment, and vaccination. As relevant and necessary, adaptations will also be undertaken to address the needs (activities, language, and so on) in indigenous communities where it will operate. Two main interventions under Component 1 include:

a. ***C/S-Service Delivery Grants.*** The component finances C/S to deliver the CPWC package of health, nutrition, and HEF promotion activities using the performance-based C/S-SDG grant. The grant adapts the successful MOH SDG system and applies the principle to the SNA. C/S-SDG will provide discretionary support to C/S over and above the C/S Fund to ensure the delivery of activities according to the CPWC guideline. The financing formula is outlined in the C/S-SDG Operation Manual and based on quantity (commune size) and quality (performance on a C/S-SDG checklist). The financial management, procurement, and environmental and social considerations of grant execution are also outlined in the C/S-SDG OM. Eligible expenditure (details in Annex 3) includes activities such as: (a) performance incentives to C/S key actors, including C/S chief, C/S deputy chief, C/S clerk, WC-FP, Village chief, village vice chief/assistance and VHSG; and (b) CPWC operational cost and other activities. Commune performance on C/S-SDGs will be systematically assessed through semiannual assessment by a district assessment team.

b. ***SDGs to DM Administration.*** These C/S-SDGs aim to strengthen the performance of District/Municipal Administration (DMA) conducting the C/S-SDG assessment process. The C/S-SDG assessment is outlined in the C/S-SDG Implementation Guideline and will build upon experience of Operational District (OD) assessment of health centers/referral hospitals under Health Equity and Quality Improvement Project (H-EQIP, P157291)[2] as well as the citizen monitoring using community scorecards under the ISAF.[3] DMA will conduct assessment of C/S, report on their own activities in a standardized checklist, and submit the scores to the NCDDS. The checklist will include elements such as the regularity and timeliness of assessment, extent of discrepancies in the previous two rounds compared to independent verification scores, participation in oversight and coaching, and responsiveness on citizen feedback. The NCDDS has hired a firm to carry out third-party, independent verification of the C/S-SDG and DMA scores on a random- and risk-sampled basis.

It is expected that CNP-I Component 2.1 will finance the SDG grants in 2021-2023 in the expanded 9-10 priority provinces; CNP-II Component 1 will finance the continuation of these activities in the 9-10 provinces in the project's outer years (i.e., 2023-2026).

Component 2: Project Management, Monitoring, and Evaluation for the NCDDS (US$1.0 million). Component 2 will finance activities otherwise eligible under subcomponent 2.3 of CNP-I, quickly disbursing to adapt to the COVID-19 context. This subcomponent will support provision of technical and operational assistance for routine administration as well as the procurement of additional goods

[2] *World Bank. 2016. Cambodia - Health Equity and Quality Improvement Project. Washington, D.C.: World Bank Group. https://hubs.worldbank.org/docs/imagebank/Pages/docProfile.aspx?nodeid=26343868*

[3] Additional mechanisms for social accountability will be considered for integration into the performance measurement system, including I4C disclosure and public disclosure of C/S-SDG scores.

(uniforms, equipment, and supplies for CPWC implementation) and services (C/S-SDG independent verification) and strengthened multisectoral coordination. The component may also support enhanced digital and communications equipment to assist with the implementation of C/S-SDG activities in the COVID-19 context.

The implementing agency for CNP-II will be the National Committee for Subnational Democratic Development-Secretariat (NCDDS) in the of the Ministry of Interior (MOI), which is one of the two implementing agencies for the CNP-I. NCDDS has the capacity to provide national-level management and leadership as well as to support sub-national implementation. NCDDS has a strong track record of harnessing existing systems which emphasize the role of decentralization, to coordinate with administrative districts, commune councils, and health centers at the selected locations.

2. Objective of the Stakeholder Engagement Plan

As per the Environmental and Social Standard ESS 10 Stakeholders Engagement and Information Disclosure, the implementing agency should provide stakeholders with timely, relevant, understandable, and accessible information, and consult with them in a culturally appropriate manner, which is free of manipulation, interference, coercion, discrimination, and intimidation.

The overall objective of this SEP is to define a program for stakeholder engagement, including public information disclosure and consultation, throughout the entire project cycle. The SEP outlines the ways in which the project team will communicate with stakeholders and includes a mechanism by which people can raise concerns, provide feedback, or make complaints about project and any activities related to the project. The involvement of the local population is essential to the success of the project in order to ensure smooth collaboration between project staff and local communities and to minimize and mitigate environmental and social risks related to the proposed project activities.

The proposed Stakeholder Engagement Plan (SEP) seeks to ensure that Project stakeholders are informed and involved in all the stages of the Project. The specific objectives of this SEP are as follows:

a. To establish a systematic approach to stakeholder engagement that will help NCDDS identify stakeholders and build and maintain a constructive relationship with them.

b. To assess the level of stakeholders' interest in and support for the project and to enable stakeholders' views to be considered in project design and environmental and social assessment and performance.

c. To promote and provide means for effective and inclusive engagement with project-affected parties throughout the project life cycle on issues that could potentially affect them.

d. To ensure the Indigenous Peoples and other vulnerable groups are reached out to and consulted within the consultation process.

e. To ensure that appropriate project information on environmental and social risks and impacts is disclosed to stakeholders in a timely, understandable, accessible and culturally appropriate manner and format.

f. To ensure that the project activities are carefully designed, consulted and implemented in an inclusive manner.

g. To provide project-affected parties with accessible and inclusive means to raise issues and grievances and allow MOH and NCDDS to respond to and manage such grievances.

The SEP is a living document and will be updated as the project progresses from project preparation to implementation and closure. The SEP establishes a mechanism that encourages and provides avenues for public participation during the project cycle. This is consistent with requirements under the Standard Operating Procedures of the NCDDS Operations Policies and Procedures manual, as well as requirements under the World Bank's new Environment and Social Framework's (ESF).

The SEP along with other environmental and social instruments such as the Environmental and Social Management Plan (ESMP), Indigenous Peoples Planning Framework (IPPF) and the Environmental and Social Commitment Plan (ESCP) will need to be disclosed and hence, consulted by project effectiveness. The SEP and other environmental and social instruments will be updated to reflect these consultations and any feedback received.

3. Scope of the SEP

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

4. Managing Risks of Stakeholder Engagement

Relevant risks associated with stakeholder engagement were assessed under the project's Environmental and Social Management Plan (ESMP). These include:

a. **COVID-19 transmission risks** due to face-to-face meetings and/or interactions with communities. An Infection Prevention and Control (IPC) protocol has been established in the project's ESMP and project implementing entities are required to adhere to such a protocol for activities with COVID-19 risks.

b. **Exclusion of vulnerable groups**, including Indigenous Peoples, to meaningfully participate and benefit from the project's activities. Such risks are expected to be managed through inclusive engagement, disclosure of information and outreach to diverse groups as outlined in the SEP. These groups include poor households, female-headed households, people with disability, Indigenous Peoples, etc. An Indigenous Peoples Planning Framework (IPPF) has been prepared to outline affirmative measures to enable inclusive engagement and outreach to Indigenous Peoples who may be present in the project's sites.

c. Appropriateness of services, which may stem from communities' perceptions of how formal health systems may not necessarily accommodate their traditional practices. Such risks are expected to be addressed through implementation of the SEP which requires informed engagement and consent as well as respect to traditional practices and inclusive social and behavior change communication campaign and outreach to diverse groups.

There are several lessons learned under the CNP I that CNP II aims to address. In particular, the absence of community health promotion and service delivery has remained a fundamental bottleneck to improving health and nutrition outcomes. Cambodia's community health and nutrition platform has largely remained informal despite the availability of C/S financing, the presence of local implementation structures, and the MOH recognition of its importance. The frontline health workers often lack the time, skills, support, and budget to carry out the prescribed responsibilities. Moreover, the Village Health Support Groups (VHSGs) are disconnected from formal systems in health and C/S and do not have the resources or support to be fully effective. Strengthening frontline primary health care is a priority to extend health information and services to the grassroots level and can further stimulate citizen voice, social accountability, social mobilization, and community surveillance for health and nutrition. The SEP is prepared to address most of these gaps and will be updated throughout the project as required.

5. Summary of Previous Stakeholder Engagement Activities

Under CNP-I, a village level consultation workshop was held on October 14, 2020 in the Kampong Cham province. The Preventive Medicine Department, MOH and NCDDs jointly conducted public consultations in Indigenous Peoples communities to further identify needs for additional activities to ensure that Indigenous Peoples groups benefit from the project, and in a culturally appropriate way. There were 58 representatives from 4 provinces (Ratanakiri, Mondulkiri, Preas Vihea and Koh Kong) who were invited to this consultation workshop. Participants were from Provincial Health Departments (PHD), Operational Districts (OD), Health Centers (HC), Village chiefs, VHSGs and representatives of Indigenous Peoples. CNP-II expects to strengthen previous engagement capacities, particularly at the C/S level.

The workshop discussed the following topics:

a. Constraints and challenges in receiving health services in health facilities
b. Constraints and challenges in receiving health services provided through outreach activities
c. Constraints and challenges in understanding of usefulness and opportunity in receiving ID poor
d. Adverse impacts of the project on Social and cultural practices
e. Actions to address and mitigate the constraints and challenges.

Key takeaways from the discussion are that Indigenous Peoples live far from health facilities and travelling to these can be expensive and dangerous due to difficult road conditions. There have been instances when people have arrived at health facilities, but no health providers were available. Secondly, women cannot undertake child spacing due to disagreements with their husbands. Thirdly, it is difficult to gather Indigenous Peoples for health promotion events due to their living situation, and at times, cultural restrictions. Therefore, health promotion events details (location and time) should be agreed on in advance by the local communities. Lastly, the complaint and feedback mechanisms should be through VHSGs.

6. Stakeholder Identification and Analysis

For the purposes of effective and tailored engagement, stakeholders of the proposed project(s) can be divided into the following core categories:

a. **Affected Parties** – persons, groups and other entities within the Project Area of Influence (PAI) that are directly influenced (actually or potentially) by the project and/or have been identified

as most susceptible to change associated with the project, and who need to be closely engaged in identifying impacts and their significance, as well as in decision-making on mitigation and management measures**.**

b. **Other Interested Parties** – individuals/groups/entities that may not experience direct impacts from the Project but who consider or perceive their interests as being affected by the project and/or who could affect the project and the process of its implementation in some way; an**d**

c. **Vulnerable Groups** – persons who may be disproportionately impacted or further disadvantaged by the project(s) as compared with any other groups due to their vulnerable status[4,] and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project.

Affected Parties

Affected Parties include local communities, community members and other parties that may be subject to direct positive impacts from the Project, from grants, capacity building, and/or service provision. Specifically, the following individuals and groups fall within this category:

a. NCDDS staff
b. Women and children in selected provinces
c. Households in selected provinces
d. Indigenous Peoples and vulnerable groups
e. Traditional health providers (i.e., healers, traditional midwives, etc.)
f. Maternal Child Health and Nutrition (MCHN) service providers
g. Relevant provincial, district and Commune/Sangkat administrations
h. Participating health centers (HC)
i. Village health support groups (VHSG)
j. Commune Committee for Women and Children (CCWC)
k. Commune and/or Sangkat governments

Other interested parties

The projects' stakeholders also include parties other than the directly affected communities, including, but not limited to:

a. Health center management committee (HCMC)
b. Operational Districts (OD)
c. Civil Society Organizations (CSOs) and Non-governmental Organizations (NGOs)
d. Other international agencies supporting health nutrition activities at the communities
e. Professional Associations

Vulnerable Groups

This category of stakeholders includes sub-groups of affected parties who may be vulnerable due to their socio-economic status (i.e., poor households), roles (i.e., female-headed households), socio-cultural circumstances, practices and beliefs, women and girls with pre-marital pregnancy, and people with disability. These sub-groups will be identified as part of community-level engagement, outreach and

[4]Vulnerable status may stem from an individual's or group's race, national, ethnic or social origin, color, gender, language, religion, political or other opinion, property, age, culture, literacy, sickness, physical or mental disability, poverty or economic disadvantage, and dependence on unique natural resources.

affirmative measures, including outreach, provisions of safe-space and relevant capacity building for implementing entities will be undertaken as part of CNP-II.

7. Stakeholder Engagement Program

The following section provides an overall strategy for stakeholder engagement under CNP-II:

Purpose and Timing of Stakeholder Engagement

The main objective of the stakeholder engagement program is to ensure that all stakeholders are kept informed and consulted according to their level of engagement into the project and can also meaningfully participate and benefit from the project.

The project will ensure that relevant publications, training programs, seminars, workshops, community engagement or ceremonial events and all other materials used by the project, shall be developed in consultation with the concerned government counterparts and the local communities to ensure easily understandable languages, messages and pictures are used and are accessible, inclusive and socially-culturally appropriate. All communication with the government whether at central, provincial, and local levels will be done in a formal way through the indicated formal channels.

Proposed strategy for information disclosure

Different engagement methods are available to cover various needs of the stakeholders, orientations for new provinces, focus group meetings/discussions, community consultations, formal interviews and site visits). However, given the ongoing limitations on public gatherings and the associated restricted movement of citizens where the general public is encouraged to stay at home, the main communication means are likely to rely on online tools. Community engagement will to the extent possible rely on the existing networks at the community level which have been established under CNP-I to minimize people's mobility. Hence, relevant capacity building, provisions of accessible information and relevant media will be provided as part of CNP-II implementation. Under CNP-II, community-level engagement is embedded as part of the project design and hence, will be delivered as part of project implementation. Key efforts shall be mobilized to promote inclusive and accessible engagement activities.

The main audiences and means of information disclosure will be:

a. Use of community representatives, leaflets, posters, radio and television programs, video clips, and mobile applications to inform communities

b. Websites, social media, newspapers, information centers and exhibitions or other visual displays to inform the public

c. Knowledge sharing events, technical and non-technical summary documents and reports to inform interested stakeholders

d. Official correspondence, project reports, meetings and meeting minutes to communicate with the government

e. Online technical and coordination meetings with relevant stakeholders using Zoom

Key elements of the information disclosure strategy at different project stages are outlined in the following matrix (refer **Table 1**).

Table 1: Information Disclosure Strategy

Timeline	List of information to be disclosed	Modality of Disclosure	Target stakeholders	PIC
Project Preparation	Project scope, roles and responsibilities, environmental and social management[5], FGRM	MOH, MOI, and NCDDS' Websites	General Public, NCDDS staff, relevant provincial, district and Commune/Sangkat administration, CCWC, health center management committee (HCMC), VHSG, community representatives, including NGOs/CSOs representing Indigenous Peoples, other international agencies supporting health nutrition activities at the communities. Project affected parties and relevant agencies.	NCDDS
Project Implementation	Project Information, including progress of implementation of specific activities, coordination mechanism, FGRM records, environmental and social management	MOH, MOI, and NCDDS Websites; Social media; Leaflets, posters; Press releases (print and electronic); Knowledge sharing platforms	NCDDS staff, relevant provincial, district and Commune/Sangkat administration, CCWC, health center management committee (HCMC), VHSG, other international agencies supporting health nutrition activities at the communities. Local communities, including vulnerable groups such as people with disability, Indigenous Peoples, poor households, etc. and their representatives, including NGOs/CSOs representing Indigenous Peoples; other interested parties and stakeholders, including development partners	NCDDS
Project Monitoring & evaluation (mid-term review)	Project Progress Reports, including documentation of grievances and community perceptions	Project progress reports	NCDDS staff, relevant provincial, district and Commune/Sangkat administration, CCWC, health center management committee (HCMC), VHSG, community representatives, including	NCDDS

[5] These include Environmental and Social Management Plan (ESMP), Stakeholder Engagement Plan (SEP), Indigenous Peoples Planning Framework (IPPF) and Environmental and Social Commitment Plan (ESCP)

			NGOs/CSOs representing Indigenous Peoples, other international agencies supporting health nutrition activities at the communities, development partners	
Project Knowledge Sharing & Learning	Studies; Knowledge Products; Print & Electronic Publications; Audiovisual Products	Knowledge sharing events/ workshops; electronic platforms; social media	NCDDS staff, relevant provincial, district and Commune/Sangkat administration, CCWC, health center management committee (HCMC), VHSG, community representatives, including NGOs/CSOs representing Indigenous Peoples, other international agencies supporting health nutrition activities at the communities. other interested parties and stakeholders	NCDDS
Project Closing	End of Project Report/ Implementation Completion Report	National workshops, NCDDS' website	NCDDS staff, relevant provincial, district and Commune/Sangkat administration, CCWC, health center management committee (HCMC), VHSG, community representatives, including NGOs/CSOs representing Indigenous Peoples, other international agencies supporting health nutrition activities at the communities. Other relevant agencies; other interested parties and stakeholders	NCDDS

Proposed Strategy for Consultation

A range of methods will be used to consult with each of the stakeholder group, including interviews with stakeholders, surveys, public meetings, workshops, focus groups on specific topics, or traditional mechanisms for consultation and decision making, and to document and disseminate the outcomes of these consultations (minutes, media reports, etc.). Further details will be identified as part of project implementation plans on specific engagement strategy and relevant activities, including production of communication materials, capacity building, awareness raising and community-level consultations.

Key elements of the consultation strategy at different project stages will be:

Project Stage	**Topics**	**Approach**	**Target Stakeholders**	**PIC**
Preparation	Project design, coordination, roles	Virtual	Project implementing agencies, sub-	NCDDS

	and responsibilities, stakeholder engagement approach, environmental and social management		national governments, community organizations, professional associations, community representatives (i.e., NGOs/CSOs)	
Project Implementation	Project activities, including refinement of Operation Manual, activity implementation, roll-out of SEP, FGRM, implementation of ESMP and IPPF	Virtual/online roundtables, Communication and awareness campaigns Face-to-face (depending on COVID-19 risks), preferably utilizing the existing community networks, disclosure of information through the NCDDS' website, village representatives, communication boards, dissemination of hardcopies and leaflets, community meetings, etc.	Provincial, district and Commune/Sangkat administrations, CCWC, health center management committee (HCMC), VHSG, traditional health providers, local communities, including vulnerable groups such as people with disability, Indigenous Peoples, poor households, etc. and their representatives including NGOs/CSOs representing Indigenous Peoples, other international agencies supporting health nutrition activities at the communities.	

Proposed Strategy to Incorporate the View of Vulnerable Groups

The project carried out a rapid social assessment as part of preparation of CNP-II, to ensure that vulnerable groups and ethnic groups have equitable access to services. In terms of nutrition impact indicators, recent analysis found that 39% and 41% of children under five years old are stunted in Pursat and Banteay Meanchey, respectively. In addition, 12% of children under 5 years old are wasted in both Pursat and Banteay Meanchey/ Forty-seven percent and fifty-three percent of all women aged 15 to 49 years old suffer from anemia in Pursat in Banteay Meanchey, respectively. As illustrated in the tables below, 15.6% of Banteay Meanchey households and 23.1% of Pursat households are classified as Poor.

District Comparison Table, Bantheay Meanchey province

Data collection round: 9, **Year:** 2015, **Date of Query:** 01/05/2017

Geographical Code	District	Poor Level 1 HHs	Poor Level 2 HHs	Poor Level 1 HHs %	Poor Level 2 HHs %	Total Poor Level 1&2 HHs %	Total HHs in District
0102	Mongkol Borei	2094	3660	5.9 %	10.4 %	16.3 %	35217
0103	Phnum Srok	837	1304	5.9 %	9.2 %	15.1 %	14153
0104	Preah Netr Preah	1264	3320	5.8 %	15.1 %	20.9 %	21935
0105	Ou Chrov	977	1285	7.1 %	9.3 %	16.4 %	13826
0106	Serei Saophoan	1107	2261	5.6 %	11.5 %	17.1 %	19700
0107	Thma Puok	1297	1938	7.4 %	11 %	18.4 %	17603
0108	Svay Chek	1202	2076	7.5 %	12.9 %	20.4 %	16102
0109	Malai	574	1443	5 %	12.6 %	17.6 %	11464
0110	Krong Paoy Paet	608	954	5.5 %	8.7 %	14.2 %	11006
Total		**9960**	**18241**	**6.2%**	**11.3%**	**17.5%**	**161006**

Source: Cambodia Ministry of Planning Poverty Rate Comparison Report

Source: Cambodia Ministry of Planning Poverty Rate Comparison Report

District Comparison Table, Pursat province

Data collection round: 10, **Year:** 2016, **Date of Query:** 12/05/2017

Geographical Code	District	Poor Level 1 HHs	Poor Level 2 HHs	Poor Level 1 HHs %	Poor Level 2 HHs %	Total Poor Level 1&2 HHs %	Total HHs in District
1501	Bakan	2796	4194	8.9%	13.3%	22.1%	31593
1502	Kandieng	1761	2448	11.7%	16.3%	28%	15028
1503	Krakor	2571	2380	11%	10.2%	21.1%	23416
1504	Phnum Kravanh	2072	1856	13.4%	12%	25.4%	15488
1505	Krong Pursat	833	1081	8.8%	11.5%	20.3%	9419
1506	Veal Veaeng	619	821	9.7%	12.9%	22.7%	6354
Total		**10652**	**12780**	**10.5%**	**12.6%**	**23.1%**	**101298**

Source: Cambodia Ministry of Planning Poverty Rate Comparison Report

Inclusion of vulnerable and disadvantaged groups is a key part of stakeholder consultation process. The strategy includes methods to involve poor, vulnerable households including Indigenous Peoples communities as they are the direct beneficiaries of the project, hence ensuring that the project benefits will be distributed in a fair and accountable manner is key to project success. Efforts to identify engagement constraints, including language barriers, scheduling, socio-cultural aspects, risks of stigmatization will be explored by community faciltiators. Relevant communication materials, including

engagement tools and media in formats accessible to diverse groups will also be developed with the project support. Engagement with the target communities will be done through: (a) conducting an orientation workshop in the new locations to sensitize beneficiaries to the project and its proposed activities, (b) continuing to use beneficiary feedback mechanisms designed for C/S-SDG systems, and (c) supporting robust communications and awareness campaigns to further sensitize the public.

Soliciting Stakeholders' Comments and Feedback

Stakeholders will be kept informed as the project develops, including reporting on project environmental and social performance and implementation of the stakeholder engagement plan and grievance mechanism.

8. Resources and Responsibilities

Resources

The NCDDS will be in charge of implementing stakeholder engagement activities in collaboration with the MOH and other implementing entities. The budget for the SEP is to be borne by project management costs administered by the NCDDS. A tentative budget of US $100,000 for the SEP implementation is included in component 2 of the project. Further details of the breakdown of the budget allocation and potential budget allocation will be confirmed prior to finalization of the SEP by project effectiveness.

Management Functions and Responsibilities

While NCDDS and MoH will remain as implementing agencies for the parent project "CNP", the NCDDS housed in the Ministry of Interior will primarily manage CNP-II. Given the strong track record of NCDDS under CNP and the aim of new operation being to build upon and expand core CNP activities, the same implementation arrangements for NCDDS under CNP will be used for CNP-II. Currently under the CNP-I project, NCDDS implements Component 2 through its technical departments and the provincial, District/Municipality (DM), and Commune/Sangkat (C/S) administrations. NCDDS has appointed a project director and a technical project manager to oversee Component 2 activities of CNP, and NCDDS' procurement and fiduciary departments are being used for project implementation. The ongoing implementation of CNP is progressing well; and the project management, including financial management, procurement, and environmental and social safeguards have all been rated Moderately Satisfactory as per the most recent Implementation Support Mission. Existing coordination mechanisms, which include coordination focal points for NCDDS will continue to function under CNP-II as they currently do in the parent project.

NCDDS, comprised of Project Manager, Social Specialist, and Project Analyst will be responsible for the overall management and implementation of the SEP, including the facilitation of the stakeholder engagement and consultations.

9. Grievance Redress Mechanism

The main objective of a Grievance Redress Mechanism (GRM) is to assist to resolve complaints and grievances in a timely, effective, and efficient manner that satisfies all parties involved. Specifically, it provides a transparent and credible process for fair, effective, and lasting outcomes. It also builds trust

and cooperation as an integral component of broader community consultation that facilitates corrective actions. Specifically, the GRM:

a. Provides affected people with avenues for making a complaint or resolving any dispute that may arise during the implementation of projects.
b. Ensures that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants and
c. Avoids the need to resort to judicial proceedings.

Description of GRM

Project-related grievances will be handled at the VHSG, with support from the Commune/Sangkat Committee for Women and Children; specifically, Women and Children Focal Person (WC FP). For activities implemented under Component 1, community members may use the subnational government system to provide feedback or report grievances on activities led by C/S and DMA by reporting through the C/S, DMA and Provincial Administration as well as the NCDDS at the national level. WC FP is assigned to collect, consolidate, and report on citizen feedback and redress of grievances. The citizen feedback and grievances will be recorded in a spreadsheet or database to ensure issues are resolved and responses tracked.

The following channels will be used through which citizens/beneficiaries/Project Affected Persons (PAPs) can make complaints/suggestions/compliments regarding project-funded activities:

a. Directly by verbal feedback to Village Health Support Groups
b. Social Media, such as Facebook and Telegram
c. Submit to suggestion boxes near schools, C/S offices, and health centers

The project may rely on the existing GRM channels under CNP-I and/or develop a new channel to support CNP-II. Such decisions will be confirmed as part of the SEP finalization prior to project effectiveness.

The GRM includes the following steps:

a. Receiving complaints from the citizens feedback mechanism:

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

b. Citizen feedback responsive mechanism

- The C/S chief is the first actor to review and respond to all citizen feedback and complaints, especially feedback related to CPWC activity implementation. After receiving feedback or complaints from citizens, the C/S chief shall respond accordingly and in a timely manner (within 20 business days) through interventions or actions of C/S administration and/or health centers. The C/S chief shall inform the VHSG to report to the community or respective individual accordingly. If complaints are received by the VHSGs, they will inform and dispatch the complaints to relevant stakeholders, including the C/S chief and/or other agencies, depending

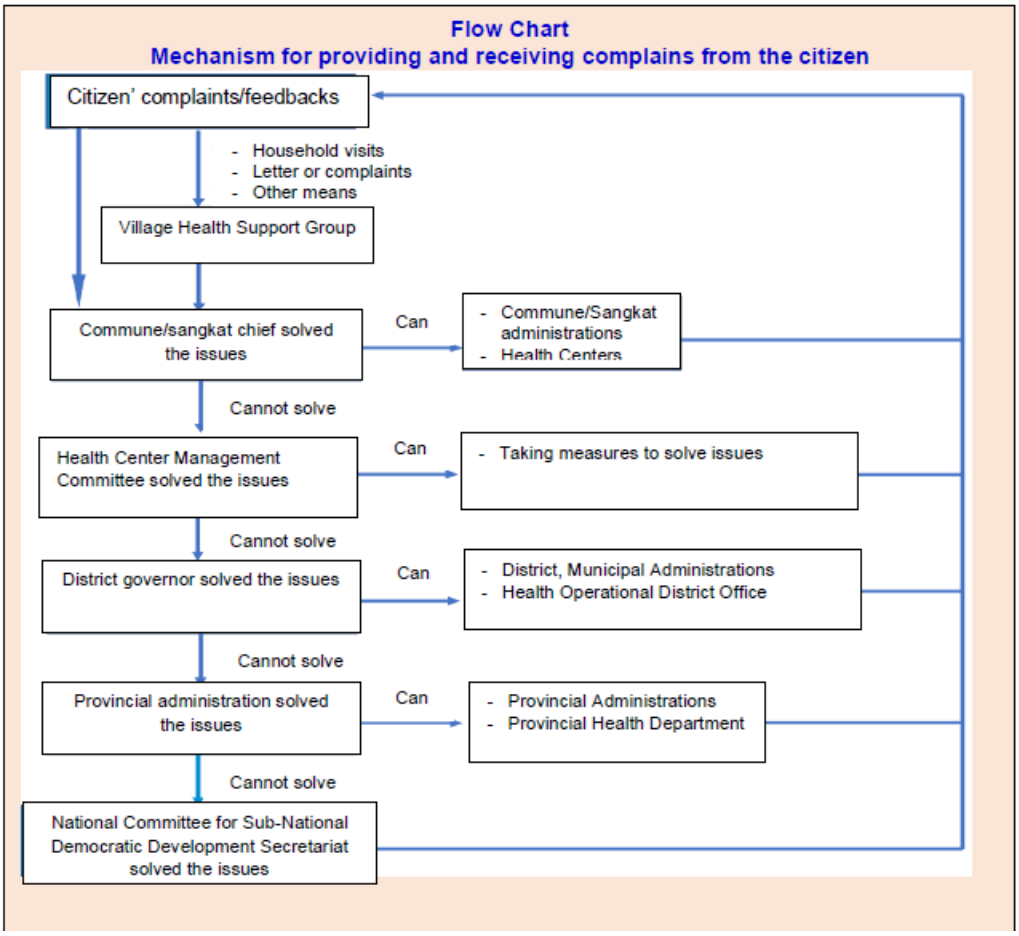
on the nature and sensitivity of the issues. These first point contacts shall provide measures to protect complainants, especially across sensitive issues such as fraud and corruption.

- If the C/S chief cannot take action to respond to the complaints or feedbacks, the C/S chief shall submit those complaints or feedbacks to Health Centre Management Committee (HCMC) meetings for further actions. At the HCMC meeting, the committee can decide if any actions or resolutions are possible.
- If the HCMC cannot come to a solution, the C/S chief shall refer the case to the DMA governor for further action. After receiving the cases, the District Municipal Administrations (DMA) governor shall act immediately through their DMA action or Operational Health District (OD). The DMA governor shall inform the results of resolutions to C/S chief, who can then inform the citizens.
- If the case cannot be solved at the DMA level, the DMA governor shall send the cases to the Provincial Administrations (PA) governor. The PA governor can take action through PA or Provincial Health Department (PHD). PA governor shall inform to DMA governor the results of interventions. The PA governor shall inform the results and resolutions to DMA governor who can inform the citizens.
- If the case cannot be solved by provincial level, the PA governor shall send the cases to NCDDS or NCHP based on the nature of case.
- The NCDDS and the National Centre for Health promotion (NCHP) are the last mechanism to solve and respond to the citizen feedback or complaints related to CPWC activities implementation. The Chairman of NCDDS and/or Chairwoman of NCHP shall inform the results of resolutions to PA governor who can inform the citizens.
- All feedback and responses shall be recorded.

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

Further details of the step-by-step is further described in **Figure 1**:

Figure 1: Grievance Redress Mechanism



The project treats sensitive and confidential complaints, including those related to Sexual Exploitation and Abuse/Harassment (SEA/SH) in line with the project's ESMP.

Once a complaint has been received, by any and all channels, it should be recorded in the complaints logbook or grievance excel-sheet/grievance database

Once all possible redress has been proposed and if the complainant is still not satisfied then they should be advised of their right to legal recourse.

10. Monitoring and Reporting

The NCDDS will monitor the overall implementation of the SEP implementation, including any issues that emerge during CNP-II implementation. This includes monitoring of grievances and community feedback through the systems outlined in Section 9.

The NCDDS will submit annual progress reports to (i) describe implementation progress, (ii) highlight issues that need attention (including SEP implementation, environmental and social compliance and mitigation actions), and (iii) report progress toward meeting the PDO and intermediate results indicator targets. At the end of the project, the NCDDS will prepare an end-of-the-project implementation report detailing achievement of project activities toward reaching the Project Development Objective (PDO) and lessons learned from implementation of the project.

The SEP will be periodically revised and updated as necessary during project implementation in order to ensure that the information presented herein is consistent and is the most recent, and that the identified methods of engagement remain appropriate and effective in relation to the project context and specific phases of the development. Any major changes to the project related activities and to its schedule will be duly reflected in the SEP. Information on public engagement activities undertaken by the Project during the year shall be conveyed to the stakeholders.

Annex 1 Cambodia Nutrition Project 1

The project aims to serve as an anchor for an enhanced and coordinated response to accelerate the country's human capital formation, focusing on facility- and community-based approaches to maternal and child health and nutrition in the early years. CNP 1 include following components.

Component 1: Strengthening the Delivery of Priority Health Services

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

Component 1.1 Performance-based Service Delivery Grants (SDGs) to Improve Availability and Quality of Priority Services. Sub-component 1.1 will build on Cambodia's National Quality Enhancement Monitoring (NQEM) processes to accelerate improvements in health service quality across the continuum of care for women and children. A performance-based SDG top-up payment will be provided to health facilities based upon the score from a Maternal and Child Health and Nutrition (MCHN) Scorecard. The MCHN Scorecard will focus on the eleven identified priority services, including reduction of gaps in routine immunization and improvements in integrated outreach.

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

Component 2: Stimulating demand and accountability at the community level

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

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

Sub-component 2.2: Building Capacities, Monitoring, and Verifying C/S-SDG. This

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

Sub-component 2.3 Project Management, Monitoring, and Evaluation for NCDD. This sub-component will support provision of technical and operational assistance for the routine administration, procurement,

financial management (FM), environmental and social safeguards management, and M&E of Component 2 activities (including financial audits of the project). The sub-component will also support the procurement of a third-party entity to conduct *ex-post* independent verification of C/S-SDG scores.

Component 3: Ensuring an Effective, Sustainable Response

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

Sub-component 3.1 Strengthening the functional and technical capacities at national and sub-national levels. This sub-component will support MOH national centers and departments to: (i) create an enabling environment and (ii) improve supply-side readiness, responsiveness, effectiveness, and delivery of identified priority interventions financed in Components 1 and 2. In addition, a DLI has been added for CARD in order to strengthen the leadership and ownership of the multisectoral nutrition agenda at the national and provincial levels, in alignment with the forthcoming revised National Strategy for Food Security and Nutrition.

Sub-component 3.2: Development of a Comprehensive SBCC Campaign. The sub- component will support the National Maternal and Child Health Center to design and roll out modern, effective SBCC campaigns and associated content. Sub-component

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

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

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

The Ministry of Health (MOH) has identified C/S administrative units as a critical link in improving health and nutrition outcomes. Through their general mandate functions, C/S can increase demand for and utilization of MCHN services and improve the management and accountability of health services to the citizens. The MOH's Community Participation Policy in Health (2008) outlines key roles and responsibilities of all actors in the MOH and the SNA to improve health and nutrition. The policy recommends the

identification of two CHWs (locally known as Village Health Support Group (leaders), or VHSGs) per village to facilitate links between the community and the health centers and to coordinate and support health center activities in the community.