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Royal Government of Cambodia

Ministry of Health

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Human Resource Development Readiness Assessment and Plan for Inclusive Delivery

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LIST OF ABBREVIATIONS

BTB	Battambang province
DHR	Department of Human Resource
DHS	Department of Hospital Services
EQHA	Enhancing Quality of Health Care Activity
ESCOP	Environmental and Social Code of Practice
ESCP	Environment and Social Commitment Plan
ESF	Environment and Social Framework
ESS	Environment and Social Standards
GBV	Gender Based Violence
GRM	Grievance Redress Mechanism
HC	Health Center
HCW	Health Care Waste
H-EQIP	Health Equity and Quality Improvement Project
IP	Indigenous People Group (Ethnic Minority)
KfW	German Development Bank
KPC	Kampong Cham Province
KPT	Kampot Province
LGBT	Lesbian Gay Bi-sexual Transgender
MoH	Ministry of Health
MRI	Micro Rainbow International Foundation
OD	Operational District
PHD	Provincial Department of Health
PIU	Project Implementing Unit
PMD	Department of Preventive Medicine
PMT	Project Management Team
PPCIL	Phnom Penh Center for Independent Living
PWD	Person/s with Disability
RGC	Royal Government of Cambodia
RH	Referral Hospital
RTC	Regional Training Center
SEP	Stakeholder Engagement Plan
SOGIE	Sexual Orientation on Gender Identity and Expression
STR	Stung Treng Province
UHS	University Health Sciences
WBG	World Bank Group
WHO	World Health Organization

Executive Summary

This "Human Resource Development Readiness Assessment and Plan for Inclusive Delivery" (HRDRAP) is one of the Environmental and Social Framework (ESF) tools prepared, consulted and disclosed by the Ministry of Health (MoH) of the Kingdom of Cambodia for the "Pre-Service Training for Health Workers" in Cambodia. This project is expected to be financed by the World Bank. The main objective of this HRDRAP is to assess and propose specific recommendations for: a) promoting the enrollment and inclusion of disadvantaged groups as medical students in Cambodia, and b) imbedding social inclusion and environmental sustainability aspects in the project activities, in line with WB's ESF standards.

The proposed project focus on the primary health care students which include medical doctors, nursing and midwifery. The students' data are taken from the government health schools which include UHS, Battambang RTC, Kampot RTC, Kampong Cham RTC and Stung Treng RTC. The data collected cover the school year 2018-2019.

The data for Public Health Workers used by this assessment was taken from the five major public hospitals at Phnom Penh, also from the provincial hospitals, referral hospitals and commune health centers from 24 provinces of Cambodia. Data collected covers the year 2019 and data collection was facilitated through the Provincial Health Departments and supplemented by the Personnel Department of MoH.

The proposed actions for health curricula and ESF inclusion are derived from the focus group discussions (FGDs) with health students, faculty teaching staff and decision makers of UHS and Stung Treng RTC, also from FGDs with medical staff (doctors, nurses and midwives) and management team of Khmer-Soviet Friendship Hospital, PPCIL (PWD sector) and Micro Rainbow International (LGBT sector).

A consultation meeting with the project stakeholders on the initial draft of HRDRAP provided additional input and refinement of the proposed actions and recommendations.

Assessment results:

1. Inclusion of Disadvantaged Groups

Primary Health Care Students in Cambodia. Year 2019

Medical Course	Number of Student	Women Students		Ethnic Minority Students		PWD Students	
		Number	Percent	Number	Percent	Number	Percent
Doctor	2,812	1,056	38%	0	0%	No data	
Nursing	1,998	1,178	59%	9	0.45%	No data	
Midwifery	1,453	1,453	100%	10	0.69%	No data	
Total	6,263	3,687	59%	19	0.30%		

Source: Own elaboration

Overall, the majority of the current health students in Cambodia are women, however there is gender imbalance in the doctor and the midwifery students. Doctor students has only about a third women and midwifery has all women students.

Based on the collected data, there is a very low number of students from ethnic minority groups (IP) and they are mostly concentrated at Stung Treng RTC. The four other medical schools surveyed were not able to give the data on ethnicity.

All the medical schools surveyed did not provide the data of students with disability, however, it was observed during the orientation of "National Exit Exam Passers" held at MoH in October 2019, that at least two nursing student passers were PWD.

On the other hand, the data for Public Health Workers were collected from five of the major public hospitals at Phnom Penh, Provincial Hospitals, Referral hospitals and Commune Health Centers from 24 provinces of Cambodia.

Public Health Workforce in Cambodia. Year 2019

Medical Professionals	Number of Workforce	Women		Ethnic Minority/Cham		Age Bracket			
		Number	Percent	Number	Percent	20-30	30-40	40-50	50-60
Doctor	2,141	415	19%	1	0.05%	14%	40%	30%	16%
Nursing	8,176	2,855	35%	51	0.6%	33%	26%	23%	18%
Midwifery	5,963	5,963	99%	22	0.4%	51%	24%	15%	10%
Total	16,280	3,687	59%	74	0.5%	37%	27%	21%	15%

Source: Own elaboration

Doctors are mainly working in the hospitals with high concentration among the major public hospitals at Phnom Penh (average of 144 Doctors/hospital). It is relevant to highlight that only a limited number of Doctors work in the rural health centers (160 doctors among the 1,220 health centers).

More than half of public primary health workers of Cambodia are women, however only less than a fifth are women doctors, a third are women nurses and midwives are almost all women.

Based on official data coming from Ministry of Planning (Yr 2019), there are about 24 different types of IP in Cambodia, totaling approximately 200,216 people or about 1.2% of Cambodia's total population of 16.5 million. However, this assessment reports that public health workers from ethnic minorities are minimal comprising only a half of one percent of the total workforce.

More than a third of all public health workers are young of ages 20-30, the number decreases as the age bracket goes up. There is however only 14 percent of young doctors while more than half of midwives are young (age bracket 20-30).

2. Inclusion of Environment and Social topics in Health Curricula

Current pre-service education has some courses on infection control which are partially relevant to occupational health and safety, and hazardous waste management in year one and two. Those courses are in line with National Guidelines for Infection Prevention and Control for Healthcare Facilities (2017).

The safeguard trainings for health workers conducted by MoH through the Department of Preventive Medicine (PMD), has limited contents in relation to the environment and social risk management. Practices and management procedures which are in line with the National Guidelines for Infection

Prevention and Control for Healthcare Facilities (2017) are integrated as part of training courses and the guidelines of the laboratories. However, it is generally focused or has an emphasis on the hospital context. Application of appropriate personal protection equipment (PPEs), segregation of wastes, and sterilizing of wastes and glassware including autoclaving methods are being practiced.

The analysis of the existing curricula shows that there are not in the country cultural competence training for students at medical schools, focusing on skills and knowledge that values diversity, understand and respond in a culturally-appropriate manner to social diversity: gender, ethnic minorities, disabled people, SOGIE, etc. There is also a lack of content related to topics like how to prevent gender-based violence and work with survivors, work with very vulnerable social groups (street children, impoverished elderly, etc.).

3. Proposed actions for Health curricula and ESF inclusion.

<u>On Health Curricula:</u>

- Include in the behavioral science subject, topics on "social inclusion and environmental sustainability" and/or soft skills courses (behavioral science courses) for medical students for having the right attitude in dealing and treatment of the vulnerable people group;
- Promote public awareness raising activities among medical students for better understanding and responding (in a culturally-appropriate manner) on ethnic minorities, PWD and SOGIE-related elements so that future health workers won't discriminate PWD, LGBT patients. (details on the process ad how to carry it out will be further discussed with the concerned group);
- Include in the medical outreach program, visits to PWD homes/communities, interact and hear from PWDs, see their situation.
- Include in the curricula or imbed in the subject "Organizational Structure and System of MoH, its departments, health institutions from national, provincial, district and commune level, in order to help new medical professionals understand the system and know how and where to refer patients.

<u>On ESF Inclusion:</u>

- Promote actions to increase the number of women enrollees for doctor students like providing equal number of quota for male and female passing the National Entrance Exam or at least increase the quota for women entering the doctor course at UHS;
- Provide equal access to opportunity for female doctors in the government hospitals. MoH to give priority to female doctors for future hiring until the gender balance among the government doctors is reached, or increase the number of women doctors by at least 35 percent from the current 19 percent in government health facilities by the end of the project period;
- Provide special support to actively promote the enrolment of disadvantaged groups (ethnic minorities, PWD, women). This is to ensure that the disadvantaged groups are provided the opportunity to enroll in medical course and are not left out. The component of the support provided to students from the disadvantage groups shall be "tailored fit" to their need, i.e. responding to their physical, psychological and cultural circumstances;

- Promote Stung Treng RTC as a focal center in the country for health professional's education with ethnic minorities through:
    - Information dissemination among high schools at the provinces with many ethnic minorities about Stung Treng RTC program and medical courses offered and to encourage the ethnic minorities' students to enroll;
    - Developing specific training materials and training activities to reach better and work with ethnic minorities in Cambodia, similar to other centers in countries like Vietnam. Promoting better understanding and responding in a culturally-appropriate manner to the needs of the patients with an ethnic background.

<u>On improving health and safety of health workers:</u>

- Health facilities to follow the healthcare waste management process including: sorting, handling, storage and final disposal of solid HCW outlined in good international practices and relevant guidelines and regulations including National Guideline on Health Care Waste Management, Infection Prevention and Control Guidelines for Health Care Facilities, etc;
- Improve and strengthen the public participation and Grievance Redress Mechanism among project implementing units, making the GRM accessible and responsive, making the workplace safe place for all, especially or vulnerable group such as women and children.

<u>On improving the documentation and record keeping of HTIs and PIUs:</u>

- Health Training Institutions (UHS and RTCs) to include in their record, documentation of student, faculty and staff coming from ethnic minorities, PWDs, LGBTs
- Project implementing units (MoH Departments, PHDs, ODs, Hospitals, Health Centers, Professional Councils, and National Exam Committee) to include in their documentation, students and personnel coming from the ethnic minorities, PWDs, LGBTs.
- National Entrance Examination and National Exit Examination to include in the documentation of applicants and passers, the number of women, ethnic minorities, PWDs.
- For baseline data on number of PWDs and ethnic minorities involved the health education and public health service, a follow up survey should be conducted at the start of project implementation.

A. Introduction and Background

The Royal Government of Cambodia (RGC), through the Ministry of Health (MoH) and with financial assistance from the World Bank Group (WBG) is proposing the "Pre-Service Training for Health Workers" project.

The project's goal is to improve the quality of education for health professionals entering the workforce in Cambodia. The project aims to strengthen the quality of education for health professionals will be through introducing competency-based education (CBE).

CBE emphasizes skill-building following the acquisition of accurate, foundational knowledge about a subject. Traditional knowledge-based education alone tends to focus on what the learner is taught and less on whether learners can use learning to solve problems, perform procedures, communicate effectively, or make good clinical decisions.

It targets two priority areas. Component 1 strengthens competency-based teaching and learning capacity in selected health schools. Component 2 seeks to improve the governance of health professionals' education in Cambodia.

MoH agreed to apply the new World Bank's Environmental and Social Framework (which came into effect in October 2018) for the proposed project as part of an appraisal tool. The following two ESF instruments were prepared, consulted and disclosed prior appraisal stage (February 2020):

- Human Resource Development Readiness Assessment and Plan for inclusive Service Delivery (HRDPAP); and
- The project's Stakeholder Engagement Plan (SEP).

This HRDRAP for inclusive service delivery is one of ESF tools needed, in order to provide the practical input for environmental sustainability and social inclusion component of the proposed project.

A.1 Objectives

The main objectives of this Human Resource Development Readiness Assessment and Plan for Inclusive Service Delivery (HRDRAP) is to review, assess, and propose recommendations for:

(a) Promoting the enrollment and inclusion of disadvantaged groups as students in health schools and medical training institutions, and encourage their joining the medical workforce,

(b) Embedding social inclusion and environmental sustainability aspects in the project activities, in line with WB's ESF standards.

A.2 Project Description

The proposed project's goal is to improve the health of the Cambodian people. To achieve this transformational change, it is aimed to create a new foundation for the training of a competent health care workforce. The project will address the root causes of the inadequacies of the present system and tackle institutional and systemic barriers to successful reform. It will have a lasting impact on the

educational system, as well as a positive effect on generations to come from doctors, nurses, midwives, pharmacists, and dentists. Project objectives are to transform the outdated pre-service curriculum to one that is competency-based, train core faculty in up-to-date methods of teaching; add new curriculum in primary care, and define new structural frameworks for student assessment and program quality assurance. Major systemic and institutional barriers identified as outdated regulation of health education, lack of basic standards for training programs, and ineffective coordination of training institutions with hospitals and health centers will be addressed. Considering the broad sweep of change required, and the many years of training of doctors (7 years) and other health care workers, the true impact of this project will not be realized for a decade or more. The project's ultimate goal is to build a strong foundation and institutional framework that will set the stage for continuous improvement far into the future.

A.3 Brief relevant country, sectoral and institutional context

A.3.1 Country Context

Cambodia has experienced remarkable political and economic transition over the past four decades. The country has transformed itself from a conflict-torn country to a peaceful one. Since 1993, Cambodia has focused on maintaining peace and stability, rebuilding infrastructure and institutions, fostering economic growth, and improving living standards of the population. Over the past 20 years, the Cambodian economy has maintained a steady and robust growth rate at 8.0 percent per annum, ranking among the top seven fastest-growing economies in the world. Growth has largely been driven by the export of goods and services, which grew 15.3 percent a year during the same period. As a result, Cambodia's per capita Gross National Income (GNI) increased almost fourfold, from US$320 in 1997 to US$1380 in 2018. Strong economic growth has also led to a dramatic decline in poverty. Poverty incidence under the national poverty line decreased from 47.8 percent in 2007 to 13.5 percent in 2017.

However, Cambodia's economic growth is subject to emerging risks that may challenge this trajectory. In short to medium-term, risks have intensified due to uncertainty over preferential access to the European Union market under the Everything But Arms agreements as well as the ongoing slowdown in the Chinese economy and the potential adverse impact of Chinese foreign direct investment and tourism to Cambodia. A prolonged construction and property boom as well as the increase of credit provided to the construction and real estate sectors alongside rising indebtedness—where combined bank and microfinance credit now accounts for over 100 percent of GDP—also present a downside risk for Cambodia. In the longer term, emerging challenges include the erosion of external competitiveness within the context of rapidly rising wage rates. In addition, persistent gaps in human and physical capital constrain Cambodia's ability to make a quicker shift towards more diversified and higher value-adding economic activities. For example, 12 percent of firms reported poorly educated workers as a constraint to doing business.

There are acute constraints in human capital. Significant gaps in health, early childhood nutrition, education, and skills constrain the productivity of Cambodia's future labor force. Cambodia's score on a recently developed Human Capital Index (HCI) is 0.49, which is far lower than the regional average (0.65 in 2017), meaning that—based upon the status of health and education outcomes—children born today

will only be 49 percent as productive when they grow up as they could be, if they had enjoyed complete education, good health, and a well-nourished childhood. Lack of access to good quality health services, especially in remote and rural areas and high levels of stunting among children under-five are significant remaining challenges to human capital development. Quality of education remains a concern. When years of schooling are adjusted for quality of learning, there is a learning gap of 2.7 years among Cambodian school children. This has knock-on effects on the health workforce. Inconsistencies in secondary schooling have led to a low quality of applicants and intake of students to health professionals' training programs.

A.3.2 Sectoral and Institutional Context

Cambodia's health outcomes have improved steadily over the past 20 years, surpassing several better-off countries. Progress and innovation in health service delivery have contributed to the achievement of most health-related Millennium Development Goals (MDGs). Life expectancy has increased, while mortality rates for infants, children, and mothers have recorded a significant decline. Despite these improvements, maternal mortality remains unacceptably high, and neonatal mortality has not declined proportionately to total child mortality – still accounting for nearly half of all under-five deaths in 2014. At 32 percent in 2014, stunting prevalence in under-five children remains 'high' according to the World Health Organization public health thresholds.

There have been significant improvements in key public health service coverage over the past two decades. These include a dramatic increase in facility-based deliveries (10 percent in 2000 to 83 percent in 2014), uptake of antenatal care (10 percent to 80 percent), and coverage of other maternal and child health services, such as polio-3 immunization rates (45 percent in 2000 to 80 percent in 2014).1 Access to health care for the most vulnerable groups also improved between 2004 and 2014, with a two-fold increase in the proportion of care-seeking behavior at public health centers. By 2014, all populations had higher than 80 percent access rate to care regardless of the place of residence.

However, gaps remain in access to care, and there are persistent and growing disparities in maternal, newborn, nutrition, and communicable disease outcomes. The country's rural, remote, ethnic minorities, and socioeconomically challenged women and children remain disproportionately affected by poor health and nutritional status. The wealth gap in child mortality has remained unchanged since 2005 at roughly three times higher for poor and rural children compared to wealthy and urban. Household wealth is one of the strongest determinants of neonatal mortality, followed by dwelling in rural areas. The stunting prevalence in the poorest wealth quintile (42 percent) is more than double that in the richest (18 percent). Full immunization of children is at 61 percent in the poorest quintile compared to 90 percent in the wealthiest. Demand-side barriers for priority services and low community awareness must be addressed to achieve sustainable improvements in access. Distance and low community awareness have been fundamental barriers.

At the same time, Cambodia is facing demographic and epidemiological transitions that change the health needs of the population and the skills required to deliver health services. The burden of disease (BoD) has shifted away from one with a high prevalence of communicable diseases to a high prevalence of non-communicable diseases (NCDs). Between 1990 and 2016, communicable diseases (including vaccine-preventable diseases), maternal and neonatal disorders, and nutritional deficiencies declined from 64 percent to 34 percent of the BoD, with NCDs accounting for the majority (55 percent) in 2016. Simultaneously, from 2030, declining fertility is projected to yield rapid increases in the elderly population. This continues to have considerable implications on the health needs of the population and, correspondingly, the skills needed within the health workforce to deliver services that are appropriate to the needs.

Health services in Cambodia are delivered through a vast network of public facilities organized by administrative level, but equally by private providers that have proliferated in the country over the past few decades. Provincial Health Departments (PHDs) are responsible for health service delivery. The PHD is responsible for supervising Operational Districts (ODs), including their OD offices, Referral Hospitals (RHs), Health Centers (HCs), and Health Posts (HPs).2 Cambodia's Minimum Package of Activities (MPA) and a Comprehensive Package of Activities (CPA) outline clinical service delivery guidelines for facilities at each level though provider adherence and service availability are variable across geographies and by type of services within the same facility.

A.4 Project stakeholders and beneficiaries

Based on the project's Stakeholder Engagement Plan (SEP), the key stakeholder's beneficiaries of this project are outlined in the table below.

Key Stakeholders	Implementing Agency	Ministry of Health
	Top Decision Making Body	Health Sector Steering Committee (HSSC)
	Top Management Level	Project Director and Project Manager
	Team Leaders (3)	For CBE, FMP and ES Safeguards

	Implementing Units	• Public Health Training Institutions (HTI)
		  ○ University of Health Sciences (UHS)
		  ○ Regional Training Centres (RTCs)
		• Project Focal Points for CBE
		  ○ Department of Human Resource (DHR)
		  ○ Department of Hospital Services (DHS)
		  ○ Department of Preventive Medicine (PMD)
		• Budget and Finance (DBF)

	Independent Bodies	Independent Verification Agency (IVA) Payment Certification Agency (PCA)

	Other stakeholders	Professional Council for Nursing, Midwifery and Medical Doctors Student and professor representatives
Other Stakeholders	Entities Implementing similar project/activities	WHO, DFAT Australia, JICA, KfW, H-EQUIP, EQHA USAID, MOE, MOEYS
	Private Medical schools	Private medical schools
	Health Institutions	Public Hospitals, Health Centres Private Hospitals and clinics
	NGOs	Groups representing women, disable people, ethnic minorities, LGBT
Project Beneficiaries	Vulnerable Groups	Poor women and children Ethnic People Persons with Disability LGBT Group
	General Public	Cambodian People

Table 1: Stakeholders and Beneficiaries

The key stakeholder of the proposed project is the Ministry of Health of Cambodia and its project implementing departments, including the implementing health schools. Other stakeholders with interest on the proposed projects are various development institutions with similar projects plus civil society and professional groups.

A.5 ESF standards applied for the project and summary of relevant national environmental and social laws

The following Environmental and Social Standards (ESS) of the WB's Environmental and Social Framework (ESF) are going to be applied to this project:

Relevant ESF's Standards	**Rationale of relevance**	**Related Cambodia ES Laws**
ESS1. Environmental and Social Assessment and Management	Sharing development benefits with disadvantaged and vulnerable groups (e.g., women, children, elderly, ethnic minorities, sexual and gender identity (SOGI), disabled people, etc.)	The EIA Sub-decree (1999) and EIA Guidelines (2009) require project proponents to address public health issues as part of their analysis of socio-economic risks and impacts. The 2008 Organic Law requires councils to consider the "needs of women, men, youth, children and vulnerable groups, including poor people and ethnic people" and rejects "any bylaw which discriminates against an individual, or a specific group of persons, based on factors of race, religion, sex, age, color, nationality, nationality at birth or mental or physical disability." The 2009 Law on the Protection and the Promotion of the Rights of Persons with Disabilities further define the principle of non-discrimination of these persons.
ESS2. Labor and Working Conditions	Promote safety and health at work; equal opportunity in the workplace	The Labor Law, which dates back to 1997, remains the key document governing the regulatory framework for labor in Cambodia. The 1997 Labor Law defines non-discrimination in employment and wages. It establishes a minimum wage level, which may vary among regions. It also establishes labor inspection and prohibits labor from paying off debts or compulsory purchases by workers from company stores. Working hours are limited to 8 hours per day, 6 days a week. A whole chapter in the Law is dedicated to health and safety in the workplace. National Guidelines for Infection Prevention and Control for Healthcare Facilities (2017) states basic guidelines to be followed

		regarding the hygiene, health, and safety at the healthcare facilities.
ESS3. Resource Efficiency and Pollution	Avoid or minimize the generation of hazardous waste, and ensure the hazardous waste are managed properly	Resource efficiency and pollution management is addressed through the 1994 Law on Investment and 1996 Law on Environmental Protection and Natural Resource Management (NRM), along with other sector-specific laws on preventing pollution from agriculture runoff, wastewater, solid and hazardous wastes, and air emissions
ESS4. Community Health and Safety	Prevent community exposure to health and safety issues and hazardous materials and promote gender-based violence prevention, an improvement on the health and safety conditions of the health workers, and hazardous and clinical waste management	The EIA Sub-decree (1999) and EIA Guidelines (2009) require project proponents to address public health issues as part of their analysis of socio-economic risks and impacts. The 2008 Organic Law on Gender-Based Violence (GBV) relates to the prevention of domestic violence within the family, and of human trafficking
ESS7. Indigenous Peoples	Equitable access to project benefits; benefits delivered in a culturally appropriate manner	The guiding document to address ethnic peoples' issues in Cambodia is the National Policy on the Development of Ethnic Peoples. The document, prepared to start in 1994 and formally issued in 2009, recognizes the need for specific policies for ethnic peoples' communities. The 2008 Organic Law recognizes ethnic peoples' vulnerability
ESS10. Stakeholder Engagement	Enhance stakeholder participation (faculty staff, students, patients); information disclosure; grievance management; accountability	Cambodia's regulations, which include the Constitution, the EIA Sub-decree (1999), and the 2001 and 2008 Organic Laws, broadly support public participation. Public disclosure and grievance redress are less well covered by laws and regulations.

Table 2: ESF Standards

A.7 Project Location

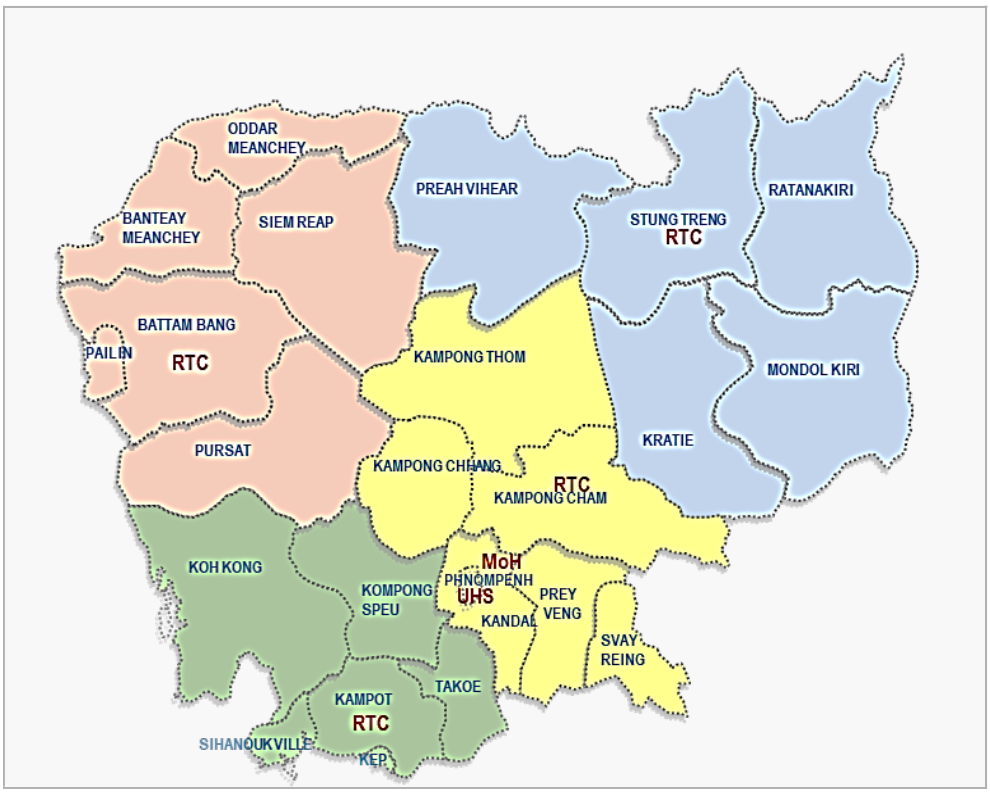

Figure 1: Location Map

The "Pre-Service Training for Health Workers" project will be implemented by the Ministry of Health (MoH) through its implementing departments, the Department of Human Resource (DHR) which will oversee the overall implementation of the project, the Department of Budget and Finance (DBF), the Department of Preventive Medicine (PMD) which is in-charge with the Environment and Social Framework aspects of the project and, the Department of Hospital Services (DHS).

This project is expected to be implemented nation-wide. The implementing units for pre-service training are the government medical schools lead by the University of Health Service (UHS) located at the capital city of Phnom Penh and the four Regional Training Centers (RTCs) covering a cluster of provinces in four regions, shown in the location map above. The Battambang Regional Training Center (pink region) covers the six northwestern provinces, Kampot RTC (green region) covers six southwestern provinces, Kampong Cham RTC (yellow region) covers seven provinces including the newly established province of Tboung Khmum and Stung Treng RTC which covers the five northeastern provinces (blue region) with large population of various ethnic minorities.

B. Assessment

B.1 Focus Groups Discussions and Key Informants Interviews

For the preparation of this HRDRAP, different focus groups and interviews with key informants were carried out in December 2019 by the ESF team from MoH as qualitative assessment. The following table illustrates the total numbers of participants and numbers of focus group discussions (FGD) conducted in Stung Treng and Phnon Penh.

Institution	**Location**	**Focus Groups discussions with:**	**Sub-groups**	**# of Participants**
Regional Training Center (RTC)	Stung Treng	Nursing Students (5 sub-groups)	2	10
		Midwifery Students	5	21
		Teachers for Nursing	2	10
		Teachers for Midwifery	2	10
		Interview - RTC Director		1
Provincial Health Department (PHD)	Stung Treng	Director and Department heads	1	6
Referral Hospital	Stung Treng	Department Heads	1	8
Phnom Penh Center for Independent Living (PPCIL)	Phnom Penh	People with Disability	1	6
University for Health Sciences (UHS)	Phnom Penh	Medicine Students	2	10
		Nursing Students	4	20
		Midwifery Students	4	20
		Combined Teachers	4	20
		Decision Makers (Vice Rector and department Heads)	1	10
		Interview with Student Affair Dir.		1
Micro Rainbow International Foundation	Phnom Penh	LGBT Group	1	2
Total Number of Participants				**155**

Table 3: Focus groups and interviews carried out for the preparation of the HRDRAP

Based on the limited resources available for the preparation of this HDRAP, focus groups and interviews were only carried out in Phnom Penh and Stung Treng. The capital city was selected since most of the medical schools are located here. Stung Treng RTC was selected as well since it is a strategic health training school to reach out and provide health training to potential and deserving ethnic minority high school graduates.

In addition, five government medical schools were selected as a sample for the quantitative analysis of health students. Only courses for medical doctors, nursing and midwifery, are considered in this survey. Data forms were given out to the "sample" schools to collect data on the number of students enrolled for the school year 2018-2019, gender, ethnicity, students with a disability, students coming from the LGBT group.

A consultation workshop carried out on January 27th, 2020, in Phnom Penh, in order to present and discuss with key stakeholders this project and plus draft versions of the ESF tools . For details, the consultation report has been attached as an annex of the propect's Stakeholder Engagement Plan (SEP). Twenty people joined the meeting. As a summary, the main conclusions of the consultations were:

On Health Curricula:

- Include in the health curricula or health activities the awareness of medical students on PWD;
- Awareness of health students on SOGIE to better understand LGBT community and medical practitioners provide health services with a sense of tolerance and acceptance and not to discriminate members of LGBT;
- Recommend including in the curricula or imbed in the subject "organizational structure and system of MoH, its departments, and health institutions from the national, provincial, district, and commune levels.

On Health Students Enrolment:

- Enrolment quota for increasing female doctor students. At national entrance exam are determined by the decision-makers at MoH;

- Enrolment of male midwifery students could be considered, but it may need more work and more time for the Khmer culture to accept or be comfortable with having male midwives;

- No discrimination on enrolment among disadvantaged as long as they qualify with the required criteria.

On Accreditation of health professional and clinics:

- The Accreditation of health professionals is the same for both public and private health practitioners. They have to register with their respective professional council;

- Accreditation of small clinics such as for hormone treatment is not yet regulated, and patients, primarily the LGBT, are at risk.

The main issues raised at the consultation workshop have been considered at the project's HDRAP and SEP.

B.2 Analysis of health student's enrollment data by gender, ethnicity, age and other demographic parameters

Based on the data collected for the preparation of this HDRAP, the following tables provide the summary results of the number of students (sample size for the analysis), gender, and ethnicity. Details are provided in the annexes. The number of students with disabilities and the students coming from LGBT are not documented in the school records. However, they were mentioned in the qualitative survey at the focus group discussions carried out for this assessment.

B.2.1 Medical students by gender in Cambodia. Year 2019

Name of Medical School	Doctor of Medicine			Nursing			Midwifery		TOTAL		
	Male	Female	Total	Male	Female	Total	Female	Total	Male	Female	Total
UHS including TSMC	1,756	1,056	2,812	181	432	613	311	311	1,937	1,799	3,736
RTC Battambang				172	221	393	394	394	172	615	787
RTC Kampot				171	241	412	331	331	171	572	743
RTC Kampong Cham				218	240	458	352	352	218	592	810
RTC Stung Treng				78	44	122	65	65	78	109	187
Total	1,756	1,056	2,812	820	1,178	1,998	1,453	1,453	2,576	3,687	6,263
Percentage Female	**38%**			**59%**			**100%**		**59%**		

Source: Own elaboration

Table 3: Medical Students by Gender

The University of Health Sciences (UHS) operates in Phnom Penh, and it offers the courses for medical doctor, nursing, midwifery, dentistry, pharmacy, postgraduate degrees, and other related medical courses. All four regional training centers (RTC) offer courses for nursing and midwifery.

The number of doctor students at UHS are coming from the eight-year course Diploma Degree in Medicine and from the four-year course in Specialized Doctor Diploma. Among all the 2,812 doctor students, only more than a third or 38 percent are women.

For nursing students, the overall result shows that more than half of the students are women. Looking closely at the data, UHS has 70 percent, female nursing students. The other three RTCS have more than half female students but Stung Treng RTC has only a third or 36 percent women students for nursing.

Midwifery students are mainly female: 100 percent of the enrolled students. All the medical schools are open to accepting the male students for midwifery, but no male students have so far enrolled for the course.

The overall enrollment for the three identified medical courses has more women (59 percent). This is because of all women enrollment for the midwifery course.

B.2.2 Medical students by ethnicity in Cambodia. Year 2019

Name of Medical School	Doctor of Medicine	Nursing			Midwifery			TOTAL		
	Khmer	Khmer	Ethnic Minority	Total	Khmer	Ethnic Minority	Total	Khmer	Ethnic Minority	Total
UHS	2,812	613	-	613	311	-	311	3,736	-	3,736
RTC Battambang		393	-	393	394	-	394	787	-	787
RTC Kampot		412	-	412	331	-	331	743	-	743
RTC Kampong Cham		458	-	458	352	-	352	810	-	810
RTC Stung Treng		113	9	122	55	10	65	168	19	187
Total	2,812	1,989	9	1,998	1,443	10	1,453	6,244	19	6,263
Percentage of ethnic minorities	**0%**	**0.45%**			**0.69%**			**0.30%**		

Source: Own elaboration

Table 4: Medical Students by Ethnicity

Based on official data coming from Ministry of Planning (Yr 2019), there are about 24 different types of IP in Cambodia, totaling approximately 200,216 people or about 1.2% of Cambodia's total population of 16.5 million[3]. The majority of the ethnic minorities are in the provinces of Ratanakiri, Mondolkiri, Stung Treng and Kratie.

In relation to the medical students, all the medical schools surveyed do not have the official data on the ethnicity of the students. Among all the schools surveyed, only Stung Treng RTC that has identified 19 students from the ethnic minority. The data is not from the school records but from the results of the focus group discussions carried out for this project with the students and teachers. They identify the ethnic minority student based on the name/s and the community the student/s come from.

Looking closely at the Stung Treng RTC, the ethnic minority students account for 10 percent of the student population. However, based in the focus groups and interviews carried out for this project,

[3] The official definition of Indigenous People/Ethnic Minority group done by the Government of Cambodia differs from the WB's definition. For the WB, based on para 8 of ESS7, the term Indigenous People (IP) is used in a generic sense to refer exclusively to a distinct social and cultural group possessing the following characteristics in varying degrees: (a) Self-identification as members of a distinct indigenous social and cultural group and recognition of this identity by others; and (b) Collective attachment to geographically distinct habitats, ancestral territories, or areas of seasonal use or occupation, as well as to the natural resources in these areas; and (c) Customary cultural, economic, social, or political institutions that are distinct or separate from those of the mainstream society or culture; and (d) A distinct language or dialect, often different from the official language or languages of the country or region in which they reside.

some ethnic minority students prefer to do not self-identify as minority since they feel ashamed. Based on that fact, the proportion may be higher.

There are Cham students[4] at UHS, but the number was not determined during the survey. UHS has set up a prayer room for the Muslims inside the campus.

There could be some ethnic minority students among the other schools surveyed. However, some ethnic minorities have been assimilated by the mainstream Khmer culture and identify themselves as Khmer, in the same manner as the Chinese and Vietnamese born and/or living in Cambodia for a long time who consider themselves Khmer. Some do not identify themselves as ethnic minorities to avoid social discrimination.

B.2.3 Number of health students versus the population in Cambodia. SY 2018-2019

RTC Region	Provinces Covered	Population 2019	Medical Students Enrolled (SY 2018-2019)				Ratio 1 Health student vs. population
			Medical Doctor	Nursing	Midwifery	Total	
Battambang RTC	7	4,124,000	-	393	394	787	5,240
Kampot RTC	6	2,832,852	-	412	331	743	3,813
Kampong Cham RTC	6	5,125,848	-	458	352	810	6,328
Stung Treng RTC	5	1,076,418	-	122	65	187	5,756
Phnom Penh	1	2,129,371	2,812	613	311	3,736	570
TOTAL	**25**	**15,288,489**	**2,812**	**1,998**	**1,453**	**6,263**	**2,441**

Source: Own elaboration

Table 5: Medical Students versus Population

Overall, the ratio of medical students attending public medical school versus the national population is 1 for every 2,441 people. The region covered by Kampong Cham RTC has the highest population and has the highest ratio of 1 student for every 6,328 people. Stung Treng RTC covers the lowest number of population; however, the number of medical students is low; thus, the student ratio versus population is high at 5,756 people per 1 student. The capital city of Phnom Penh is the convergence place for the medical students primarily for the doctor students. These doctor students, however, come from various provinces and the resulting ratio of 570 people per student may not be reflective of the real condition.- Random interview with the five interns from Year 6 doctor students of UHS showed that out of 5 students four are from the provinces of Prey Veng, Pursat, Battambang and Kampong Cham, only one student is from Phnom Penh.

Doctor students from the provinces would prefer to enroll at UHS and compete to enter the UHS program because of the scholarship top 10 percent of the National Entrance Exam are free of school fees. In addition, with the allowance from the government through MoH, the tuition fee is lower than

[4] Cham group does not fulfill the four criteria stated in para 8 of ESS7 to be considered as an Indigenous People (IP) group for WB.

the private medical school. Additional incentives for students to enroll UHS are: the school is known as most of the doctors in the provinces graduated from UHS, prestige, all students enrolled at UHS are screened and passed the national entrance exam, international program for best students who study with international teachers, better chance to pass the National Exit Exam and better chance to get job from government health facilities.

Stung Treng RTC has a declined enrollment according to the information reported by the school senior management. Nursing and midwifery course has become less attractive as a significant part of students get no job after they graduate, there is limited recruitment of government health workforce, and competition among nurses and midwives is high. Students from Stung Treng are at disadvantages in terms of access to opportunity in the cities, high demand of nursing, and midwifery graduates among private clinics, but the salary is low at $120/ month for 20-hours duty/day (below the minimum wage and exploitative). It has been reported that no strict enforcement for minimum wage standards among private clinics.

B.3 Quantitative and qualitative analysis of the current public health workforce by gender, ethnicity, age and other demographic parameters

The data for public health workers were collected in December 2019 for all the 24 provinces of Cambodia through the Provincial Health Departments (PHDs). The public health institution surveyed includes the provincial hospital at the provincial level, referral hospitals at the operational districts (OD), and rural health centers at the commune/Sangkat level. Similar data were also collected from the five major public hospitals in the capital city of Phnom Penh. Only data for doctors, nurses, and midwives were collected for this study. The data for public health workers for Phnom Penh is not yet exhaustive; only 5 out of 7 major hospitals provided the data, health centers and referral hospitals have also not provided the data.

B.3.1 Public health workforce by gender in Cambodia. Year 2019

Public Hospitals	Units	Doctors			Nurses			Midwives			Total Workforce		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Phnom Penh Hospitals	5	556	146	702	509	654	1,163	-	185	185	1,065	985	2,050
Provincial Hospitals	24	574	128	702	810	600	1,410	-	705	705	1,384	1,433	2,817
Referral Hospitals	72	461	116	577	795	399	1,194	1	840	841	1,257	1,355	2,612
Health Centers	1,119	135	25	160	3,207	1,202	4,409	57	4,175	4,232	3,399	5,402	8,801
Total	1,220	1,726	415	2,141	5,321	2,855	8,176	58	5,905	5,963	7,105	9,175	16,280
Percentage Female			**19%**			**35%**			**99%**			**56%**	

Source: Own elaboration based on data provided by Provincial Health Departments, MoH Personnel Department

Table 6: Public Health Workforce by Gender

Among the three government health professions surveyed, Nurses account for half of the total number. Midwives account for 37 percent and doctor's 13 percent. Doctors are mainly working in hospitals with high concentration among the major public hospitals at Phnom Penh (average of 144 Doctors/hospital). It is relevant to highlight that only a limited number of Doctors work in rural health centers (160 doctors among the 1,220 health centers).

The ratio of female doctors working in public hospitals and health centers accounts for less than a fifth only. Female nurses, on the other hand, accounts for a third of the nurse workforce. Midwives are mostly women. While there are no male midwifery students, the health centers at Ratanakiri province employed male midwives. There is also one male midwife working at the referral hospital at Prey Veng province. These male midwives could be good examples to promote male enrollment for midwifery.

During the discussions with the medical students and teachers at Stung Treng RTC for the preparation of this HRDRAP, they considered that men could be competent midwives as they are strong to assist and carry mothers giving birth, especially in times of emergency.

The resulting ratio of women working in the government health facilities shows that there is a gender imbalance. Data shows that the male health workforce dominates the hospital at the national, provincial, and district levels, while female health workers primarily midwives dominate the health centers at the commune level.

B.3.2 Public health workers by age bracket in Cambodia. Year 2019

Government Hospitals	Nurses					Midwives				
	Age Bracket					Age Bracket				
	20-30	30-40	40-50	50-60	Total	20-30	30-40	40-50	50-60	Total
Phnom Penh Hospitals	390	387	176	210	1,163	64	59	26	36	185
Provincial Hospitals	378	302	368	362	1,410	261	124	174	146	705
Referral Hospitals	467	310	276	141	1,194	496	177	107	61	841
Health Centres	1,452	1,088	1,072	797	4,409	2,244	1,060	568	360	4,232
TOTAL	2,687	2,087	1,892	1,510	8,176	3,069	1,420	875	603	5,967
Percentage/bracket	**33%**	**26%**	**23%**	**18%**	**100%**	**51%**	**24%**	**15%**	**10%**	**100%**

Provinces	Doctors					Total Medical Staff				
	Age Bracket					Age Bracket				
	20-30	30-40	40-50	50-60	Total	20-30	30-40	40-50	50-60	Total
Phnom Penh Hospitals	13	298	222	169	702	467	744	424	415	2,050

Provincial Hospitals	94	278	224	106	702	733	704	766	614	2,817
Referral Hospitals	165	239	132	41	577	1,128	726	515	243	2,612
Health Centres	32	47	57	24	160	3,728	2,195	1,697	1,181	8,801
TOTAL	304	862	635	340	2,141	6,060	4,369	3,402	2,453	16,280
Percentage	**14%**	**40%**	**30%**	**16%**	**100%**	**37%**	**27%**	**21%**	**15%**	**100%**

Source: Own elaboration

Table 7: Public Health Workforce by Age Bracket

Among all the public health workforce, the number of younger staff (ages 20-30) account for more than a third of the whole workforce, and the number goes down as the age increases. The number of the senior workforce or those of reliable age is 15 percent.

More than half of the midwives are young (ages 20-30), most of them (73 percent) work at the health centers in the rural areas. About 10 percent of the midwives are retriable (age 50-60). Only 14 percent of doctors are young (age bracket 20-30), this could be because doctors study 8 long years in the medical school. Two-fifths of the doctors are of middle age (30-40), these age bracket could have enough experience in medical practice, while 30 percent are adults (ages 40-50) they could already have substantial experience in medical practice. The retirable age doctors account to 16 percent.

B.3.3 Health workforce by ethnicity in Cambodia. Year 2019

Public Hospitals	Doctors			Nurses			Midwives			Total Medical Staff		
	Khmer	Ethnic Minority	Total	Khmer	Ethnic Minority	Total	Khmer	Ethnic Minority	Total	Khmer	Ethnic Minority	Total
Phnom Penh Hospitals	702	-	702	1,163	-	1,163	185	-	185	2,050	-	2,050
Provincial Hospitals	701	1	702	1,407	3	1,410	704	1	705	2,812	5	2,817
Referral Hospitals	577	-	577	1,194	-	1,194	841	-	841	2,612	-	2,612
Health Centres	160	-	160	4,361	48	4,409	4,211	21	4,232	8,732	69	8,801
TOTAL	2,140	1	2,141	8,125	51	8,176	5,941	22	5,963	16,206	74	16,280
Percentage Ethnic Minorities		**0.05%**			**0.6%**			**0.4%**			**0.5%**	

Source: Own elaboration

Table 8: Public Health Workforce by Ethnicity

Like the medical schools, hospitals and health centers do not record the ethnicity of the staff, or if they do, most of the staff will put their ethnicity as Khmer, with the view that they are born and live in Cambodia, and therefore, they are Khmer. Discussion with teachers and students at Stung Treng RTC revealed that some people from the ethnic minority assimilate with Khmer culture and society and would identify themselves as Khmer to avoid social discrimination.

The ethnic minorities column in Table 8 includes the ethnic minorities and the Cham people.

Overall, there is a very minimal number of ethnic minorities among the public health workforce. It has been reported that there is only one doctor of Cham ethnicity working at the provincial hospital at Ratanakiri.

B.3.4 Number of Public Health Workers versus Population in Cambodia. Year 2019

Region	Provinces Covered	Population	Public Health Workforce				Ratio of Health Workers vs. Population
			Doctor	Nurses	Midwives	Total	
Battambang RTC	7	4,124,000	407	2,203	1,765	4,375	943
Kampot RTC	6	2,832,852	329	1,582	1,302	3,213	882
Kampong Cham RTC	6	5,125,848	568	2,293	1,937	4,798	1,068
Stung Treng RTC	5	1,076,418	135	935	774	1,844	584
Phnom Penh	1	2,129,371	702	1,163	185	2,050	1,039
TOTAL Cambodia	**25**	**15,288,489**	**2,141**	**8,176**	**5,963**	**16,280**	**939**

Source: Own elaboration. PHDs, Personnel Department of MoH, Population is taken from the 2019 National Census.

Table 9: Number of Public Health Workers versus Population

Overall, the ratio of the public health workforce with respect to the population of Cambodia is 1 health worker versus 939 people. Stung Treng RTC region has the lowest ratio. This region has a lesser population but is distributed in a large geographical area, and the proximity of the communities to the hospital and health centers are far. The remoteness of the communities needs more health workers to be able to respond to the health needs of the people in the communities.

B.4 Analysis of current practices and the most relevant current health sector curricula from an environmental and social perspective.

The following table shows the relevant current practices and training courses related to environmental and social perspectives.

Relevant ESF's Standards	**Health School Curricula**	**DHR/PMD Training Curricula**
ESS1. Environmental and Social Assessment and Management	• Not included in the medical curricula, but all the health schools have the waste management system in place. Social assessment may be limited to the assessment of the patient's health • There are not in the country cultural competence training for students at medical schools,	• Environment and Social Safeguards for the construction of new health centers • Not included in the training curricula courses on cultural competence training to understand and respond to social diversity • PMD is still developing the ES assessment guidelines for the

	focusing on skills and knowledge that values diversity, understand and respond in a culturally-appropriate manner to social diversity: gender, ethnic minorities, disabled people, SOGIE, etc.	construction of new health centers and other MoH future construction projects, the new WB Environment and Social Standards used for the Pre-Service Training for Health Workers could be the starting point for this initiative. • Health and Hygiene environment (water and sanitation improvement initiatives))
ESS2. Labor and Working Conditions	• Current pre-service education has some courses on infection control, which are quite relevant to occupational health and safety, and hazardous waste management in year one and two. Those courses are in line with National Guidelines for Infection Prevention and Control for Healthcare Facilities (2017). • The practice of utilizing appropriate personal protection equipment (PPE) for laboratory classes and clinical practice. Not discussed in class lectures but students develop the habit with practical application (learning by doing and applying the PPE) • Lack of content related to topics like how to prevent gender-based violence and work with survivors, work with very vulnerable social groups (street children, impoverished elderly, etc.).	• DHR provides the orientation seminar on 1997 Labor Law of Cambodia and its implementing guidelines for the human resource officers of all offices under MoH, including the RTCs
ESS3. Resource Efficiency and Pollution		• Training course on Arsenicosis Management
ESS4. Community Health and Safety		• Training course on Occupational Health • Public Disaster Management in Disaster for Health Center • PMD provides a seminar for the PHDs on the Disaster and risk management for natural disaster (flooding, hurricane) and epidemic diseases such as the African Swine Flu (ASF)
ESS7. Indigenous Peoples	• There are not in the country cultural competence training for students at medical schools, focusing on skills and knowledge that values diversity, understand and respond in a culturally-appropriate manner to the special	• Not included in the training curricula courses on cultural competence training to promote better understanding and responding in a culturally-appropriate manner to the needs of the patients with an ethnic background

	needs of ethnic minorities.	
ESS10. Stakeholder Engagement	• Not included in the teaching curricula but included in the school system the participation of students and teachers in the school's strategic planning. There is also available for students a grievance system	• No training on Stakeholder Engagement but is being practiced in many of the MoH projects.

Table 10: Relevant current health sector curricula from an environmental and social perspective

From the site visits of some laboratories and facilities under UHS during the preparation of HRDRAP, it was observed that clinical and hazardous waste management and occupational health and safety are considered as important. Appropriate practices and management procedures, which are in line with the National Guidelines for Infection Prevention and Control for Healthcare Facilities (2017), are integrated as part of training courses and the guidelines of the laboratories. However, it is generally focused or has an emphasis on the hospital context. Application of appropriate personal protection equipment (PPEs), segregation of wastes, and sterilizing of wastes and glassware, including autoclaving methods, are currently practiced. For the clinical and hazardous wastes, UHS has contracted with the Red Cross for collection and final disposal of sterilized wastes while the UHS campus for nursing and midwifery sent them to the incinerator of the nearby hospital. To further improve on the practices of the clinical and hazardous waste management, pollution prevention, and improvement of the occupational health and safety, appropriate measures are included as part of HRDRAP of the project. However, regardless of the length of training, education, and practices on environment, health and safety remain limited in the regional training centers (RTCs).

C. Plan for Inclusive Service Delivery

Pre-service training may be specific to individual professional disciplines such as medicine, nursing, and midwifery. Still, concepts on environmental sustainability and social health and safety should be introduced early in the curriculum for all. Under Component 1, which is strengthening competency-based teaching and learning capacity of the project, which will support the development and delivery of competency-based training programs in health professions, the following are the recommendations for project implementation.

C.1 Recommendation to promote the enrollment and inclusion of disadvantaged groups

- Promote actions to increase the number of women enrollees for doctor students like providing equal number of quota for male and female passing the National Entrance Exam or at least increase the quota for women entering the doctor course at UHS;
- Provide equal access to opportunity for female doctors in the government hospitals. MoH to give priority to female doctors for future hiring until the gender balance among the government

doctors is reached, or increase the number of women doctors by at least 35 percent from the current 19 percent in government health facilities by the end of the project period;

- Provide special support to actively promote the enrolment of disadvantaged groups (ethnic minorities, PWD, women). This is to ensure that the disadvantaged groups are provided the opportunity to enroll in medical course and are not left out. The component of the support provided to students from the disadvantage groups shall be "tailored fit" to their need, i.e. responding to their physical, psychological and cultural circumstances.

C.2 Recommendations to embedding social inclusion and environmental sustainability in the health sector in Cambodia.

- Include in the Health Curricula the behavioral science subject, topics on "social inclusion and environmental sustainability" and/or soft skills courses (behavioral science courses) for medical students for having the right attitude in dealing and treatment of the vulnerable people group;
- Soft skills course (behavioral science course) for medical students to have the right attitude in dealing and treatment of the vulnerable people group;
- Promote public awareness raising activities among medical students for better understanding and responding (in a culturally-appropriate manner) on ethnic minorities, PWD and SOGIE-related elements so that future health workers won't discriminate PWD, LGBT patients;
- Include in the medical outreach program, visits to PWD homes/communities, interact and hear from PWDs, see their situation;
- Health facilities to follow the healthcare waste management process including sorting, handling, storage and final disposal of solid HCW outlined in good international practices and relevant guidelines and regulations including National Guideline on Health Care Waste Management, Infection Prevention and Control Guidelines for Health Care Facilities, etc;
- Develop/improve standardized policies and frameworks on (i) occupational health and safety environment, (ii) hazardous and clinical waste management, pollution prevention, and resource efficiency, and (iii) community health and safety in line with relevant good practices of WHO standards such as Safe management of wastes from health-care activities and Prevention of hospital-acquired infections , and applicable national guidelines;
- Improve and strengthen the public participation and Grievance Redress Mechanism among project implementing units, making the GRM accessible and responsive, making the workplace safe place for all, especially or vulnerable group such as women and children;
- Review the existing curriculums related to the above-mentioned items;
- Revise or developing appropriate courses consistent with the standardized frameworks and integrating those into pre-service curricula;
- Ensure that relevant, reliable facilities and agencies are in place by the National regulations and World Bank's Environment Safeguards Standards. For instance, having incinerators and contracting qualified hazardous waste handling agencies are in place to accept the final hazardous waste disposal;.

C.2.1 Promoting the equitable access to project benefits to Ethnic Peoples and other socially vulnerable groups

- Promote Stung Treng RTC as a focal center in the country for health professional's education with ethnic minorities through:
    - Information dissemination among high schools at the provinces with many ethnic minorities about Stung Treng RTC program and medical courses offered and to encourage the ethnic minorities' students to enroll;
    - Developing specific training materials and training activities to reach better and work with ethnic minorities in Cambodia, similar to other centers in countries like Vietnam. Promoting better understanding and responding in a culturally-appropriate manner to the needs of the patients with an ethnic background.
- Support activities for ethnic minority medical students, to include support for "remedial or tutorial classes in order to improve their academic competencies at the time of entry to the RTC;
- Right for the students and patients to express their sexual preference, Medical Forms on Gender (Male, Female, Others);
- Build health facilities that are PWD friendly, with wheelchair ramp and rails, reachable counters, provide "PWD" signs to help easy mobility for PWDs.

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D. Occupational and Community Health and Safety

According to WHO[5], health workers working at health care facilities and laboratories are exposed to a complex variety of health and safety hazards every day, including:

- biological hazards, such as TB, Hepatitis, HIV/AIDS, SARS;
- chemical hazards, such as glutaraldehyde, ethylene oxide;
- physical hazards, such as noise, radiation, slips trips and falls;
- ergonomic hazards, such as heavy lifting;
- psychosocial hazards, such as shift work, violence, and stress;
- fire and explosion hazards, such as using oxygen, alcohol sanitizing gels; and
- electrical hazards, such as frayed electrical cords.

Due to these, health workers need protection from these workplace hazards when they enter their workplace. Unsafe working conditions contribute to health worker attrition in many countries due to work-related illness and injury and the resulting fear of health workers of occupational infection, including from HIV and Tuberculosis. Infections caused by accidental blood exposure are generally preventable if health workers use appropriate protective wear such as gloves and eye protection, spills of body fluids are cleaned up promptly, and biomedical waste is disposed of correctly. Protecting the occupational health of health workers is critical to having an adequate workforce of trained and healthy health personnel.

[5] https://www.who.int/occupational_health/topics/hcworkers/en/

Health and safety issues of the community, including patients and visitors related to the health care facilities and laboratories, are similar to those issues exposed to the health care workers. Thus, it is important to recognize shared health and safety risks between health care staff and patients and identify opportunities to integrate patient and worker safety activities across departments and programs.

Without basic health and safety guidelines and the ability to implement them, health workers, patients, and visitors to health care facilities and laboratories are vulnerable to accidents and exposure to infectious diseases. Following are some recommended steps to be adopted for the safe environment for healthcare-related facilities:

- Develop the capacity and policy tools
- Adopt appropriate measures for a safe work environment
- Initiate and reinforce a safe work environment
- Setting up regularly auditing system
- Developing appropriate curricula and educational resources in line with relevant good practices of WHO standards such as Safe management of wastes from health-care activities [6] and Prevention of hospital-acquired infections[7], and applicable national guidelines to be integrated into the pre-service training to ensure that all health workers are properly trained for a safe environment

Gender focus: the health services sector is a major employer of women. Special emphasis should be placed on the particular challenges faced by them in the health care working environment. The program, education, and training initiatives should ensure that both men and women understand their rights within the workplace and outside it.

E. Hazardous and clinical waste management

Health care waste (HCW) includes all wastes generated in the delivery of health care services. WHO (1999a) estimates that 75-90% of the waste produced by the health care facilities originates from non-risk or general sources (e.g., janitorial, kitchens, administration) and is comparable to domestic waste. The remaining 10-25% of HCW are classified as hazardous and poses a variety of potential health risks. Categories of health care waste, as defined in WHO (1999a), which are considered of most concern in Cambodian health care facilities, are summarized in Table 1.

Exposure to hazardous healthcare waste can result in disease or injury. All individuals exposed to hazardous healthcare waste are potentially at risk, including those within healthcare establishments and those outside these sources. The main groups at risk are health staff (doctors, nurses, technicians, auxiliary and maintenance staff, janitors); patients, their relatives and visitors; workers at waste disposal sites including scavengers; and nearby communities.

[6] Safe management of wastes from health-care activities / edited by Y. Chartier et al. – 2nd ed. WHO 2014
[7] Prevention of hospital-acquired infections. A practical guide – 2nd edition. WHO 2002

Pathogens in infectious waste may enter the human body by a number of routes: through a puncture, abrasion, or cut in the skin; through the mucous membranes; by inhalation; or by ingestion. Sharps may not only cause cuts and punctures but also infect wounds if they are contaminated with pathogens. Sharp injuries are the most popular accidents in health facilities. Sharp injury is the main transmission way of several dangerous infectious diseases. Unless healthcare wastes are managed strictly, they easily cause pollution of the environment and health impacts.

Classification	**Characteristics/Associated Hazards**
Infectious	Comprises waste that is suspected of containing pathogens including laboratory cultures, surgery and autopsy waste from patients with infectious diseases, bodily wastes from patients in infectious disease wards, and miscellaneous waste such as disposable gloves, tubing, and towels generated during the treatment of infectious patients). Pathogens from infectious waste may enter the human body through puncture of skin cuts, mucous membranes, inhalation or ingestion.
Pathological	Consists of tissue, organs, body parts, blood and body fluids. Pathological wastes are considered a sub-category of infectious wastes and pose the same hazards.
Sharps	Describes items that could cause cuts or puncture wounds, including hypodermic needles, scalpel, and broken glass. Because sharps can not only cause cuts and punctures but also infect these wounds if they are contaminated with pathogens, this sub-category of infectious wastes is considered very hazardous.
Chemical	Consists of discarded solid, liquid and gaseous chemicals with toxic, corrosive, flammable, reactive, and genotoxic properties. Chemicals most commonly used in HCF include formaldehyde, photographic chemicals, heavy metals such as mercury from broken clinical equipment, solvents, organic and inorganic chemicals, and expired, used or spilt pharmaceuticals. Hazards from chemical and pharmaceutical waste include intoxication as a result of acute or chronic exposure from dermal contact, inhalation or ingestion and contact burns from corrosive or reactive chemicals.
Radioactive	Includes solid, liquid and gaseous materials contaminated with radio nuclides; produced as a result of procedures such as *in-vitro* analysis of body tissue and fluid, *in-vivo* organ imaging and various investigative and therapeutic practices. Because radioactive waste is genotoxic, health workers in handling active sources and contaminated surfaces must take extreme care.

Table 11: Health care waste characteristics and hazards profile

To address clinical and hazardous waste issues, several regulations and guidelines have been prepared by the MOH, including a national guideline on healthcare wastes management for use by health care facilities. The guideline is intended to supplement WHO's comprehensive health care waste management guidelines (WHO, 2000; 1999a) and focus on practical aspects of safe hospital waste management, including waste minimization, collection, segregation, storage, transportation, and disposal. Additional guidelines on injection safety have also been developed by the MOH to provide specific guidance to health care facilities on the distribution, use, collection and safe destruction of disposable syringes and safety boxes.

A system has been established to safely collect sharp wastes from health facilities for incineration in the designated high temperature incinerators (Sicsim). However, weak management at the health facility level hinders the implementation of the guidelines for health care waste management, including proper waste segregation and storage and maintenance of incinerators.

Recognizing that sanitary or engineered landfills are unlikely to be available in remote locations, another option is the safe burial of health care waste on health care facility and training center premises. On-site disposal represents an acceptable disposal option only if certain requirements are met as follows:

- Restricted access to disposal site by authorized personnel only
- The lining of burial site with a material of low permeability such as clay to prevent groundwater pollution
- Limit use to hazardous materials that cannot safely be incinerated to maximize the lifetime of a landfill.

Notwithstanding the availability of health care waste management guidelines, it is apparent that there is considerable scope for adopting more rigorous health care waste management practices in health centers and training centers.

D.1 Health Care Waste Management Plan

Health facilities will follow a healthcare waste management process, including sorting, handling, storage, and final disposal of solid HCW outlined in good international practices and relevant guidelines and regulations, including the National Guideline on Health Care Waste Management, Infection Prevention and Control Guidelines for Health Care Facilities, etc. The following section briefly describes guidance for health care wastes segregation, handling, storage, and final disposal indicated in the MOH guidelines and good international practices.

D.1.1 Waste Segregation

Segregation of health care waste is intended to ensure that wastes are properly identified and separated and that different waste streams are handled and disposed of correctly. It typically involves sorting different wastes into color-coded plastic bags or containers at the source. Recommended handling and disposal practices for different categories of health care waste will vary according to the resources

available to health care facilities. Examples of WHO (1999a) recommended health care waste handling practices appropriate for health care facilities that apply minimal waste management programs are:

- General health care waste (in black bags or containers) should join the domestic refuse stream for disposal.
- Sharps should be collected together into puncture-proof yellow safety boxes and held for high-temperature incineration. Encapsulation and disposal to a secure landfill is a suitable alternative for sharps.
- Highly infectious waste should be sterilized by autoclaving as soon as possible. For other infectious waste, disinfection is sufficient to reduce microbial content. Treated infectious waste should then be deposited in yellow bags and containers marked with the international infectious substance symbol. Incineration is the preferred method for disposal of infectious waste, although landfilling is also appropriate. Blood should be disinfected before discharge to the sewer system or wastewater treatment plant, if available, or maybe incinerated.
- Large quantities of chemical wastes should be packed in chemical-resistant containers and sent to specialized treatment facilities. Small quantities of chemical waste can be held in leak-proof containers and enter the infectious waste stream for incineration or landfilling. It is noted that incineration at low temperatures may be insufficient to destroy thermally-resistant pharmaceuticals. Small quantities of chemical waste or drug waste can be collected together with the infectious waste per exception in the Infection prevention and control guideline provides.
- Waste containing high heavy metal concentrations should be collected separately in brown containers and sent to specialized treatment facilities.
- Low-level radioactive waste should be collected to yellow bags or containers for incineration. High-level radioactive waste must be sent to specialized disposal facilities.

It is important to train all healthcare workers, including physicians, to keep contaminated and non-contaminated waste separate. Only a small percentage of the waste generated by a healthcare facility is clinical and hazardous waste that must be specially handled to reduce the risk of infections or injury. Segregation of the waste at the point where it is generated can conserve resources by greatly reducing the amount of waste that needs special handling. Poor separation of waste at the point where it is generated leads to large amounts of waste that must be handled especially – which can overwhelm the disposal system, lead to improper disposal of clinical and hazardous waste, and put everyone at risk.

D.1.2 Waste Handling

Staff and students should handle medical and hazardous waste as little as possible before storage and disposal. The more waste is handled, the greater the chance for accidents. Special care must be taken when handling used needles and other sharps, which pose the greatest risk of accidental injury and infection.

Emptying waste containers

Waste containers that are too full also present greater opportunities for accidents. Waste should be removed before the containers become completely full. Dispose of sharps containers when they are 3/4 full. (When sharps-disposal containers become too full, people may push sharps into the container, causing injury.)

Staff should wear utility gloves, heavy-duty apron, and boots when collecting waste.

Do not collect clinical and hazardous waste from the storage areas by emptying it into open carts or wheelbarrows, as this may lead to spills and contamination of the surroundings, may encourage scavenging of waste, and may increase the risk of injury to staff, patients, and visitors.

Handle clinical and hazardous waste as little as possible.

D.1.3 Interim storage of waste

If possible, the final disposal of waste should take place immediately, but it is often more practical to store waste briefly in the facility before final disposal. Interim storage should be short-term.

If it is necessary to store clinical and hazardous waste on-site before final disposal:

- Place waste in a closed area that is minimally accessible to staff, patients, visitors and animals. As few people as possible should come into contact with stored clinical and hazardous waste.
- All containers should have lids to prevent accidental contamination, spillage, and access by insects, rodents, and other animals.
- Contaminated clinical and hazardous waste poses serious health threats to the community. Never store clinical and hazardous waste in open containers & never throw waste into an open pile.

D.1.4 Treatment and Disposal of healthcare waste

Health facilities, laboratories and training centers can apply one or several treatment options as below:

- Transportation to the nearest approved disposal site;
- Handling of waste immediately by friendly environment methods such as needle shredder machine, concrete tank, labeled bin;

Although the national guidelines on health care waste management and infection control reflect best practices and deem adequate and training on the guidelines has been provided, attention should be given to ensuring their proper application by health care facilities. Weak management at health facility level hinders the implementation of the guidelines for health care waste management, including proper waste segregation storage and disposal, and maintenance of incinerators.

To address this weakness, it is recommended that capacity building be provided to improve site-specific waste management practices at health facilities. Capacity-building should comprise both training and technical support. Training in best health care handling and disposal practices is expected to create

more awareness of HCWM issues and foster responsibility among health care facilities staff in an effort to prevent occupational exposure to hazardous HCW. Training should be provided to all health care facility staff – both health care personnel and auxiliary and support staff. Recognizing that sustaining adequate waste management practices at health care facilities ultimately depends on auxiliary staff, it is highly recommended that waste management responsibilities be clearly defined and linked with performance-based monitoring and evaluation.

Adequate waste handling and disposal infrastructure and management systems should be put in place at health care facilities. A standard health care waste management package intended to improve health care waste handling at health care facilities would encompass: (i) color-coded waste plastic bags and containers; and (ii) safety boxes for disposal of used needle and syringes. The segregation of waste at source to minimize mixed waste must be practiced as it would improve the waste disposal system. Therefore an appropriate system and management should be put in place to ensure waste segregation at the point of generation itself.

D.1.5 Waste Water from laboratories and training facilities

Safe disposal practices for wastewater as specified in the MOH's Waste Management Guidelines should be followed in handling of sanitary wastes from laboratories and training centers. Specific mitigation measures to ensure environmentally-safe disposal of wastewater from health care facilities are also described in WHO (1999a). Recommended practices include:

- Where possible, facilities should be connected to municipal WWTP.
- Facilities that are not connected to municipal WWTP should install compact on-site sewage treatment (i.e., primary and secondary treatment, disinfection) to ensure that wastewater discharges meet applicable permit requirements. This should continue to be monitored by the project.

F. Environmental and Social Risks Management Process

This section is developed for those proposed project's activities, which involves the facilities renovation activities. This section describes the environmental and social risks management processing guidance of the project. The following guidance shall serve to ensure that potential impacts and practical mitigation measures are identified and prepared early on in the planning and development of subprojects, in order to avoid or mitigate the potential impact that may be generated by subprojects financed under the project.

The project will adopt a simplified three-step process, as follows:

First step – Eligibility screening of all proposed subprojects, particularly infrastructure-related subprojects, to determine the eligibility of subprojects for support under the project.

The investment financed by this project will not include:

- Activities that have the potential to cause any significant loss or degradation of critical natural habitats whether directly or indirectly;

- Activities that could affect forest and forest health;
- Activities requiring land acquisition;
- Activities causing directly or indirectly physical or economic displacement;
- Activities that could harm Indigenous Peoples/ethnic minorities;
- Activities that could affect sites with archeological, paleontological, historical, religious, or unique natural values;
- Activities that have potential establishment of new buildings or extension of new infrastructures.

Second step – Environmental and Social Risks Screening. If the subproject is deemed eligible, the subproject, especially infrastructure subproject, is screened using the Environmental and Social Checklist (Annex I.10) to determine potential environmental risks and categorization.

Third Step – Preparation of ESF Instrument. Based on the results of risks screening described above, subprojects that are not required additional measures/instruments will follow the ESCOPs prepared as part of this document. Subprojects, especially infrastructure-related subprojects that need additional instruments or measures, subproject specific instruments such as site-specific Environmental and Social Management Plan (ESMP) will be prepared before the start of any civil work/activities. The sample outline of the ESMP is mentioned in Annex H.11.

E.1 Mitigation Measures for Facilities Renovation Activities

Prior to the execution of minor civil works or facilities renovation activities, the participating facilities will ensure to prepare and review the design for minor works, building renovation where applicable. The designs for these works shall be approved by facility management and or competent local agencies in line with the relevant legislation. During construction, the facility staff shall be responsible for ensuring implementation of the Environmental and Social Code of Practices (ESCOPs) (see Annex H.9). The ESCOPs will also be incorporated into the project Operations Manual (OM) and where applicable included in contractor contract. Overall implementation of these ESCOPs and ESMP will be supervised and monitored by the PMD.

G. Project's Labor-Management Procedure

Labor Management Procedures (LMP) are mandated by ESS2 – Labor and Working Conditions of the World Bank Environmental and Social Framework (ESF) to identify the main labor requirements and risks associated with the project and to determine the resources necessary to address project labor issues. The LMP is a living document to be reviewed and updated throughout the development and implementation of the project. The LMP applies to all project workers, irrespective of the contract being full-time, part-time, temporary, or casual.

1. The World Bank ESS2 defines four categories of project workers:

   Direct workers - people employed or engaged directly by the Borrower (including the project proponent and the project implementing agencies) to work specifically in relation to the project

Contracted workers - people employed or engaged through third parties to perform work related to core functions of the project, regardless of location. These could be either international or national workers.

Primary supply workers - people employed or engaged by the Borrower's primary suppliers (primary supply workers);

Community workers - people employed or engaged in providing community labor, generally voluntarily. There will be no community workers engaged on the project.

Civil Servant- those employed directly by the Government. Overview of Labor Use on the Project

2. This project will only engage staff from the Ministry of Health (Government Civil Servants), the public University of Health Sciences (UHS) and consultants (contracted workers). Some workers may be contracted through a firm for the minor works required for the upgrading of some physical facilities -the nature and location of those minor works are unknown at this stage of project preparation-. In this project, there are no expected primary supply workers or community workers.

3. This section describes the expected labor use on the project, based on available information. As the project progresses and more information becomes available, this information will be revised. Migrant workers are not expected as a result of this project.

Project Component	Number of Project Workers	Characteristics of Project Workers	Timing of Labor Requirements	Contracted Workers
Component 1: Strengthening competency-based teaching and learning capacity	Approx. 30 direct or contracted workers	National and international skilled consultants are expected to strengthen the teaching and learning capacity in the UHS and the four public Regional Training Centers (RTCs). Works for the upgrading of physical facilities may require national and international skilled and unskilled workers.	Project implementation	Consultancy contracts are likely to be tendered to individual consultants. Minor works for the upgrading of physical facilities (clinical skill laboratories, libraries, lecture halls, class-rooms) are likely to be tendered to a private firm. Number of contracted and sub-contracted workers is unknown at this stage.

Component 2: Health professionals education governance and project management				
Subcomponent 2.1: Health Professionals education governance	Approx. 15 direct or contracted workers	Combination of International and national skilled consultants	Project implementation	Consultancy contracts are likely to be tendered to individual consultants. Number of contracted and sub-contracted workers is unknown at this stage.
Subcomponent 2.2: Project management	Approx. 6-10 direct or contracted workers	Mostly national, but also international skilled consultants	Project implementation	Unknown at this stage.

Table 12: Proposed project workforce

F.1 Assessment of Key Potential Labor Risks

F.1.1 Project Activities and Key Labor Risks

4. Activities under this project are not expected to have any significant negative impact related to labor and working conditions.
5. The key labor risks that have been identified associated with the project activities include Occupational Health and Safety (OHS) due to the minor works for the upgrading of physical facilities (clinical skill laboratories, libraries, lecture halls, class-rooms) under Component 1.
6. Minor renovations under Component 1 are the only ones involving physical works, whilst the remaining components are consultancy and technical assistance activities.

Project Component	Activities	Key Labor Risks
Component 1: Strengthening competency-based teaching and learning capacity	(a) Strengthen the teaching and learning capacity in the UHS and the four public Regional Training Centers (RTCs). (b) Works for the upgrading of physical facilities may require skilled and unskilled workers	OHS for activities (a), including a. Ground transportation; b. Air travel; c. Sedentary work. OHS for activities (a), including d. Operating machinery; e. Working in enclosed spaces (trenches);

		f. Working at heights'; g. Traffic management hazards; and h. Electrical hazards;
Subcomponent 2.1: Health Professionals education governance	Support MoH in the establishment of regulations and standards for health professional's education; external review and quality assessment of health professional's education programs; and development and operation of the national licensing examination system	OHS, including: i. Ground transportation; j. Air travel; k. Sedentary work.
Subcomponent 2.2: Project management	Support the implementation, coordination, and management of project activities on planning and execution, financial management (FM), procurement, supervision and reporting, internal and external audits, environmental and social standards management, and monitoring and evaluation	OHS, including: l. Ground transportation; m. Air travel; n. Sedentary work.

Table 13: Potential labor Risks related to the proposed project activities

F.1.2 Overview of the Labor Legislation: Terms and Conditions

7. Cambodia has national legislation that outlines worker's rights. The Labor Law (1997) remains the key document governing the regulatory framework for labor in Cambodia.

8. The 1997 Labor Law defines non-discrimination in employment and in wages. It establishes a minimum wage level, which may vary among regions. Working hours are limited to 8 hours per day, 6 days a week. There are strong regulatory provisions against discrimination in the work place, enhancing from a legal point of view fair treatment, non-discrimination and equal opportunity, special protection and assistance to vulnerable workers. A whole chapter in the Law is dedicated to health and safety in the workplace. The Law also covers those who work for subcontractors.

9. Child labor remains a noticeable gap in the legal framework despite many years of participation in related international programs. The Labor Law defines 12 years old as the minimum working age for children. This is in contradiction with the international standards in which the minimum working age is 15 years, or countries with special weaknesses being allowed to lower this age limit to 14. In

addition, the Labor Law does not cover domestic helpers who are likely to include very young workers. Types of work that are allowed for 12 to 18 years old are defined in additional documents but in a rather lose manner. The Prakas on the Prohibition of Hazardous Child Labor (2004) allow hazardous work for well-trained children above 16, provided it is not night work.

F.1.3 Overview of the Labor Legislation: Occupational Health and Safety

10. The Labor Law (1997) includes provisions on Occupational Health and Safety (OHS) mostly consistent with ESS2 of the World Bank's Environmental and Social Framework (ESF).

F.2 Responsible Staff

11. This section identifies the functions and/or individuals within the project responsible for oversight mechanisms.

12. **Engagement and Management of Contractors/Subcontractors.** The Ministry of Health (MoH) is responsible for contractor engagement and compliance with contract conditions (payment of invoices). The MoH will address all LMP aspects as part of procurement for works and consultancy/technical assistance activities. The responsible implementing agency for contractor management will be a Project Implementation Unit (PIU) to be established in MoH, who will be responsible for overseeing all aspects of implementation of the project, including compliance and contractor induction.

13. The contractor is subsequently responsible for management in accordance with contract specific Labor Management Plans (LMP). Implementation of which will be supervised by MoH as defined by specific Plans. The detailed approach is described in the following sections.

14. **Occupational Health and Safety**. Contractors must designate a minimum of one safety representative to ensure day-to-day compliance with specified safety measures and records of any incidents. Minor incidents and near misses are reported to MoH on a monthly basis, serious incidents are reported immediately. Minor incidents are reflected in the quarterly reports to the World Bank, major issues are flagged to the World Bank immediately.

15. **Labor and Working Conditions**. Contractors will keep records in accordance with specifications set out in this LMP. MoH may at any time require records to ensure that labor conditions are met. MoH will review records against actuals at a minimum on a monthly basis and can require immediate remedial actions if warranted. A summary of issues and remedial actions will be included in quarterly reports to the World Bank.

16. **Training of Workers**. Contractors are required to, at all times, have a qualified safety officer on board. If training is required, this will be the contractor's responsibility. The safety officer will provide instructions to contractor staff. The contractor will be obligated to make staff available for any mandatory trainings required by MoH, as specified by the contract.

17. **Addressing Worker Grievances**. The Contractors will be required to implement a Grievance Redress Mechanism (GRM) for Project staff. Contractors will be required to present a worker grievance redress mechanism which responds to the minimum requirements in this LMP. The MoH's ESF Focal

Point Team will review records on a monthly basis. MoH will keep abreast of GRM complaints, resolutions and reflect in quarterly reports to the World Bank.

Responsibility	Organization	Function	Individual
Engagement of project workers.	MoH	MoH's ESF Focal Point	To Be Determined (TBD)
Management of project workers.	MoH	MoH's ESF Focal Point	To Be Determined (TBD)
Occupational Health and Safety.	Contractor(s)	Designated Safety Representative(s)	TBD
Training of Workers.	Contractor(s)	Designated Safety Representative(s)	TBD
Addressing Worker Grievances.	Contractor(s) MoH	Management MoH's ESF Focal Point	TBD TBD

Table 14: Grievance Redress Mechanism

F.2.1 Occupational, Health and Safety

18. The project implementing agencies will:

    o. Comply with Cambodia legislation, WB's ESS2 requirements and other applicable requirements which relate to OHS hazards;

    p. Enable active participation in OHS risks elimination through promotion of appropriate skills, knowledge and attitudes towards hazards;

    q. Continually improving the OHS management system and performance;

    r. Communicate this policy statement to all persons working on the project with emphasis on individual OHS responsibilities; and

    s. Make this policy statement available to all interested parties.

19. Contractors will be required to have at least one designated Safety Officer on each site. The Safety Officer will be responsible for:

    t. Identification of potential hazards to project workers, particularly those that may be life threatening;

    u. Provision of preventative and protective measures, including modification, substitution, or elimination of hazardous conditions or substances;

    v. Training of project workers and maintenance of training records;

    w. Documentation and reporting of incidents;

x. Emergency prevention and preparedness and response arrangements to emergency situations; and

y. Remedies for adverse impacts such as occupational injuries, deaths, disability and disease.

20. The contractor(s) will be required to:

z. Develop and implement procedures to establish and maintain a safe working environment, including that workplaces, machinery, equipment and processes under their control are safe and without risk to health;

aa. Actively collaborate and consult with project workers in promoting understanding and methods for implementation of OHS requirements;

bb. Provide OHS training to all employees involved in works or site supervision;

cc. Provide laminated signs of relevant safe working procedures in a visible area on work sites, in English and local language as required;

dd. Provide PPE as suitable to the task and hazards of each worker, without cost to the worker;

ee. Put in place processes for project workers to report work situations that they believe are not safe or healthy and to remove themselves from situations they have reasonable justification to believe are unsafe;

ff. Confirm appropriate measures are in place for working in communities with known risk of conflict / violence;

gg. Ensure availability of first aid boxes in all work locations;

hh. Provide employees with access to toilets and potable drinking water; and

ii. Properly dispose of solid waste at designated permitted disposal/landfill sites.

21. Further to enforcing the compliance of environmental and social management, contractors are responsible and liable for the safety of site equipment, labors and daily workers attending to the construction site and safety of citizens for each subproject site, as mandatory measures.

F.2.2 Policies and Procedures

22. Most environmental and social impacts of the project resulting from activities directly under the control of contractors will be mitigated directly by the same contractors. As such, the approach is to ensure that contractors effectively mitigate project related impacts. MoH will incorporate standardized environmental and social clauses in the tender documentation and contract documents in order for potential bidders to be aware of environmental and social performance requirements that shall expected from them, are able to reflect that in their bids, and required to implement the clauses for the duration of the contract. MoH will enforce compliance by contractors with these clauses.

23. As a core contractual requirement, the contractor is required to ensure all documentation related to environmental and social management, including the LMP, is available for inspection at any time by

the MoH. The contractual arrangements with each project worker must be clearly defined. All environmental and social requirements will be included in the bidding documents and contracts.

24. Under no circumstances will contractors, suppliers or sub-contractors engage forced labor.

F.2.3 Age of Employment

25. For this project, the minimum age will be 18 years. This rule will apply for both national and international workers.
26. Workers will be required to provide proof of their identity and age before commencing any works on site.
27. If any contractor employs a person under the minimum age, that contractor be required to undertake relevant management measures to ensure the safety of the worker and implement immediate measures no repeat action is taken.

F.2.4 Terms and Conditions and equal opportunities

28. All terms and conditions as outlined in the World Bank Environmental and Social Framework (ESF) ESS2, paragraphs 10 to 15 apply to contracted workers.
29. In line with national law, the maximum working hours are limited to 8 hours per day, 6 days a week.
30. Employment opportunities will be available to all.

F.3 Grievance Mechanism

31. A formal Grievance Redress Mechanism (GRM) will for project workers is as per the process outlined below. This takes into account culturally appropriate ways of handling the concerns of direct and contracted workers. Processes for documenting complaints and concerns have been specified, including time commitments to resolve issues.
32. In addition, this GRM has been and will continue to be communicated to all stakeholder groups during each planned engagement activity. Special communications will be held with the vulnerable groups identified at each location.

F.3.1 Communications

All project workers will be informed of the Grievance Mechanism process as part of their contract and induction package.

F.3.2 Process

33. The process for the Worker GRM is as follows:

    jj. The Aggrieved Person/Party may report their grievance in person, by phone, text message, mail or email (including anonymously if required) to the Contractor in the first instance, as the initial focal point for information and raising grievances;

kk. For complaints that were satisfactorily resolved by the Aggrieved Person/Party or Contractor, the incident and resultant resolution will be logged and reported to the MoH's ESF Focal Point.

ll. Where the Aggrieved Person/Party is not satisfied, the Contractor will refer the aggrieved party to the MoH's ESF Focal Point. Grievances may also be referred or reported to the MoH if deemed suitable.

mm. The MoH's ESF Focal Point endeavors to address and resolve the complaint and inform the Aggrieved Person/Party. For complaints that were satisfactorily resolved by the MoH's ESF Focal Point, the incident and resultant resolution will be logged by the MoH's ESF Focal Point. Where the complaint has not been resolved, the MoH's ESF Focal Point will refer to the general manager of the MoH's PIU for further action or resolution;

nn. If the matter remains unresolved, or the Aggrieved Person/Party is not satisfied with the outcome, the general manager of the MoH's PIU refers the matter to the Project Steering Committee for a resolution. The MoH's ESF Focal Point will log details of issue and resultant resolution status;

oo. If it remains unresolved or the complainant is dissatisfied with the outcome proposed by the Project Steering Committee, the Aggrieved Person may refer the matter to the appropriate legal or judicial authority. A decision of the Court will be final; and

pp. Feedback must be provided to the lodger of each step no less than weekly, or more often if suitable.

34. Steps a through e should be undertaken immediately. Where the matter is referred to the MoH's ESF Focal Point, a resolution should be sought within two weeks. If unsuccessful and the matter is referred to the Project Steering Committee, this should occur within a month

35. Each record is allocated a unique number reflecting year and sequence of received complaint (for example 2019-01, 2019-02 etc.). Complaint records (letter, email, record of conversation) should be stored together, electronically or in hard copy. The MoH's ESF Focal Point will be responsible for undertaking a regular (at least monthly) review of all grievances to analyze and respond to any common issues arising. The MoH's ESF Focal Point is also responsible for oversight of the GRM.

36. These steps should be undertaken immediately. Where the matter is referred to the MoH's ESF Focal Point, a resolution should be sought within two weeks. If unsuccessful and the matter is referred to the Project Steering Committee, this should occur within a month

37. Each record is allocated a unique number reflecting year and sequence of received complaint (for example 2019-01, 2019-02 etc.). Complaint records (letter, email, record of conversation) should be stored together, electronically or in hard copy.

38. Any grievance related to corruption or any unethical practice should be referred immediately to the Cambodia Supreme Court.

F.3.3 Contractor Management

39. The tendering process for contractors will require that contractors can demonstrate their labor management and OHS standards, which will be a factor in the assessment processes.

40. Contractual provisions will require that contractors:

    qq. Monitor, keep records and report on terms and conditions related to labor management;

    rr. Provide workers with evidence of all payments made, including benefits and any valid deductions;

    ss. Keep records regarding labor conditions and workers engaged under the project, including contracts, registry of induction of workers including Code of Conduct, hours worked, remuneration and deductions (including overtime);

    tt. Record safety incidents and corresponding Root Cause Analysis (lost time incidents, medical treatment cases), first aid cases, high potential near misses, and remedial and preventive activities required (for example, revised job safety analysis, new or different equipment, skills training, etc.);

    uu. Report evidence that no child labor is involved;

    vv. Training/induction dates, number of trainees, and topics; and

    ww. Details of any worker grievances including occurrence date, grievance, and date submitted; actions taken and dates; resolution (if any) and date; and follow-up yet to be taken. Grievances listed should include those received since the preceding report and those that were unresolved at the time of that report.

41. Monitoring and performance management of contractors will be the responsibility of MoH. MoH will be responsible for oversight of labor management provisions as well as contract supervision.

F.3.4 Gender Based violence prevention

42. Gender based violence (GBV) is an assault that is directed at individual based on his or her biological sex or gender orientation. It includes physical, sexual, verbal, emotional, and psychological abuse, denial of resources or access to services, threats, coercion, and economic or educational deprivation, whether occurring in public or private life.

43. GBV is a human rights violation, a public health challenge and a barrier to civic, social, political and economic participation. It undermines not only the safety, dignity and overall health status of individuals who experience it, but also the public health, economic stability and security of the country.

Forms of Gender Based Violence:

Sexual Harassment	A behavior characterized by the making of unwelcome and inappropriate sexual remarks or physical advances in a workplace or other professional or social situation. Sexual harassment by employer is a form of illegal employment discrimination

Rape	A type of sexual assault usually involving sexual penetration carried out forcibly or under threat of injury against the person's will
Acid throwing	Is a form of violent assault involving the act of throwing acid or similarly corrosive substance onto the body of another "with the intention to disfigure, maim, torture

Table 15: Health Sector Curricula

Gender Based Violence Prevention

- Increase awareness of the scope of the GBV problem and its impact
- Partner and/or coordinate with the Ministry of Social Affairs and with NGOs such as LICHADO,
- GBV to be included Grievance Redress Mechanism of the proposed project
- Strengthen prevention effort by adopting and promoting WHO's RESPECT Women Framework to prevent violence against women and girls:
  - ***R**-elationships skills strengthened*
  - ***E**-mpowerment of women*
  - ***S**-ervices ensured*
  - ***P**-overty reduced*
  - ***E**-nvironments made safe*
  - ***C**-hild and adolescent abuse prevented*
  - ***T**-ransformed attitudes, beliefs and norms*

H. Implementation arrangements of the Plan for Inclusive Service Delivery

Institutional implementation arrangement

The "Pre-Service Training for Health Workers" will be implemented by the MOH over a period of six years. The Minister of Health will appoint a Secretary of State for Health as the Project Director, and a senior expert on professional health education as the Program Manager. Thee relevant senior government officials will be appointed as Team Leaders; one to oversee technical aspects related to the introduction of competency-based training, one to oversee financial management and procurement, and the third one to oversee the implantation of HRDRAP, including gender mainstreaming.

The project activities will be carried out by (a) the project focal points in this and relevant MOH departments who will be responsible for development or updating all frameworks and documents related to competency-based education. Various working groups will be established to support the project focal point to develop or update all CBE framework documents and decrees/sub-decrees, regulations, Prakas, and standards. the Department of Preventive Medicine (PMD) is responsible to implement and monitor the project activities in compliance with social, environmental commitment plan, implementation of HRDRAP, and gender mainstream framework.

To ensure that the implementation of this instrument for the project is effective, MoH has assigned an ESF Focal Point in the Project Implementation Unit -under the PMD- to provide ongoing support, advice and monitoring to all the institutional stakeholders. In addition, it may be required to recruit part

time/full time consultants to support the stakeholder engagement processes, technical advisory work and (in case it is required) supervise the improvement of physical facilities/equipping the existing facilities. Hiring suitable staff has been included in the ESCP as one of the commitments.

A Health Sector Steering Committee (HSSC) will be established as the apex decision making body in the MOH. The HSSC will be chaired by His Excellency the Minister of Health and its members would include relevant Secretaries of State and Under-secretaries of State, Director Generals from the MOH, and senior representative from the Ministry of Economy and Finance (MEF). It will provide leadership, guidance, oversight, and strategic direction to the project management and implementation teams.

The Project Director will appoint an Independent Verification Agency (IVA) to verify achievement reported by the project implementing units, including PMD.

Monitoring and Reporting

The ESF Focal at PMD will be the main responsible for the monitoring the implementation of the plan and expected outcomes. The PMD will have the overall responsibility for data collection, monitoring, and analysis across the various components, as part of the Project's M&E efforts.

To attain the effectiveness and sustainability of the HRDRAP during implementation of Pre-Service Training for Health Workers Project, PMD with the support of hired qualified ES Specialist will monitor the implementation of environmental and social performances, and the recommendations of the HRDRAP, and the requirements stated in the ESCP. The ES monitoring report will be reviewed submitted regularly to the HSSC/MoH. Then HSSC/MoH will submit the ES monitoring report together with the project's reports to the World Bank.

I. Annex

H.1 Cambodia Population 2019

Region	No	Province	HH	male	Female	Total
Battambang RTC	1	Battambang	218,584	458,902	528,498	987,400
	2	Banteay Meanchey	177,526	426,104	433,441	859,545
	3	Odor Meanchey	56,331	134,350	126,902	261,252
	4	Siem Reap	218,659	491,568	514,944	1,006,512
	5	Pursat	102,253	200,392	211,367	411,759
	6	Kampong Chhnang	122,925	251,895	274,037	525,932
	7	Pailin	16,833	36,151	35,449	71,600
	Sub-Total		*913,111*	*1,999,362*	*2,124,638*	*4,124,000*
Kampot RTC	1	Kampot	138,374	280,537	312,308	592,845
	2	Sihanouk	51,983	153,255	149,632	302,887
	3	Koh Kong	26,716	62,304	61,314	123,618
	4	Kep	9,347	20,615	21,183	41,798
	5	Takeo	199,362	432,649	466,836	899,485
	6	Kampong Spue	187,835	424,039	448,180	872,219
	Sub-Total		*613,617*	*1,373,399*	*1,459,453*	*2,832,852*
Kampong Cham RTC	1	Kampong Cham	215,923	428,481	467,282	895,763
	2	Kampong Thom	154,458	327,013	350,247	677,260
	3	Tboung Khmum	169,281	377,205	398,091	775,296
	4	Prey Veng	227,008	501,346	556,082	1,057,428
	5	Svay Rieng	131,937	249,446	275,108	524,554
	6	Kandal	273,111	580,129	615,418	1,195,547
	Sub-Total		*1,171,718*	*2,463,620*	*2,662,228*	*5,125,848*
Stung Treng RTC	1	Stung Treng	34,627	83,093	76,472	159,565
	2	Kratie	86,137	185,429	187,396	372,825
	3	Mondolkiri	19,609	45,533	43,116	88,649
	4	Preah Vihear	56,331	126,624	124,728	251,352
	5	Ratanakiri	47,417	102,325	101,702	204,027
	Sub-Total		*244,121*	*543,004*	*533,414*	*1,076,418*
		Phnom Penh	399,203	1,039,192	1,090,179	2,129,371
Total			**3,341,770**	**7,418,577**	**7,869,912**	**15,288,489**

H.2 Health Students

H.2.1 UHS Student Data

UNIVERSITY HEALTH SERVICES (UHS)

No	Courses	Year Level	Number of Students (2018-2019)			Ethnic Composition		
			Male	Female	Total	Khmer	Ethnic Minority	Cham
1	Diploma degree in Medicine	1st Year	155	143	298	298		
		2nd Year	156	127	283	283		
		3rd Year	149	113	262	262		
		4th Year	171	103	274	274		
		5th Year	180	92	272	272		
		6th Year	209	116	325	325		
		7th Year	135	85	220	220		
		8th Year	120	65	185	185		
		Total	*1275*	*844*	*2119*	*2119*		
2	Specialized Doctor Diploma	1st Year	78	38	116	116		
		2nd Year	100	55	155	155		
		3rd Year	167	90	257	257		
		4th Year	136	29	165	165		
		Total	*481*	*212*	*693*	*693*		
3	Bachelor in Nursing	1st Year	29	69	98	98		
		2nd Year	28	67	95	95		
		3rd Year	21	44	65	65		
		4th Year	10	25	35	35		
		Total	*88*	*205*	*293*	*293*		
4	Bachelor in Midwifery	1st Year	0	60	60	60		
		2nd Year	0	58	58	58		
		3rd Year	0	40	40	40		
		4th Year	0	16	16	16		
		Total	*0*	*174*	*174*	*174*		
5	Assoc. degree in Nursing	1st Year	29	79	108	108		
		2nd Year	30	72	102	102		
		3rd Year	34	76	110	110		
		Total	*93*	*227*	*320*	*320*		
6	Assoc. Degree in Midwifery	1st Year	0	37	37	37		
		2nd Year	0	49	49	49		
		3rd Year	0	51	51	51		
		Total	*0*	*137*	*137*	*137*		
	TOTAL		***1,937***	***1,799***	***3,736***	***3,736***		

H.2.2 Battambang RTC Student Data

BATTAMBANG REGIONAL TRAINING CENTER

No	Courses	Year Level	Number of Students (2018-2019)			Ethnicity
			Male	Female	Total	Khmer
1	Bachelor degree in Nursing and Midwifery	1st Year	0	39	39	39
		Total	0	39	39	39
2	Associate degree in Nurse	1st Year	43	78	121	121
		2nd Year	26	41	67	67
		3rd Year	58	80	138	138
		Total	127	199	326	326
3	Continue Primary Nurse to Associate degree	1st Year	0	0	0	0
		2nd Year	2	8	10	10
		3rd Year	43	14	57	57
		Total	45	22	67	67
4	Continue Primary Midwife to Associate degree	1st Year	0	0	0	0
		2nd Year	0	50	50	50
		3rd Year	0	100	100	100
		Total	0	150	150	150
5	Associate degree in Midwifery	1st Year	0	37	37	37
		2nd Year	0	48	48	48
		3rd Year	0	120	120	120
		Total	*0*	*205*	*205*	*205*
	TOTAL		***172***	***615***	***787***	***787***

H.2.3 Stung Treng RTC Student Data

STUNG TRENG REGIONAL TRAINING CENTER

No	Courses Offered	Year Level	Number of Students (2018-2019)			Ethnic Composition	
			Male	Female	Total	Khmer	Ethnic Minority
1	Associate degree in Nursing	1st Year	8	10	18	113	9
		2nd Year	16	13	29		
		3rd Year	54	21	75		
		Total	*78*	*44*	*122*	*113*	*9*
2	Associate degree in Midwifery	1st Year	0	13	13	55	10
		2nd Year	0	14	14		
		3rd Year	0	38	38		

		Total	*0*	*65*	*65*	*55*	*10*
	TOTAL		***78***	***109***	***187***	***168***	***19***

H.2.4 Kampot RTC Student Data

KAMPOT REGIONAL TRAINING CENTER

No	Courses Offered	Year Level	Number of Students (2018-2019)			Ethnicity
			Male	Female	Total	Khmer
1	Bachelor degree in Nursing and Midwifery	1st Year				
		2nd Year				
		3rd Year				
		4th Year	0	54	54	54
		Total	*0*	*54*	*54*	*54*
2	Associate degree in Midwifery	1st Year	0	43	43	43
		2nd Year	0	78	78	78
		3rd Year	0	71	71	71
		3rd Year up-grade	0	85	85	85
		Total	*0*	*277*	*277*	*277*
3	Associate degree in Nursing	1st Year	31	74	105	105
		2nd Year	43	61	104	104
		3rd Year	65	90	155	155
		Total	*139*	*225*	*364*	*364*
4	Associate Degree in Dental Nursing	1st Year	12	8	20	20
		2nd Year	12	5	17	17
		3rd Year	8	3	11	11
		Total	*32*	*16*	*48*	*48*
	TOTAL		***171***	***572***	***743***	***743***

H.2.4 Kampong Cham RTC Student Data

KAMPONG CHAM REGIONAL TRAINING CENTER

No	Courses Offered	Year Level	Number of Students (2018-2019)			Ethnicity
			Male	Female	Total	Khmer
2	Associate degree in Nursing	1st Year	22	14	36	36
		2nd Year	18	12	30	30
		3rd Year	34	8	42	42
		Total	*74*	*34*	*108*	*108*
3	Primary Midwife to Associate degree in Midwifery	1st Year		34	34	34
		2nd Year		89	89	89
		3rd Year		174	174	174
				55	55	55
		Total		*352*	*352*	*352*
6	Primary Pharma to Assoc. D in Nursing	1st Year	43	73	116	116
		2nd Year	52	60	112	112
		3rd Year	49	73	122	122
		Total	144	206	350	350
	TOTAL				***810***	***810***

H.3 Public Health Workforce

H.3.1 Health Workers by Gender

Provincial Hospitals - Health Workers by Gender

No	Name of Hospital	Doctors			Nurses			Midwives			Total Staff		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
1	Battambang	54	8	62	89	51	140	0	76	76	143	135	278
2	Banteay Meanchey	23	5	28	29	22	51	0	47	47	52	74	126
3	Otdar Meanchey	12	2	14	26	7	33	0	10	10	38	19	57
4	Siem Reap	51	6	57	49	34	83	0	45	45	100	85	185
5	Pursat	21	3	24	27	14	41	0	27	27	48	44	92
6	Kampong Chhnang	23	8	31	31	43	74	0	39	39	54	90	144
7	Pailin	12	8	20	26	12	38	0	19	19	38	39	77
8	Kampot	22	5	27	43	40	83	*0*	33	33	65	78	143
9	Sihanouk Ville	26	3	29	31	29	60	0	32	32	57	64	121
10	Koh Kong	14	3	17	20	5	25	0	12	12	34	20	54
11	Kep	12	0	12	6	5	11	0	10	10	18	15	33
12	Takeo	41	5	46	73	63	136	0	42	42	114	110	224
13	Kampong Speu	30	1	31	24	27	51	0	14	14	54	42	96
14	Kampong Cham	48	12	60	70	54	124	0	55	55	118	121	239
15	Kampong Thom	30	13	43	22	28	50	0	21	21	52	62	114
16	Tboung Khmum	12	3	15	16	8	24	0	17	17	28	28	56
17	Prey Veng	14	4	18	13	13	26	0	23	23	27	40	67
18	Svay Rieng	24	3	27	38	28	66	0	20	20	62	51	113
19	Kandal	37	14	51	28	58	86	0	36	36	65	108	173
20	Stung Treng	14	4	18	31	12	43	0	34	34	45	50	95
21	Kratie	10	9	19	45	24	69	0	20	20	55	53	108
22	Ratanakiri	17	3	20	29	7	36	0	26	26	46	36	82
23	Mondolkiri	11	2	13	18	10	28	0	12	12	29	24	53
24	Preah Vihear	16	4	20	26	6	32	0	35	35	42	45	87
Total		**574**	**128**	**702**	**810**	**600**	**1410**	**0**	**705**	**705**	**1384**	**1433**	**2817**
Percent Women		**22%**			**43%**			**100%**			**51%**		

Referral Hospitals _ Health Workers by Gender

No	Name of Hospital	Doctors			Nurses			Midwives			Total Staff		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
1	Battambang	13	13	26	68	35	103	0	50	50	81	98	179
2	Banteay Meanchey	42	5	47	88	29	117	0	86	86	130	120	250
3	Otdar Meanchey	5	0	5	11	5	16	0	8	8	16	13	29
4	Siem Reap	23	5	28	33	23	56	0	27	27	56	55	111
5	Pursat	6	4	10	23	5	28	0	21	21	29	30	59
6	Kampong Chhnang	13	2	15	14	24	38	0	0	0	27	26	53
7	Pailin	0	0	0	0	0	0	0	0	0	0	0	0
8	Kampot	23	5	28	48	32	80	0	32	32	71	69	140
9	Sihanouk Ville	0	0	0	0	0	0	0	0	0	0	0	0
10	Koh Kong	8	0	8	10	3	13	0	11	11	18	14	32
11	Kep	0	0	0	0	0	0	0	0	0	0	0	0
12	Takeo	37	4	41	92	30	122	0	70	70	129	104	233
13	Kampong Speu	22	7	29	27	19	46	0	67	67	49	93	142
14	Kampong Cham	38	10	48	60	26	86	0	65	65	98	101	199
15	Kampong Thom	22	8	30	20	14	34	0	15	15	42	37	79
16	Tboung Khmum	47	11	58	61	31	92	0	69	69	108	111	219
17	Prey Veng	48	11	59	80	38	118	1	118	119	129	167	296
18	Svay Rieng	26	5	31	39	17	56	0	42	42	65	64	129
19	Kandal	61	18	79	60	57	117	0	104	104	121	179	300
20	Stung Treng	0	0	0	0	0	0	0	0	0	0	0	0
21	Kratie	11	5	16	35	7	42	0	24	24	46	36	82
22	Ratanakiri	7	1	8	8	1	9	0	12	12	15	14	29
23	Mondolkiri	6	0	6	9	2	11	0	8	8	15	10	25
24	Preah Vihear	3	2	5	9	1	10	0	11	11	12	14	26
Total		**461**	**116**	**577**	**795**	**399**	**1194**	**1**	**840**	**841**	**1257**	**1355**	**2612**
Percentage Female		**20%**			**33%**			**100%**			**52%**		

Health Center - Health Workers by Gender

No	Name of Hospital	No. of HC	Doctors			Nurses			Midwives			Total Staff		
			Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
1	Battambang	79	13	3	16	244	90	334	0	355	355	257	448	705
2	Banteay Meanchey	66	1	0	1	203	50	253	0	238	238	204	288	492
3	Otdar Meanchey	34	10	1	11	113	19	132	0	116	116	123	136	259
4	Siem Reap	89	3	1	4	193	90	283	0	264	264	196	355	551
5	Pursat	40	2	1	3	105	26	131	0	157	157	107	184	291
6	Kampong Chhnang	41	2	1	3	120	73	193	0	157	157	122	231	353
7	Pailin	6	1	1	2	23	36	59	0	23	23	24	60	84
8	Kampot	59	*10*	*1*	11	*164*	*117*	281	*0*	*257*	257	174	375	549
9	Sihanouk Ville	13	10	4	14	60	28	88	0	67	67	70	99	169
10	Koh Kong	12	6	0	6	42	17	59	0	67	67	48	84	132
11	Kep	4	1	0	1	14	9	23	0	29	29	15	38	53
12	Takeo	79	13	3	16	206	62	268	0	349	349	219	414	633
13	Kampong Speu	54	11	2	13	173	63	236	0	210	210	184	275	459
14	Kampong Cham	87	2	0	2	174	62	236	0	260	260	176	322	498
15	Kampong Thom	52	10	1	11	126	70	196	0	190	190	136	261	397
16	Tboung Khmum	63	4	2	6	127	52	179	0	217	217	131	271	402
17	Prey Veng	103	10	1	11	305	65	370	0	276	276	315	342	657
18	Svay Rieng	43	0	0	0	127	61	188	0	150	150	127	211	338
19	Kandal	99	17	2	19	138	107	245	0	258	258	155	367	522
20	Stung Treng	12	0	0	0	84	21	105	0	89	89	84	110	194
21	Kratie	30	3	0	3	146	40	186	0	210	210	149	250	399
22	Ratanakiri	16	1	0	1	123	9	132	57	27	84	181	36	217
23	Mondolkiri	11	0	0	0	47	22	69	0	67	67	47	89	136
24	Preah Vihear	27	5	1	6	150	13	163	0	142	142	155	156	311
Total		**1,119**	**135**	**25**	**160**	**3207**	**1202**	**4409**	**57**	**4175**	**4232**	**3399**	**5402**	**8801**
Percentage Female				**19%**			**27%**			**100%**			**61%**	

H.3.2 Health Workers by Age Bracket

Provincial Hospital - Health Workers by Age Bracket

No	Provinces	No. of Provincial Hospitals	Doctors					Nurses					Midwives				
			Age Bracket					Age Bracket					Age Bracket				
			20-30	30-40	40-50	50-60	Total	20-30	30-40	40-50	50-60	Total	20-30	30-40	40-50	50-60	Total
1	Battambang	1	6	17	27	12	62	26	14	63	37	140	17	5	32	22	76
2	Banteay Meanchey	1	2	10	8	8	28	11	8	26	6	51	25	4	16	2	47
3	Otdar Meanchey	1	4	7	2	1	14	14	8	8	3	33	4	6	0	0	10
4	Siem Reap	1	4	14	27	12	57	26	6	30	21	83	9	9	10	17	45
5	Pursat	1	3	5	14	2	24	11	9	8	13	41	4	4	4	15	27
6	Kampong Chhnang	1	6	15	7	3	31	29	12	9	24	74	21	4	11	3	39
7	Pailin	1	4	15	1	0	20	14	9	13	2	38	11	6	1	1	19
8	Kampot	1	6	15	3	3	27	16	15	17	35	83	9	14	5	5	33
9	Sihanouk Ville	1	1	13	11	4	29	7	16	10	27	60	11	2	11	8	32
10	Koh Kong	1	5	9	2	1	17	9	9	3	4	25	3	1	6	2	12
11	Kep	1	2	7	3	0	12	10	1	0	0	11	9	0	1	0	10
12	Takeo	1	5	15	17	9	46	34	37	35	30	136	20	7	12	3	42
13	Kampong Speu	1	1	11	13	6	31	11	8	14	18	51	4	2	5	3	14
14	Kampong Cham	1	9	18	14	19	60	43	31	24	26	124	16	13	10	16	55
15	Kampong Thom	1	6	11	23	3	43	12	6	10	22	50	7	3	5	6	21
16	Tboung Khmum	1	1	7	3	4	15	8	8	2	6	24	8	3	4	2	17
17	Prey Veng	1	3	7	8	0	18	4	1	8	13	26	6	2	9	6	23
18	Svay Rieng	1	4	12	8	3	27	19	15	14	18	66	8	1	2	9	20
19	Kandal	1	9	14	20	8	51	23	20	18	25	86	18	10	3	5	36
20	Stung Treng	1	3	13	2	0	18	12	15	11	5	43	19	4	10	1	34
21	Kratie	1	2	11	4	2	19	13	19	26	11	69	4	8	5	3	20
22	Ratanakiri	1	3	12	2	3	20	10	14	7	5	36	13	6	2	5	26
23	Mondolkiri	1	3	9	1	0	13	10	5	7	6	28	4	3	4	1	12
24	Preah Vihear	1	2	11	4	3	20	6	16	5	5	32	11	7	6	11	35
	Total		**94**	**278**	**224**	**106**	**702**	**378**	**302**	**368**	**362**	**1410**	**261**	**124**	**174**	**146**	**705**
	Percentage per bracket		**13%**	**40%**	**32%**	**15%**	**100%**	**27%**	**21%**	**26%**	**26%**	**100%**	**37%**	**17%**	**25%**	**21%**	**99%**

Referral Hospitals (RH)_Health Workers by Age Bracket

No	Provinces	No. of RH	Doctors					Nurses					Midwives				
			Age Bracket					Age Bracket					Age Bracket				
			20-30	30-40	40-50	50-60	Total	20-30	30-40	40-50	50-60	Total	20-30	30-40	40-50	50-60	Total
1	Battambang	3	8	8	6	4	26	28	20	48	7	103	15	12	13	10	50
2	Banteay Meanchey	5	15	19	10	3	47	20	20	55	22	117	42	13	25	6	86
3	Otdar Meanchey	1	5	0	0	0	5	7	3	4	2	16	6	1	1	0	8
4	Siem Reap	4	7	15	6	0	28	19	16	12	9	56	11	5	9	2	27
5	Pursat	3	4	5	1	0	10	8	9	7	4	28	9	4	1	7	21
6	Kampong Chhnang	2	3	9	3	0	15	19	12	4	3	38	0	0	0	0	0
7	Pailin	0					0					0					0
8	Kampot	4	8	10	7	3	28	25	17	25	13	80	17	12	3	0	32
9	Sihanouk Ville (No RH)	0					0					0					0
10	Koh Kong	1	2	3	2	1	8	6	5	0	2	13	6	2	0	3	11
11	Kep (No RH)	0					0					0					0
12	Takeo	5	14	16	10	1	41	47	58	11	6	122	40	19	5	6	70
13	Kampong Speu	3	8	11	4	6	29	14	9	13	10	46	41	14	9	3	67
14	Kampong Cham	6	13	14	18	3	48	41	19	21	5	86	34	18	10	3	65
15	Kampong Thom	2	10	8	10	2	30	15	9	8	2	34	0	5	6	4	15
16	Tboung Khmum	5	8	40	9	1	58	53	25	11	3	92	42	20	3	4	69
17	Prey Veng	9	18	19	17	5	59	53	29	23	13	118	87	14	14	4	119
18	Svay Rieng	4	8	19	3	1	31	29	7	6	14	56	35	4	1	2	42
19	Kandal	10	18	27	24	10	79	59	25	17	16	117	75	21	3	5	104
20	Stung Treng	0					0					0					0
21	Kratie	2	7	6	2	1	16	12	19	8	3	42	16	5	2	1	24
22	Ratanakiri	1	3	5	0	0	8	2	5	0	2	9	5	6	1	0	12
23	Mondolkiri	1	2	4	0	0	6	6	1	2	2	11	6	1	0	1	8
24	Preah Vihear	1	4	1	0	0	5	4	2	1	3	10	9	1	1	0	11

Total	**72**	**165**	**239**	**132**	**41**	**577**	**467**	**310**	**276**	**141**	**1194**	**496**	**177**	**107**	**61**	**841**
Percentage per bracket		**29%**	**41%**	**23%**	**7%**	**100%**	**39%**	**26%**	**23%**	**12%**	**100%**	**59%**	**21%**	**13%**	**7%**	**100%**

Health Centers - Health Workers by Age Bracket

No	Provinces	No. of Health Centers	Doctors					Nurses					Midwives				
			Age Bracket					Age Bracket					Age Bracket				
			20-30	30-40	40-50	50-60	Total	20-30	30-40	40-50	50-60	Total	20-30	30-40	40-50	50-60	Total
1	Battambang	79	5	5	4	2	16	68	92	92	82	334	143	87	80	45	355
2	Banteay Meanchey	66	0	0	0	1	1	59	39	101	54	253	104	61	58	15	238
3	Otdar Meanchey	34	10	0	0	1	11	73	9	32	18	132	80	24	5	7	116
4	Siem Reap	89	2	1	1	0	4	101	63	85	34	283	146	64	37	17	264
5	Pursat	40	0	2	1	0	3	38	19	42	32	131	70	40	32	15	157
6	Kampong Chhnang	41	0	0	3	0	3	72	31	48	42	193	72	19	40	26	157
7	Pailin	6	0	1	1	0	2	26	21	7	5	59	13	8	2	0	23
8	Kampot	59	0	3	6	2	11	96	75	56	54	281	146	62	31	18	257
9	Sihanouk Ville	13	6	2	4	2	14	27	21	18	22	88	35	20	6	6	67
10	Koh Kong	12	2	3	1	0	6	33	13	4	9	59	47	12	3	5	67
11	Kep	4	1	0	0	0	1	15	2	5	1	23	21	6	2	0	29
12	Takeo	79	0	4	8	4	16	68	75	72	53	268	165	122	39	23	349
13	Kampong Speu	54	0	5	6	2	13	58	56	67	55	236	117	47	24	22	210
14	Kampong Cham	87	0	0	2	0	2	64	47	92	33	236	129	61	48	22	260
15	Kampong Thom	52	3	1	5	2	11	77	36	35	48	196	106	28	24	32	190
16	Tboung Khmum	63	0	2	1	3	6	78	45	40	16	179	135	62	16	4	217
17	Prey Veng	103	0	5	5	1	11	125	89	88	68	370	149	53	52	22	276
18	Svay Rieng	43	0	0	0	0	0	56	26	33	73	188	101	35	3	11	150
19	Kandal	99	0	7	8	4	19	94	86	36	29	245	147	60	22	29	258
20	Stung Treng	12	0	0	0	0	0	40	36	20	9	105	45	30	9	5	89

21	Kratie	30	2	1	0	0	3	61	64	48	13	186	111	67	18	14	210
22	Ratanakiri	16	0	1	0	0	1	37	46	18	31	132	42	25	8	9	84
23	Mondolkiri	11	0	0	0	0	0	23	27	12	7	69	39	24	1	3	67
24	Preah Vihear	27	1	4	1	0	6	63	70	21	9	163	81	43	8	10	142
	Total	1,119	32	47	57	24	160	1452	1088	1072	797	4409	2244	1060	568	360	4232
	Percentage per bracket		20%	29%	36%	15%	100%	33%	25%	24%	18%	100%	53%	25%	13%	9%	100%

H.4 FGD UHS

FGD UNIVERSITY HEALTH SERVICES (UHS) MAIN CAMPUS		
FGD Questions	**Doctor Students (3 groups, 6 participants)** **17 Dec. 2019 (04:00-5:00 pm)**	**Combined Teaching Staff (18 participants)** **17 Dec. 2019 (04:00-5:00 pm)**
1. What can be done to promote the gender balance in the enrolment for nursing and midwifery?	•Give priority to women during, equal number of quota given to women during National Entrance. •Inform women about group during National Entrance (NEE) •Provide accommodation female students •Provide access to equal opportunity for woman •Provide baby care for female doctor in the work place •Access to information related to medical journey (school to hospital++ through any means	•Government should give opportunity to students to work •Government to open more places for job for medical graduates •Increase salary for medical workers
2. What can be done to promote the enrollment of more ethnic minorities as nurses and midwives?	• Provide document related to ethnicity to • Provide scholarship for Ethnic minority (Tuition, accommodation and food • Priority in work hiring • Financial support • Job guarantee back to serve to their own community • Promote equity and equality	• Give priority, support, provision of jobs to IPS Medical Graduate- send them back to their communities • Partner with ORG working with IPs in terms of foundational education to enable IPS cope competitive in Medical Entrance Exam.
3. What can be done to promote the enrollment of more persons with disabilities as nurses/midwives?	• Building should be friendly to PWD • Signs for PWD for CR, stairs • Support equipment for PWD	• To add curriculum responding the needs of PWD, responsive to their physical psycho emotional needs & wellbeing of PWD a
4. What can be done to make sure the curricula for nursing and midwifery education is more responsive/inclusive to better include vulnerable	• Focus on family medicine, include family care in the curriculum • Make doctor more inclusive (behavioral sciences +community-based education-student support services	• Offer more English classes for medical students • Medical classes are in French is mainly used for Medicine and Pharmacy • Nursing and midwifery are in English teaching

groups (poorest of the poor, disable, mental disorders, street children, SOGI, etc.)?		
5. What can be done to make sure the curricula for nursing and midwifery education promote environmental sustainability (better treatment of medical waste, occupational health and safety, etc.)?	• Government police requiring medical Doctor Graduates will be required to work in the countryside for 2 years (support housing, living allowances) • Make doctor more environmental sustainable(equip and empower students with knowledge and skills related to Environment i.e. infection control, and waste management; study tour to communities/facilities related to environmental protection • Short course on how to manage Materials and infection control The subject on SOGIE, PWD, Environment etc could be embedded in the curriculum or create another media such as exposure visit/trips, fora, workshop, awareness raising activities, etc. in order to *concientisize* the issues among medical students	• Government schools to provide more scholarship for poor people • Research on people who suffered for medical waste hazards • To improve the KSA on environment specifically of medical health hazards. • CRC in charge of collecting processing the medical wastes, in the provinces medical waste are collect or sent to PHD. (Incinerators) • Train medical workers staff working in clinic • Improve the implementation/enforcement of PPE and waste disposals

FGD UNIVERSITY HEALTH SERVICES - TSMC CAMPUS		
FGD Questions	**Nursing Students (participants)** **17 Dec. 2019 (02:30-3:30 pm)**	**Midwifery Students (21 participants)** **17 Dec. 2019 (02:30-3:30 pm)**
1. What can be done to promote the gender balance in the enrolment for nursing and midwifery?	•nursing work need men as they have more strength and more rational •tell them the advantages of studying and the role of nurses •	•Open school for male midwifery •Encourage men to register as men •WS for male •Advertise, give them the value of this job •Encourage men that midwifery can also be good midwives, they are stronger and wiser •Change the Khmer stereotyping. Make video that men can also work as midwife

2. What can be done to promote the enrollment of more ethnic minorities as nurses and midwives?	• Information dissemination of the nursing course among the IP communities • Scholarship for IPS • Benefits of taking up nursing	•Identify traditional midwives and train them in the RTCS •Inform advertise through social media •Encourage Ethnic and give equal opportunity •Minimize if not eliminate discrimination in the society •Full scholarship for IP(Tuition and living allowance •Family-based promotion among IPS to make them aware and to encourage them to send their children to study midwifery
3. What can be done to promote the enrollment of more persons with disabilities as nurses/midwives?	• Info dissemination among the PWD • Minor disability are able to work as nurse	• Institute should give opportunity to PWD to get a job • Scholarship for PWD
4. What can be done to make sure the curricula for nursing and midwifery education is more responsive/inclusive to better include vulnerable groups (poorest of the poor, disable, mental disorders, street children, SOGI, etc.)?	• Nursing service is for all kinds of people…serve with fairness and justice	• Scholarship for the poor • Midwifery should have code of ethics • Follow the policies of health • Midwives to have the mindset of inclusiveness to all people/ sector especially to the disadvantaged groups
5. What can be done to make sure the curricula for nursing and midwifery education promote environmental sustainability (better treatment of medical waste, occupational health and safety, etc.)?	• Add environment subject in the curriculum • Exposure to environment related activities • Waste sorting, recycle, wastes	• Same with others • Information dissemination, educate people, awareness raising on environments concerns and apply

FGD with UHS Decision Makers 4:00-5:00 pm 17 December 2019	
-Which are the main ways students and teaching staff can participate/been consulted in the decision making of the Faculty?	• Orientation meeting at the beginning of every semester for every class and one Students general meeting at the end of the school year are venues where students could ask clarification on the school program, policies and regulations, they could also raise feedback and concerns related to the previous semester/year. • Each faculty has student association where they elected class representatives. The class

	representatives choose from among themselves the faculty representative who participate in the UHS planning and strategic workshops. • UHS Formulation of Strategic Plan 2019-2023 was with the participation by faculty and students representatives. • Each faculty conducted consultative meeting with the teaching staff and with the student body. The faculty dean brings up the issues and concerns to the management level for deliberation and for action.
-Have the students/teaching staff any possibility to evaluate/influence the contents of the curricula?	• Curricula for medical courses are regulated by MoH and the UHS has to stick on it, curricula however was designed 12 years ago in 2007 and there are many new and updated medical concepts and technologies that UHS need to be at pace with. UHS has adopted the national program and international program • Monthly staff meeting by department to evaluate and discuss how to improve teaching content and materials.
-Is there in place any mechanism to raise feedback and complaints? In case it is: how is it working?	1. UHS has three level complain pathway: • 1st level: aggrieved students raise their complaints to →class representative, if not resolved → faculty, if not resolved →Dean • 2nd level: if not resolved at the Dean level, the aggrieved party raise the complaints to the Student Affaire Rectorate • 3rd level: if not resolved at the SA Rectorate the complainant can raise the complaint to the UHS Rector by dropping a complaint letter at the complaint box. The complaint box is made of glass and is installed in a place where the UHS Rector could see before reaching his office, Only the Rector has the key of the complaint box and when he see any letter in the complaint , he has the responsibility to respond and take action on it. 2. UHS has website and Face Book account, some students raise their feedback and concerns by means of these social media. 3. Evaluation of Teachers by the students (using the evaluation forms) which purpose are: • To improve the teaching methodology and course content • Basis for selection of the “Best Teacher”
-Is there in place any specific provision to promote safety and health at work? And easy accessibility for PWD?	• All regular staff of the university have Health Card from the National Social Security Fund (NSS) for free or subsidized medical treatment. Health Care was issued in the Rectangular Strategy Phase III of the Royal Government and established by Sub-Decree No. 01 SD.E, dated 06 January 2016, concerning the Establishment of Social Security Scheme on Health Care for Persons Defined by the Provisions of the Labour Law. The implementation of social security schemes on Occupational Risk and Health Care is two consistent mechanisms because health prevention of

	workers shall not only receive disease or injury treatments due to work but also include the prevention of personal health or non-work injury. The implementation of both schemes is a mutual connection and has a comprehensiveness to protect workers. • Both of UHS campuses (main campus and TSMC campus) have dispensary clinics for students and faculty staff. There are also first aid units for each of the faculty building, laboratory and for the campus administrative building. • Each laboratory has safety regulations which are discussed with the students at the start of their laboratory classes/course. • UHS also installed lift for their high story building for easy accessibility for PWDs, pregnant staff and students • There are also fire hydrants at the campuses and fire training drills are conducted with faculty staff and students. • Handicap International provide training workshops for students on road accidents and Red Cross Cambodia conduct first aid training for interested students, UHS encourage all students to attend the first aide training.
Is there in place provisions to promote fair treatment, nondiscrimination and equal opportunity of students/teaching staff?	• UHS is open for all qualified students regardless of ethnicity, religion, sexual orientation, physical form as long as they pass the National Entrance Examination and have finished Grade 12 education. • Promotion of teaching staff are based on qualification and tenure. • UHS also provide prayer room for the Muslim Cham students and employees
-Is there in place provisions to prevent and address harassment, intimidation and/or bulling of students/teaching staff?	• Harassment, intimidation and bullying are not tolerated and are against the UHS code of ethics. • Any cases of harassment and intimidation are to be reported to the school authorities through the faculty dean, the Student Affairs office and if needed to the UHS Rector.
-What you consider can be done to promote inclusion as students and faculty member (e.g. more ethnic minorities as students/teachers or more women at management level)	• UHS believes in inclusiveness and non-discriminatory to any qualified students and teaching staff, in fact there students with physical deformities that are enrolled at the university. IPs, Cham, LGBT and PWD are welcome to study and work at UHS as long as they pass the national entrance test. • Scholarship for poor students (8-11 slots) supported by charity foundation • There are two women in the management level of UHS. RGC promote women in leadership and management but at this point, the number of women in the leadership is still low, UHS would welcome more women on top position.
Others; How to improve the curriculum that is responsive to	1. UHS follow the National Curriculum by MoH which was since 2007, however faculty staff modify the implementation to make the course updated and responsive to current need and technological advancement.

	2. There is a need to revise the current curricula and upgrade them into "competency-based curricula" but need the external Medical Curriculum Expert/s who could give practical inputs and who would facilitate discussions and workshops with UHS and other Medical schools and with MoH in designing the international best practice - competency-based curricula that is tailored fit for Cambodia context. 3. The medium of instruction at UHS are French English and Khmer.

H.5 FGD Stung Treng RTC

FGD with Students and Teachers			
FGD Questions	**Nursing Students (22 participants- 5 groups)** **9 Dec. 2019 (10:00-11:00 am)**	**Midwifery Students (10 participants- 2 groups)** **9 Dec. 2019 (10:00-11:00 am)**	**Combined teachers for Midwifery and Nursing** **9 Dec. 2019 (11:00-12:00 am)**
6. What can be done to promote the gender balance in the enrolment for nursing and midwifery?	• There are a number of male nursing students at STR_RTC • Advertise the nursing course, opportunity for work, benefits • Men is strong and make nursing care improved • 3 years only short to get a profession • Proactive promotion of nursing enrollment among male year 12 students • MoH increase the number to absorb nurses in the public health institutions (HC, RH, PH)- mention by all 5 groups • Increase salary of nursing staff (current $300/mo) to be attractive to men	• Men midwives are better in managing emergency cases, stronger in carrying the women during birth delivery, men are not scared, can be more rational and quick in making decisions during emergency • Special scholarship for male midwifery students • Men can be encouraged to take up midwifery as there are also male doctors conducting birth delivery. • Breaking cultural barrier of "shame" and the mindset that "midwifery is the women's work" • Motivate men, "I'm a man, I am strong, I can do it" • Sports activities/competition at school to attract men to study at RTC	• Nursing students have both men and women students, only midwifery students are all women. • Cambodian Law does not prohibit men to become midwives, however, it had not been encouraged for men to train for midwifery. • Culturally, women and also husbands would not be comfortable to have male midwives to assist during birth delivery unless it is emergency no other choice • Men could be good midwives because there are also many male doctors in Cambodia who do birth delivery of babies. • It needs to be promoted and accepted for male midwives but maybe it will take

		•Men as midwives can help their own family and their community	time
7. What can be done to promote the enrollment of more ethnic minorities as nurses and midwives?	• Information dissemination among high schools at the provinces with many ethnic minorities about Stung Treng RTC program and medical courses offered and to encouraging the IP students to enroll • Poor high school training in remote areas make it difficult for IP students to pass the national entrance exam for medical course • Discrimination at school, makes the IPS students ashamed to be identified as IP, fear of being looked down or discriminated. • Working with government need to take the civil service exam • Special scholarship for IP students, ensure non-discrimination for the IP students • Free to study at RTC, make billboards with message such as "minority can study nurse at RTC" • For not so smart IPs but are interested to study nursing, to provide extra or remedial tutorial to cope with the nursing course.	• Proactive promotion among the IP communities about the opportunity to study nursing at RTC • Graduates to be assisted to get the job as nurse, make it easy for the IPs to get work to help family and also the community • Partner with organizations/NGOs working among the IP communities, in encouraging and promoting enrollment among the IP's high school graduates to study nursing at Stung Treng RTC • Advocate and promote the IPs, educate them, strengthen • Health post at the IP community to promote awareness and interest among them to send their children to midwifery school • Fundraising to support the poor, orphan and IPs for medical education • Acceptance and tolerance for the IPs • RTC has dormitory free for IPs, have full scholarship for IPs • IP medical graduates to be assured of work and be assigned back in their communities.	• There are around 10 IP students currently enrolled at Stung Treng RTC and they assimilate with the Khmer students • The constraints for IPs to study nursing is passing the national entrance exam and national exit exam, • National exit exam (NEE)s are taken at Phnom Penh, students from RTC Stung Treng are at disadvantaged as they have to travel far, spend more money, adjust to environment of the city. • Suggests for NEE to be conducted at Stung Treng RTC or at Kampong Cham RTC to be nearer to the examinees • Intentional promotion of enrolment to midwifery among the IP students at the high school campuses

8. What can be done to promote the enrollment of more persons with disabilities as nurses/midwives?	• There are some nursing students with physical disability enrolled at RTC • Promote medical courses among the PWD groups and offer scholarship and support for them • Make classroom and facilities conducive for the PWD (PWD friendly school facilities) • Assurance of work for PWD medical graduates • Atmosphere of tolerance for PWD, in the school • Full scholarship for the poor and deserving students, PWD	• PWD can study at RTC like normal students, motivate and give priority to PWDs • Give work opportunity for PWDs when they finished their nursing course • No discrimination, give priority for PWD, motivate PWD to study • Motivate the PWD to study as midwife, make the atmosphere conducive for learning, update quality of teaching • Acceptance and tolerance • Exposure trips to PWD Centers. • Encourage participation in by these vulnerable groups	• The school is open to accept the PWD students as long as they pass the qualification requirements • There has been a decrease in the number of students enrolled at RTC Stung Treng. Students feel it is difficult as there are many exams and it is not easy for them to pass the national exit exam • Currently RTC offers free tuition, free housing (1 dormitory for boys and 1 dormitory for girls, however the space is not enough to accommodate all students, some students stay in the boarding houses near the school campus. •
9. What can be done to make sure the curricula for nursing and midwifery education is <u>more responsive/inclusive</u> to better include vulnerable groups (poorest of the poor, disable, mental disorders, street children, SOGI, etc.)?	• Medical outreach of students to the areas with vulnerable groups • Include in the curriculum, how to deal, manage, treat and care for the persons from vulnerable groups (mental disorders, PWD, SOGI) • Request for MoH to prepare fundraising to support the vulnerable groups (similar to that of like Kontha Bopha) • Advertise nursing is free for top 30 of the year 12 graduates • No discrimination, extra care for the vulnerable • Fair treatment, boost the morale of PWD enrolled in nursing	• Soft skills course (behavioral science course) for medical students to have the right attitude in dealing and treatment of the vulnerable people group. • Evaluate the curriculum if respond to Q4 and upgrade if needed • Provide nursing care for the vulnerable groups in the same manner with the normal people and even extra care for them to boost their morale • Provide free medical treatment for vulnerable people • Open information to the community to all people for acceptance of vulnerable people and discourage discrimination • Cut down mortality rate of mother and child during birth delivery	• The curricula used at RTC are prescribed from MoH which is not updated since 2007. The curricula are time-based are and adopted from other countries, they need to be upgraded into competency based curriculum (CBC) • Need to revise the curriculum using best international practice but responding to the local context.

		• Free schooling for the vulnerable group	
10. What can be done to make sure the curricula for nursing and midwifery education promote environmental sustainability (better treatment of medical waste, occupational health and safety, etc.)?	• Greening of the school campus, planting of more trees as part of students social activities • At school wastes or garbage are normal, only at hospital practice that have medical wastes which are sorted as contaminated and non-contaminated. Contaminated wastes are burned in the incinerator, non-contaminated wastes are sorted out to be recycled or to be buried or decomposed • Implement and apply what have been learned in the school on medical waste management and PPE rule of the curriculum garbage bin for general and clinical waste, practice the proper waste disposal, • Maintain Clean the room regularly, sign board to promote clean and sustainable environment	• Social outreach for students to clean the public places • Environment awareness raising activities environment • Promote the practice of daily hygiene, sign for dust bin of proper waste disposal, segregation of wastes • Minimize, cut down of using plastic, join or promote tree planting activities, the importance of maintaining the forest • Stricter the rule and implementation of environment , • Start from self in the environment protection conservation • Sorting of wastes • Explain to medical staff and patients about health and hygiene in each department	• Personal Protection Equipment (PPE) not enough, lack of material support at school. • Curriculum not clear on PPE, • Waste disposal system at school use, incinerator for burning, burry and recycling

Interview with RTC Director: Tek Leng Soeu Dec 9 2019 (11:00-12:00 nn)	
-Which are the main ways students and teaching staff can participate/been consulted in the decision making of the Faculty?	- During the orientation meeting at the beginning of every semester, there is venue where the teachers and the students express their concerns regarding the school policies. - There is the student council elected by the students and every class elect their representative, these student representatives and leaders bring the concerns of the students to the school management. The student leaders also join the meetings of the RTC management whenever there participation are needed or when there are concerns affecting the students.

	- For teachers they have periodic meeting with the faculty dean and whatever issues plans they discuss, the dean brings up to the upper management of the RTC. In the same manner, whatever are discuss in the management level, the dean would inform to the teachers.
-Have the students/teaching staff any possibility to evaluate/influence the contents of the curricula?	The school has just follow the curricula provided by MoH, but in the implementation, the teachers supplement the teaching materials with updated teaching content and materials. The RTC Director had also translated the teaching materials from English to Khmer. The RTC had joined the workshop for curriculum assessment conducted by MoH.
-Is there in place any mechanism to raise feedback and complaints? In case it is: how is it working?	Feed backing and complaints are done in several ways: 1st level- students/teacher could bring their concerns/complain to their class level then to the faculty dean level 2nd level- students/teachers bring up the concern to the RTC Director - Complain box is provided for those who want to give feedback and complain but don't want to be identified, this medium is not used much. - Complaints and feed back via Face Book Messenger and or Telegram. Complaints are resolved by level it is raised to, those which are not resolve at the lower level are resolve at the Directors level. The use of social media has given opportunity for students and teachers to bring up their feedback to concerned person, office.
Is there in place any specific provision to promote safety and health at work?	All regular RTC staff have the National Social Security Fund card, which they can use for health care (hospitalization). Safety rules and guidelines are implemented such as having fire extinguishers in the classrooms and offices Personal Protection Equipment for students and teachers during Clinical Practice at hospital (this however is limited) Safety rules, health and hygiene, health hazards are discussed during the orientation at the beginning of the semester
-Is there in place provisions to promote fair treatment, nondiscrimination and equal opportunity of students/teaching staff?	The RTC provides equal treatment for all students and teaching staff. Follow the guidelines of the RGC labour law for the RTC work force. IP students are given priority in the dormitory accommodation.

How to improve the quality of Pre-Service Training for Health Workers?	1. Quality of teachers – need capacity development Trainer teacher (preceptors) paid 2,000 Riels per hour (same since 1996) Policy to encourage to increase compensation rate of preceptors The compensation is low affecting the quality of teaching 2. Materials and equipment - Books are of mix language - All teaching documents are English or French, either to translate books into Khmer or the students' language proficiency need to be improved - Create a committee to translate the teaching materials and documents into Khmer - Standardize teaching materials and translate to Khmer. - Include English subject in the curriculum but the constraints at Stung Treng is the availability of good English teachers and the salary for those teachers 3. Students' problem - after finishing nursing or midwifery course, no work available for them - decrease in the number of students studying at RTC because no job after they graduate, there is limited recruitment of government, low salary, competition among nurses and midwives is high - Hiring of nursing and midwifery graduates is limited and salary with private clinic is lower - Needs Policy on minimum wage standard - Increase recruitment for private clinics – but no standardized policy on minimum standard policy - $120/month salary for private clinics (20 hour work/day) - $250/month salary for government but limited hiring
-What you consider can be done to <u>promote inclusion</u> as students and faculty member (e.g. more ethnic minorities as students/teachers or more women at management level)	Partner with organizations assisting the IPs in information dissemination and in promoting the health course and introduce to them the opportunity to study at RTC. Provide information about RTC to secondary schools in the provinces of Ratanakiri, Mondolkiri, Kratie, Preah Vihear, so that students especially the graduating once would know about Stung Treng RTC. The Dean for Midwifery and Nursing are women.
Other issues:	To enter the medical profession, the students need to take several qualifying exams: - National Entrance Exam - National Exit Exam

	- Exam to enter work with government These exams are theoretical and are of multiple choice questions (MCQ), the quality and type of exam need to be reviewed and improved and with practical exam - Professional Councils to oversee (prepare and conduct) the National Exit Exam (NEE) for their line of profession, i.e. NEE for Nursing to be taken cared by the National Council of Nurses, the same with Medical Doctors and Midwifery. Examinations, Evaluation and Accreditation should be by the respective professional Councils After passing the NEE. MoH issue the certificate but where to register? How to guarantee the quality/qualification of the medical professional? RTC suggests but not being listened to by the upper level

H.6 FGD Khmer-Soviet Friendship Hospital

FGD Khmer Soviet Friendship Hospital, 16 December 2019 (2:30-4:30)

Questions	**Nurses (20 Participants)**	**Midwives (20 Participants)**
1. Existing practices of Clinical Hazardous waste management system, Occupational health safety	- Medical waste Sharp wastes-safety box (burn), tissues-yellow plastic (burn) chemical waste(burry), radioactive waste (burry) - General waste (black plastic/ bin) to Cintri truck (garbage collection truck)	- Hospital provide PPE (masks, gloves, apron) but midwives don't like to use them - Infection control, always give training but when check/ monitor, the midwives do not apply - Not enough garbage bin (only 2 (yellow, green) so difficult to sort out wastes, request to upper level but no response
1.b occupational health and safety	- Follow the RGC law - PPE (old, goggles not clear, not enough), PPE are limited, nurses have to provide for their own to keep them safe while performing the duty.	-
2. Labor Management	- Hospital must have training course for nursing staff to upgrade clinical skills - Frequency should be often 2 local training, 1 international exposure training. - CPD is ongoing as required for Nursing License with the National Council for Nurses)l	- Russian hospital is higher standard 2nd to Calamet Hospital, strict in recruiting the staff, qualified. - Advertizee, interview, exam select, hire - New heard, orientation on hospital policy, JD, - For regular staff CPD 2 times a year in the hospital and international training for the selected staff - -promotion- discussed at management level, interview, observe, performance, give project assignment - retirement (70% of monthly salary+ NSSF card and send off party)
3. Stakeholders engagement	- Hospital Partners (PSE, INP, CCF, NSSF, H.EQIP, EDC, Operation Smile, Friends International)	- Small group discussion at lower level, to upper level if not resolve up to the board level (related to the budget)
4. Grievance Mechanism	- **<u>More security guards during night shift</u>** - Hospital to motivate good performing staff with rewards and incentives - Complains are channeled through chief of department - Want to train abroad - Complain box but seldom used as channel to complain.	- Complain to file, service department head to the board - Complain box - Complains include: - Work overload - Hard work, no rest so many patient, asks - No complain about sexual harassment

5. Recommendation to improve the pre-service training for Health Workers	- Increase hourly rate for Preceptors (clinical teachers) as it is very low. - Medical students are more advance in information technology, they search information on internet than learning clinical practice at hospital. Clinical Teachers need to be updated with advance medical practice through training workshop	- Not all students are serious in clinical practice, National Exit Exam to include practical exam on clinical work ex. filling up of patients form, getting of vital signs of patients, prenatal check, and other necessary clinical practice.

Con't. FGD Khmer Soviet Friendship Hospital, 16 DECEMBER 2019, 2:30-4:30

Questions	Doctors (10 Participants)	Decision Makers (10 Participants)
1. Existing practices of Clinical Hazardous waste management system, Occupational health safety	Medical Waste: -contaminated waste (with blood stains and fluid stains) burned in the incinerator. -non-contaminated wastes are sorted out at workplace then to waste management facility Non-medical waste are disposed to Cintri garbage truck	- The hospital follow the Australian protocol and guidelines on waste management and disposal and pollution control- the staff in-charge are trained on environmental protection, pollution control and waste management and disposal - On waste disposal → garbage bins are labeled for clinical waste and for non-clinical waste. For clinical waste bins there sub-label for contaminated waste and non-contaminated waste. Hospital employees and patients are guided how and where to throw their wastes. The hospital cleaners collect wastes, sort them out. Non-clinical waste are disposed to garbage collection truck. Clinical wastes ate brought to the waste management facility.
1.b occupational health and safety	Occupational Health safety: - radiation protection at operating theater (OT) not meeting the radiation protection standard, need to improve wall with radiation protection - need to upgrade clinical protection, supplement the	- The hospital follow the Health guidelines on Personal Protection Equipment (PPE). The hospital provide the PPE to health workers but some health workers do not use them all the time.

	lacking clinical supply and to upgrade the OT	
2. Labor Management	- Competency upgrading ex. Implementation of safety procedure. - Continuing Professional Development (CPD) done by medical Professional Councils 2-3 times/year on rotation per province. - Teach, present, listen attend workshops local and abroad) - Nurses training are general-recommend to specialize nursing training. - Most staff are happy, hospital pay higher that labor law (5 times higher) - hospital operate as semi-private	- The hospital follow the Cambodian Labor Law, all regular staff are have the National Social Security Fund (NSSF) card which entitle them for medical care/medical insurance. - Staff on probation period are not provided with NSSF Card but the hospital provide them free medical care and treatment when they are sick - All staff regular and contractual) sign contract with the hospital. - Regular staff renew contract on a yearly basis, the hospital submit the names of staff to MoH for approval as per recommendation of the hospital management based the staff performance evaluation.
3. Stakeholders Engagement	- Hospital Annual Meeting, Hospital management attended by Department heads and Board of Directors (BoD)	- The relationship between and MoH (regulatory) → Medical School (train medical workforce → Hospital (absorb Health workforce) is already working but need to be strengthened and improved in terms of information sharing - Constraints → everybody are busy with their own activities and targets - This "Pre-Service Training for Health Workers" could be a venue for this key stakeholders to meet together and do the "SWOT" analysis of the for Cambodia's Health Workers
4. Grievance Mechanism	- Complaint Box - There is a grievance mechanism but seldom that there is a complainant - Most staff prefer to keep silent but share the issues with co-workers	- There is a grievance mechanism in place at the hospital but rarely do people made a complaint.

5. Recommendation to improve the pre-service training for Health Workers	- Teaching and evaluation of medical students must be serious-those who does not qualify (theory, practice and behavior) should not be allowed to go up to the next year level. - Medical student needs seriousness, discipline and hard work because we deal with people's lives). - There are cases of nurses who are not qualified yet to work-very low knowledge, skill and not good attitude but able to graduate. Difficult for doctors to work with them - More practical experience or exposure to clinical practice in hospital.	- Medical Schools and hospital to talk and discuss on how to make the hospital internship of students effective and useful. - Medical schools should get feedback on students internship performance (absenteeism, lack of interest) - The time frame of internship is sometimes shorter than the planned time frame. Internship is delayed due to official letter. - Time is short for clinical practice, practicum is low quality. - Students undertaking internship are preoccupied with OSCE as they are concerned with passing the National Exit Exam. The practical experience or clinical practice are left behind. - Recommend for Theory and Practice for National Exit Exam, i.e. to add

H.7 FGD PPCIL (PWD)

FGD- PPCIL (PWD), 13 December 2019 (2:30-4:00)	
Phnom Penh Center for Independent Living (PPCIL) is founded by Cambodians with disabilities led by Mr. Mey Samit and promotes rights based approach to disabilities and development aimed at empowering disabled persons through the independent living movement. PPCIL Believes that the most effective way to bring about lasting social change is to promote equal opportunities for disable persons through independent Living movement.	UNICEF support for PWD healthcare and rehabilitation, project and services in areas of: - Information - Personal assistance from home to HC - ID Poor for easy access to health services
	- PPCIL has 15 staff, 10 of them have disability, all 15 staff have National Social Security Fund (NSSF) by RGC and Ministry of Labor (MoL) to cover work accident and health insurance, premium paid by PPCIL for group insurance for 15 staff ($80-$90/month) 10 - ID Poor identification card for PPCIL communities in 15 Sangkat from 5 district in Phnom Penh and Kandal province. 2 Sangkat are supporting the PPCIL with $75/person/month from the Commune/Sangkat Fund, 2 PWD per Commune/Sangkat with severe disability are recipient of the C/S Fund support Direct beneficiaries 90 PWDs of which 35% are female, medical care with Health Centers (HC) For common sickness → support on medicine is $5/month For serious cases → ask donation from donors (Japan, UK) - Rehab: PPCIL staff help to bring PWD Beneficiary to HC or clinic with PWD easy accessibility Tuktuk (motorcycle trailer)
	- Personal assistance service: 2 days/week to wash hair, assist in shower, change clothes @ least 2-3 times per week

	- Going out for exposure and live better
	- PWD have chance to work with PPCIL for advocacy work, negotiate with government specifically with the Ministry of Social Affairs (MoSA)
PWDs challenges for going to get medical treatment	Inability to take care of self and limited mobility: - Problem of accessibility - Use of inappropriate words by health providers at HC and public hospitals, so that most PWD go to private clinic - Lack of PWD signs at hospitals to guide them what to do and where to go
PWDs" expectations from the health service providers	- Understanding of people with disability, Medical schools to orient medical students on PWD - Theory and visit program to PWD homes/communities, medical outreaches, interact and hear from PWDs, see their situation
Experiences with HC and public hospitals	- Queuing, waiting time, PWDs are not given assistance to get the priority number but has to queue in the same way as the normal people, request to give priority to PWD in terms of medical treatment, PWDs have disadvantages in terms of mobility to go ahead of the queue line - Medical secretary (welcoming the patients) to treat PWDs with fairness and no discrimination, not let PWD feel small, please help boost the morale of PWD patients - Even if there is the law for free medical services for identified poor PWDs, still the government hospitals collect service fees from them. - PWD should be treated free but have to wait long, PWD will have to inform the medical staff that they will pay so that they will not wait very long, - Some hospital have very high counter for pharmacy and cashier, difficult for PWD in wheelchair to reach to the personnel
Recommendation for Health facilities	- Build health facilities that are PWD friendly, with wheelchair ramp and rails - Building design to be accessible with ramp and guard rails - Toilet and bath that are PWD Friendly, spacious to accommodate wheel chair - Signs and guide arrows for PWD - National Accessibility Guidelines (NAG), parking area for PWD should be bigger and L shape ($90^{0)}$ for opening the car door, for easy unloading of wheel chair - Most hospitals have good service now, but no signs for PWD to follow where to go, maybe they forgot to consider about the needs of PWDs. PWDs are treated like normal people in terms of queuing for lines. - Provide special places and facilities for PWD including parking space and PWD signs

H.8 FGD MRI (LGBT)

FGD- MRI (LGBT), 19 December 2019 (4:30-6:00)	
Micro Rainbow International (MRI) Foundation	MRI's vision is to contribute to a world where lesbian, gay, bi-sexual, trans and intersex (LGBTI) people can achieve their full potential in life and have equal access to employment, training, education, financial services, healthcare, housing, places of faith, and public places and services. - Although homosexuality is not criminalized, LGBT people in Cambodia are regularly abused and subjected to socio-economic exclusion by their families, communities, employers, local authorities, health care providers and the police. As a result, LGBTI people in Cambodia are more at risk of becoming vulnerable and remain poor.
SOGIE(Sexual Orientation on Gender Identity and Expression)-sexual characteristics LGBT (Lesbian, Gay, Bisexual, Transgender)	- Gender based violence (GBV) - Social Norms (male and female) - Gender norms (male, female and others) Harassment, stigma, bullying and discrimination
LGBT Issues in accessing to health services	- Gay community are most vulnerable to HIV, but most of them do not get medical treatment. - Fear/shame to go to health service providers because of social stigma, i.e. getting negative treatment from guard, receptionist, nurses, doctors, other patients Fear and shame of being exposed to many people as LGBT person with sexually transmitted disease. - Feeling of discrimination and of being a social outcast - Gay, bisexual, and other men who have sex with men (MSM) represent an incredibly diverse community. However, these men are disproportionately impacted by syphilis, HIV, and other sexually transmitted diseases (STDs).
MRI activities for SOGIE/LGBT inclusion	Ministry of Education, Youth and Sports (MOEYS): - Included teachers orientation on SOGIE - SOGIE and their Human Rights - SOGIE sexual characteristics - Gender based violence (GBV), LGBT persons are most vulnerable to GBV from family in particular and society.in general UNESCO supported the LGBT initiative on SOGIE orientation &ToT of teachers among government schools
Clinics in Cambodia that cater to LGBT	- Chhuk Sor (White Lotus) Clinic in Battambang –treat LGBT with HIV (blood testing, provide medicine for HIV patients). PREP pills → HIV prevention medicine; PEP → curative medicine - RACHA (Reproductive and Child Health Alliance) – Provide advice and consultation on the use of sexual hormones, but still limited in terms the holistic and comprehensive professional service/advice. There are clinics that prescribed sexual hormones for LGBT people

	but are not registered, there are already some cases of death due to use of these un-regulated hormones/ drugs. **Need regulations and guidelines on dispensation, selling and use of dangerous and non- certified sexual hormones in Cambodia** - KHANA supported by (UNAIDS) work for HIV prevention, care & support services at the community level in Cambodia, as well as integrated sexual and reproductive health, family planning, maternal child health.
Recommendations	- Sexual education at schools and should be inclusive to include, LGBT/SOGIE - Orientation on SOGIE at Medical Schools, so that future health workers won't discriminate LGBT patients - LGBT community would appreciate if their concerns are heard/included and consulted in any health project or socio-economic project. - Social acceptance particularly by health workers - Sexual Right → Right express sexual preference (Medical Forms on Gender (Male, Female, Others)

H.9 Environmental and Social Codes of Practices (ESCOP)[8]

Environmental Issues	Measures
Dust, Noise and Vibration	Comply with relevant national legislation with respect to ambient air quality, noise and vibration Ensure that the generation of dust is minimized and implement a dust control plan to maintain a safe working environment and minimize disturbances for patients, staff and surrounding community Implement dust suppression measures (e.g. water paths, covering of material stockpiles, etc.) as required. Materials used shall be covered and secured properly during transportation to prevent scattering of soil, sand, materials, or generating dust. Exposed soil and material stockpiles shall be protected against wind erosion; Ensure onsite latrine be properly operated and maintained to collect and dispose waste water from those who do the works; Should not carry out construction activities generating high level of noise during HCF activities, especially when services are being delivered to the clients.
Asbestos Containing Materials	No Asbestos Containing Materials (ACM) will be used If ACM at a given HF is to be removed or repaired, the HF will stipulate required removal and repair procedures in the contractor's contract. Adherence to best practices regarding asbestos that meet the Good Practice Note provided in the WBG Environmental, Health and Safety Guidelines F to ensure construction worker protection during renovation and demolition activities. Occupational exposure can be avoided by controlling dust emissions, and through use of effective respiratory protective equipment. Contractors will remove or repair ACM strictly in accordance with their contract. Removal personnel will have proper training prior to removal or repair of ACM. All asbestos waste is to be buried at an appropriate landfill.

[8] The ECOPs is to be followed by those who are doing the renovation works in HFs e.g. contractor or HF staff.

Protection of Water Resources	Location of toilets/septic tanks installation should be at least 30 m away from groundwater sources such as shallow well/deep well; All existing stream courses and drains within, and adjacent to, the Site will be kept safe and free from any debris and any excavated materials arising from the Works. Chemicals, sanitary wastewater, spoil, waste oil and concrete agitator washings will not be deposited in the watercourses. In the event of any spoil or debris from construction works being deposited on adjacent land or any silt washed down to any area, then all such spoil, debris or material and silt shall be immediately removed and the affected land and areas restored to their natural state by the Contractor to the satisfaction of the Health Facilities person in charge.
Waste Management	Use litter bins, containers and waste collection facilities at all places during works. Dispose of waste at designated place identified and approved by HF management or local authority. It is prohibited to dispose of any debris or construction material/paint in environmentally sensitive areas (including watercourse) Recyclable materials such as wooden plates for trench works, steel, scaffolding material, site holding, packaging material, etc shall be segregated and collected on-site from other waste sources for reuse or recycle (sale). Procurement of asbestos-containing building materials shall be prohibited.
Safety Risks During Works	The HF/contractor shall provide safety measures as appropriate during works such as installation of fences, use of restricted access zones, warning signs, lighting system to protect hospital/HCF staff and patients against falling debris and other risks. Follow national and good practice regulations regarding workers' safety. Use of appropriate personal protective equipment.
Site Clearing: Cleaning the site	The contractor will clean the site carefully and remove all construction waste materials and dispose at designated dumping site. Burning of waste should not be encouraged.

Social Issues	Measures
Displacement of physical or economic displacement	No construction works will be eligible in case the project activities will directly or indirectly cause physical or economic displacement
Labor and Working conditions	Follow national legislation and the project's Labor Management Procedures
Prevention of Gender-Based Violence	Code of Conduct of workers will be signed in line with the project's Labor Management Procedures
Community health and safety	The contractor will minimize labor influx of workers through promoting hiring local workers

H.10 Environmental and Social risk screening checklist

Proposed Activity: ……

Brief Description: ……

……

Location: ……

Filled out by: ……

Organization: ……

Date: ……

Attachments: ……

I. Subproject Screening:

Has the subproject been screened against the list of ineligible activities? If yes, proceed. If no, screen the sub-project using question 1-3 in the below table.

	Will the Sub-project:	Yes	No
1	has potential to cause any significant loss or degradation of critical natural habitats whether directly or indirectly?		
2	could affect forest and forest health?		
3	could affect sites with archeological, paleontological, historical, religious, or unique natural values?		
4	have potential establishment of new buildings or extension of new infrastructures?		
5	has the potential to cause full or partial physical or economic displacement whether directly or indirectly?		

If the answer to any question from 1-5 is "Yes", the sub-project is ineligible to be financed.

II. Areas for Potential Environmental and Social Risks

Will the subproject or any of its associated activities:		Yes	No	Explanation
1	**Resource Use** Require a large amount of energy, water or other natural resources during project construction or operation?			
2	**Water Use** Extract or use of ground or surface water resources, leading to reduction in the volume and the quality of water available for the public water supply?			
3	**Water Quality** Occur pollution of ground or surface water, via direct or indirect discharges or seepages, or through interception of an aquifer by drilling, cuts or excavation?			
4	**Soil Quality** Create a risk of increased soil degradation, soil erosion or increase in soil salinity?			
5	**Sensitive Receptors** Be located adjacent to the sensitive community area (e.g. school, hospital or medical facility)?			
6	**Air Quality** Have any chance to increase the levels of harmful air emissions including dust?			
7	**Noise** Increase significantly in existing noise levels that will adversely affect nearby community area?			
8	**Waste Generation** Generate solid or liquid waste that could adversely impact on soils, vegetation, rivers, streams or groundwater?			
9	**Labor and Working Conditions** Is going to cause significant labor influx of workers? Will the project use forced labor or child labor?			

10	**Community Health and Safety** Would elements of Project construction, operation, or decommissioning pose potential safety risks to local communities?			
	If the subproject includes laboratory related activities, the following screening process shall be undergone.	***Yes***	***No***	***Explanation***
1	**Biosafety Level** Has the targeted laboratory been assessed for biosafety risks and assigned a biosafety level?			
2	**Hazardous Waste Management** Is there any chance for the generation of hazardous waste during the operation period?			
3	**Wastewater Management** Is there any chance for the generation of toxic wastewater from the operation of laboratory?			
4	**Hazardous Materials Management** Is there any chance for using hazardous materials / chemicals in the operation of laboratory?			
5	**Identification of risk of existing laboratory** Does the existing laboratory have high risk of chemical or biological or physical?			

If the answer to any of questions is "Yes", Please prepare relevant subproject specific instruments or subproject's ESMP together with subproject application.

H. 11 Outline of Sample ESMP

The following are the essential contents that must be considered in the ESMP but not limited to those. It shall refer to the structure of this "Table of Contents" in preparing ESMP of relevant subprojects.

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2 Potential Environmental and Social Impact Identification 2.1 Environmental Impacts 2.1.1 Air Pollution 2.1.2 Water and Wastewater Pollution 2.1.3 Solid Waste 2.1.4 Noise 2.1.5 Odor 2.1.6 etc. 2.2 Social Impacts 2.2.1 Occupational Health and Safety (OHS) 2.2.2 Community Health and Safety (CHS) 2.2.3 Conflicts 2.2.4 Gender Based Violence 2.2.5 Labor Influx
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