STAKEHOLDER ENGAGEMENT PLAN

Sindh Integrated Health and Population Project 2022-2027

October 2022

Disclaimer: *The SEP document has been prepared during the Flood Emergency Period Aug – Oct 2022. The scope of consultations, especially in the project districts, was limited as many areas remained inaccessible. Health department agencies remained engaged in rescue efforts and disengaging them from their work for SEP consultations was not considered feasible at this point. The floods have also displaced many people from their villages and neighborhoods. As families try to cope with this natural calamity, more in-depth consultations with them have been deferred. Nonetheless, efforts were made to reach out to key stakeholders, details of which are in the document, to develop a* ***Preliminary SEP Plan****.*

This plan is expected to be updated within three months of project effectiveness to present a more wholesome engagement.

Contents

List of Acronyms

ANC	Antenatal Care
BHU	Basic Health Unit
CCP	Concept Clearance Proposal
CIP	Costed Implementation Plan
CMW	Community Midwife
DHQ	District Head Quarter Hospital
DoH	Department of Health
EMR	Electronic Medical Record
EPI	Expanded Program on Immunization
ESCP	Environment and Social Commitment Plan
ESF	Environment and Social Framework
ESS	Environment and Social Standards
FP	Family Planning
FPRH	Family Planning Reproductive Health
FWW	Family Welfare Worker
GBV	Gender Based Violence
GD	Government Dispensary
GoS	Government of Sindh
HDI	Human Development Index
CHW	Lady Health Worker
MIS	Management Information System
MR	Medical Record
PAD	Project Appraisal Document
PDO	Project Development Objective
PHC	Primary Healthcare
PMU	Project Management Unit
PNC	Postnatal Care
PPHI	People Primary Health Initiative
PWD	Population Welfare Department
RHC	Rural Health Center
RHS	Reproductive Health Service
RMNCAH+N	Reproductive, Maternal, Neonatal, Child & Adolescent Health and Nutrition
SEA/SH	Sexual Exploitation Abuse/Sexual Harassment
SEF	Sindh Education Foundation
SELD	Sindh Education & Literacy Department
SELECT	Sindh Early Learning Enhancement through Classroom Transformation
SEP	Stakeholder Engagement Plan
SEPA	Sindh Environment Protection Agency
SIHP	Sindh Integrated Health and Population Project
SHCI	Sindh Human Capital Investment Program
SPPRA	Sindh Public Procurement Regulatory Authority
SRHR	Sexual Reproductive Health Right
THQ	Taluka Head Quarter
UC	Union Council
UHC	Universal Health Coverage
WASH	Water, sanitation, and hygiene
WHO	World Health Organization
WMO	Woman Medical Office

1. Introduction

1.1 Project Description

Health indicators in Sindh compel the need for investment in human capital. 18 districts in the province fall below average in terms of composite health care based on three indicators: child immunization, assisted delivery, and antenatal care. Malnutrition and food insecurity also contribute to poor health outcomes, with Sindh reporting the highest number of underweight children and high prevalence of stunting.

The Sindh Integrated Health & Population Project has been conceptualized by the Government of Sindh (GoS) to provide provision of missing primary healthcare services in Reproductive, Maternal, Newborn, Child, Adolescent Health + Nutrition (RMNCAH+N). PC 1 of the project has been approved by GoS. Implementing agencies are the Department of Health (DoH) and Population Welfare Department (PWD). The Stakeholder Engagement Plan (SEP) has been developed as part of the Environmental and Social Standards (ESS) under the World Bank's Environmental and Social Framework (ESF).

The Sindh Integrated Health and Population (SIHP) project is part of the Human Capital Investment Project. It addresses the supply side gaps by aiming to refurbish 392 Government Dispensaries (GDs) in 290 Union Councils (UCs) and its demand side includes social mobilization and strengthening medical record system.

1.2 Project Objectives

The Project Development Objective (PDO) is to improve utilization and quality of essential health and family planning services, for poor and vulnerable populations, especially women, in targeted areas of Sindh. The PDO will be measured by the following indicators:

- Married women who were counseled for family planning at GDs and availed FP services
- Pregnant women who have had at least 4 Antenatal Care (ANC) visits at health facilities during their last pregnancy in the catchment population
- Pregnant women who had their deliveries conducted by skilled birth attendant at a health facility in the catchment population
- Newborn babies with chlorhexidine gel applied to umbilical cord
- Children between the ages of 12 to 23 months fully immunized as per the age specific protocol
- Children aged 6-23 months who receive yearly a minimum of 90 micronutrient sprinkles sachets for three months in intervention areas

1.3 Project Components

Component 1: Improving RMNCAH+N services utilization and quality and support during public health emergencies

This component will support an integrated care of RMNCAH+N services. It will enhance patient referral pathways between GDs and other health facilities such as BHUs, RHCs, Tehsil THQs and DHQs through proper mapping of facilities and provision of adequate resources. This component will also finance the relief, rehabilitation and reconstruction needs arising from floods and rain related damages and losses to health infrastructure and disruption of healthcare service delivery in the project supported areas since mid-June 2022.

Subcomponent 1.1: Strengthening of the GDs for providing preventive care.

It will support provision of Minimum Service Delivery Standards (MSDS) (including GBV responses) for RMNCAH+N through (a) revitalization of an identified set of GDs in the catchment areas of the underserved and unserved population of Sindh by including refurbishment of GDs, purchase of equipment including solar panels (which are not critical to achieve strengthened preventive care), medicines and supplies, and ambulance services for referral; (b) recruitment and deployment of female health workers, specifically woman medical officers (WMOs), community midwives (CMWs), lady health visitors (LHVs), and lady health workers (LHWs)/community health workers (CHWs); (c) effective structural and functional integration of health facility-based FP services and community-based services; (d) training of the healthcare providers on MSDS, GBV prevention and management, climate-induced disaster and epidemic response including disease surveillance and telehealth services for RMNCAH+N at places with access to the internet; and (e) establishment of a dynamic, integrated electronic medical records system linked to the Sindh District Health Information System (DHIS) and other key health databases, to track patients.

Sub-component 1.2: Strengthening of referral hospitals for effective delivery and neonatal care.

It will support identified set of THQ and DHQ hospitals to provide comprehensive obstetric and neonatal care through (a) purchase of equipment, medicines and supplies; (b) recruitment of clinicians (obstetricians, pediatricians and anesthetists) needed for operative care for deliveries; (c) provision of blood storage units and; (d) training of the healthcare providers on MSDS and management of GD referred mothers and children.

Component 2: Strengthening demand for RMNCAH+N services including women's empowerment for availing health services

This component will cover social and behavior change communication and related activities to encourage uptake of RMNCAH+N services using social marketing strategy and rebranding of GDs and their services package to create awareness. It will also include women's empowerment for exercising sexual and reproductive health rights. Social and behavior change activities will include extensive community outreach, mid-media, face-to-face discussions or focus groups at the women's community centers, and interventions to engage other gatekeepers (such as husbands, mothers-in-law, and community leaders) on key issues. The demand will be enhanced through social movement in health by

conducting social accountability interventions, annual health assembly and social audits, through partnering with nongovernmental organizations (NGOs), community-based organizations, and other private sector organizations.

Component 3: Project Management, Monitoring and Evaluation and Research

This component will support the strengthening of the DoH and its coordinating structures and agencies for the coordination and management of project activities including financial management, procurement, PPs, stakeholder engagement, and compliance with the Environment and Social Commitment Plan. This component would also support monitoring and evaluation (M&E) including third-party monitoring and rapid surveys. The relevant structures will be strengthened by recruitment of additional staff/consultants, use of information technology and communication equipment and workshops and training**.** It will also build the capacity of DoH for clinical and public health research for policy information. A feasibility study on service delivery redesign will be conducted with the support from Global Financing Facility of the World Bank.

Component 4: Contingency Emergency Response Component (CERC)

In the event of an Eligible Crisis or Emergency, the project will contribute to providing immediate and effective response to said crisis or emergency.

1.4 Summary of Potential Environment Impacts

The environmental risks primarily associated with Component 1 involve refurbishment of GDs entailing minor to moderate civil works. These civil works include repainting, stocking of relevant furniture, installation of equipment, expansion of rooms in GD and upgrading of lighting using solar panels. Additionally, this component will include procurement of related goods including medical equipment, medicines, and ambulances (project owned, with Operations and Management (O&M) by private sector). Risks entail: occupational hazards associated with refurbishments (construction and equipment installation) of GDs and related impacts including minor to moderate amounts of construction waste generation, noise, and air pollution, as well as use of chemicals/solvents such as paints and varnishes. Envisaged operational risks pertain to infection prevention and control including: occupational health and safety risks to health care workers, and medical waste management. Risks are related to spread of diseases like COVID-19 as an increased number of people especially pregnant women will be visiting the health facilities and the frequent community mobilization and awareness raising campaigns at community level in the context of the current COVID-19 pandemic may lead to spread of disease at the community level, especially if guidelines and SOPs including use of mask and social distancing measures are not observed. Further, the generation of used oils and oil filters during ambulance maintenance is also anticipated during project operation. The environmental risks and impacts are expected to be temporary, localized, and reversible in nature. Components 1 (establishment of a dynamic, integrated electronic medical records (EMR) system linked to the Sindh DHIS, and other key health databases to track patients) and 3 involve purchase of information technology and communication (ICT) equipment. Since the departments have limited number of existing ICT equipment and the procurement will not be replacing existing ICT machinery, e-waste will not be generated.

1.5 Summary of Potential Social Impacts

The project design is to reach the unserved and vulnerable groups and women and children. Primary social risks include lack of meaningful engagement with vulnerable groups such as religious and ethnic minorities, seasonal migrants, and people with disabilities, which could lead to their exclusion, particularly in remote and underserved areas, and elite capture and social tensions. These concerns can be largely mitigated by ensuring comprehensive stakeholder engagement throughout the lifecycle of the project. A robust and transparent criteria will be developed for merit based recruitment of female health workers and clinicians, and for selection of beneficiaries for various trainings. Another important social risk is related with digital privacy and data protection and misuse of sensitive personal data (e.g., medical histories) (under component 1.1). In order to guard against abuse of sensitive personal data, the project will incorporate good international practices for dealing with such data. Privacy-by-design features for digital privacy will also be considered. Land acquisition is not part of the project; however, there is some possibility of informal settlers found on the sites selected for GD refurbishment. No labor influx is anticipated, as civil works involved will be completed using local contractors who will follow all requirements of ESS2. Primary Suppliers, including those for solar panels, will be screened for forced labor, use of child labor etc. , as per Labor Management Plan. In such cases, RAP / ARAP and / or livelihood restoration plan will be developed proportionate to the site specific impacts. Social and behavior change communication under component 2 might run the risk of being ineffective if not developed with due consideration to the cultural and demographic context of the target population. The material under this component will be developed in local languages using culturally appropriate messaging. Finally, operational concerns may arise due to remoteness and security issues, which will be mitigated through informed selection of project locations.

A grievance redress mechanism has also been included in this SEP, to be implemented accordingly, and provisions will be made for extra discretion in the handling of grievances.

1.6 Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH) Risk

GBV, including sexual exploitation and abuse (SEA) and sexual harassment (SH) risks, could emerge for different community groups including children and women and women healthcare workers in and around health centers and at the household level of beneficiaries. The project GBV risk rating is assessed as moderate according to both health and infra tool. This risk will be mitigated through explicit inclusion in robust stakeholder identification and consultation processes and by the development of a strong SEA/SH action plan and accountability and response framework, which will be implemented throughout the project duration. The project will train staff of PMU and GRM, contractors, and project workers on SEA/SH risks and mitigation to ensure robust monitoring of risks throughout the project. Behavioral standards with general misconduct and harassment prohibitions will be developed and project staff will be trained in it. Project workers will sign the code of conduct before commencement of civil works. Mapping of GBV service providers will be conducted for the project. The project will also undertake GBV training of GD health service providers to ensure women, girls and other vulnerable groups have access to GBV responsive health services.

1.7 Objectives of SEP

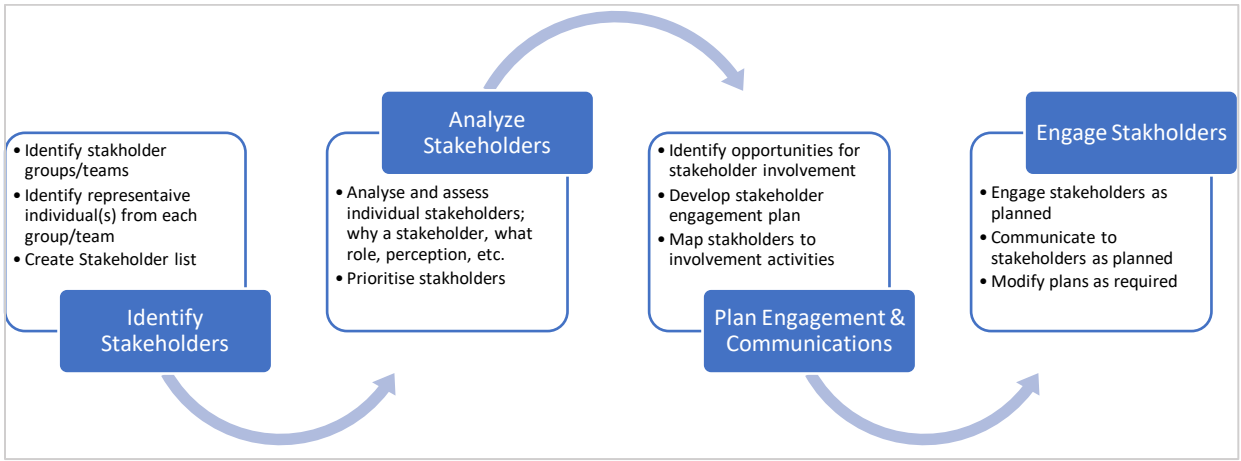
Under World Bank-financed projects, **a Stakeholder Engagement Plan (SEP), and project level Grievance Redress Mechanism (GRM) need to be developed in accordance with ESS10 (Stakeholder**

Engagement and Information Disclosure) of the World Bank's Environmental and Social Framework (ESF) and any corresponding national legislation. ESS10 requires the Department of Health (Sindh) to engage with stakeholders throughout the project life cycle, commencing such engagement as early as possible in the project development process and in a timeframe that enables meaningful consultations with stakeholders on project design. The nature, scope and frequency of stakeholder engagement have to be proportionate to the nature and scale of the project and its potential risks and impacts.

The overall objective of this SEP is to define a program for stakeholder engagement, including public information disclosure and consultation, throughout the project lifecycle. **The SEP outlines the ways in which the project team will communicate with stakeholders and includes a mechanism by which people can raise concerns, provide feedback, or make complaints about the project and any activities related to the project.** It does this by:

- Establishing a systematic approach to stakeholder engagement that will help DoH identify stakeholders and build a constructive relationship with them
- Assessing the level of stakeholder interest and support for the project, and to enable stakeholder views to be taken into account in project design and environment and social performance
- Promoting and providing means for effective, inclusive engagement with project stakeholders throughout the project lifecycle
- Ensuring that appropriate project information on environmental and social risks and impacts is disclosed to stakeholders in a timely, understandable, accessible, and appropriate manner

Figure 1: Process of Stakeholder Engagement



2. Stakeholders Identification & Analysis

2.1 Methodology

For meaningful and substantive engagement, it is necessary to determine who the stakeholders are and understand their needs and expectations for engagement, as well as their priorities and objectives in

relation to the Project. This information will then be used to tailor engagement to each type of stakeholder. As part of this process, it is particularly important to understand how each stakeholder may be affected – or perceives they may be affected – so that engagement can be modified accordingly.

Stakeholder analysis identifies relationships between the project and potential stakeholders. Stakeholders are defined as individuals, communities, and organizations/institutions that Project stakeholders are defined as individuals, groups, or other entities who:

i. are impacted or likely to be impacted directly or indirectly, positively, or adversely, by the Project (also known as 'affected parties'); and

ii. may have an interest in the Project ('interested parties'). They include individuals or groups whose interests may be affected by the Project and who have the potential to influence the Project outcomes in any way.

iii. are highly vulnerable to potential project impacts and do not have a voice to express concerns or understand the project's risks and impacts. Aspects of vulnerability may include: gender, ethnicity, religious identity, health conditions, disabilities, economic marginalization, financial and food insecurity, and disadvantaged status. Stakeholders in this category are referred to as "disadvantaged/vulnerable individuals and groups"

Stakeholder mapping, identification, and categorization has been done through review of the project documents: PC1 Sindh Human Capital Investment: 1000 Days, Project Appraisal Document (PAD), Environment and Social Review Summary. Two extensive consultations were held with Technical Advisor, Costed Implementation Plan (CIP) in Population Welfare Department, who is also the focal person for this project.

2.2 Categorization of Stakeholders

- ***Affected Parties***

For the purpose of the SEP, the term "affected parties" includes "those likely to be affected by the project because of actual impacts or potential risks to their physical environment, health, security, cultural practices, wellbeing, or livelihoods". The **"Affected Parties"** in the project context refer to all those stakeholders, who are recipients of the project benefits, or/and those who are likely to be adversely impacted by it, including local communities, healthcare providers, non-medical staff related to health facilities (e.g., ambulance drivers), patients and their caretakers, service providers under the PPP mode, and others. The list of all project stakeholders is given in Table 3.

- ***Other Interested Parties (OIPs)***

The **Other Interested Parties (OIPs**) refer to individuals, groups, or organizations with an interest in the project because of the project location, its characteristics, or matters related to public health. In the context of the project the relevant organizations include local and international non-government organizations working independently or in conjunction with DoH, PWD, or DHOs. These also include social and private primary healthcare/family planning franchises. Donor and international agencies' health initiatives and national and provincial drives/programs on various health verticals that directly or

indirectly contribute to RMNCAH+N goals also come under this category. These stakeholders are not likely to be directly responsible for execution of any project component. However, based on their experience and knowledge they can either assist in informed decision making or might be considered for public private partnership initiatives.

- ***Disadvantaged/Vulnerable Groups***

Disadvantaged/vulnerable individuals or groups are potentially disproportionally affected and less able to benefit from opportunities offered by the project. In Sindh, the population spread in many *talukas* and UCs is sequestered which makes them hard to reach. Accessibility in some cases is compromised because of lack of proper road infrastructure and long and unsafe distances. Populations settled in such settings are also likely to be very poor and hence most vulnerable. It has been observed by the DoH that the distance of 4 kilometers or more is one of the reasons for increased infant and maternal mortality.

The SIHP project design inherently addresses primary healthcare gaps to this vulnerable group. Exclusion of vulnerable groups, if any, is likely to be the result of delay or non-execution/poor execution of project activities. The main component includes rehabilitation of primary healthcare facilities for such groups. The selection of GDs for this project is based on set criteria that includes: i) UCs which are hard to reach areas, that are under-served or un-served in terms of health facilities; ii) GDs that are 4 kilometer or more from a functional Basic Health Unit (BHU); iii) UCs where there is no LHWs coverage. Annex Two lists the number of GDs selected in each project district.

Other vulnerable groups include seasonal workers, disabled persons, and individuals suffering from psychological problems or any severe ailment. As far as religious minorities are concerned, Sindh overall enjoys harmonious co-existence with Hindu communities (the largest religious minority group). No major incidence of denial or exclusion on religious grounds have been observed in the past in provision of healthcare facilities and services.

2.3 Level of Project Impact on Stakeholders

Table 1: Impact on Stakeholders

S.N.	Category of Stakeholders	Level of Impact
	Affected Parties	
1	Users of GDs, BHUs, RHCs, THQ, DHQ (Mothers/Newborn/Children/Adolescents/Men)	**+ve High:** Upgrading of primary healthcare services will increase access and usage of primary healthcare and family planning facilities/services at the UC level and improve general health of the users, especially in the districts with low HDI
2	Staff and management of Primary public healthcare facilities (GDs/BHUs/RHCs) including doctors, nurses, dispensers, LHW, CHW, FHW etc.	**+ve High:** Improved infrastructure, facilities, staffing will make primary healthcare facilities user friendly for ANC, normal delivery, Postnatal Care (PNC), immunization, and nutritional support and telehealth services

S.N.	Category of Stakeholders	Level of Impact
		-ve High to Moderate: Primary healthcare facilities have limited staff. Increased patient load, execution of existing health verticals or introduction to new ones will put additional workload on staff **-ve High to Moderate:** Increased patient load might render physical space inadequate and compromise maintenance and upkeep of the building
3	Staff of Secondary and tertiary public healthcare facilities (*taluka* and district hospitals) including medical superintendents, doctors, nurses, dispensers, administrators, non-medical staff, lab technicians, primary vendors, waste managers, etc.	**+ve High:** Improved management for referral cases **-ve Moderate to Low**: Increased referral cases of PPH/C-sections will increase caseload **-ve High to Moderate:** Improper management of blood banks and blood transfusion can cause medical complications -**ve High to Moderate:** Not all THQ are staffed adequately to manage complicated cases. They further refer the referral patient to DHQ
4	Community Health Workers/Family Healthcare Workers	**+ve High**: Capacity building of CHW and new recruitments of FHWs (one male – one female) at GD will help integrate Family Planning (FP) with PHC services
5	Community Midwives	**+ve High:** Permanent posting of CMWs at GDs and provision of 24/7 services of delivery at GDs will encourage birth by trained attendants **-ve High:** Evidence suggests that CMWs cater to more than 100 cases per day at GDs/RHCs/BHUs. With their increased role and improved facilities more patients are likely to visit GDs, catering to whom might be beyond the capacity of a single CMW
6	PPHI	**+ve High:** PPHI has demonstrated experience in running BHUs successfully. 392 GDs will be transferred to PPHI in a phased manner, allowing an expanded role of the organization in PHC
7	District Health Offices	**-ve Moderate to Low:** As GDs are transferred

S.N.	Category of Stakeholders	Level of Impact
		to PPHI, some DHOs might not cooperate in facilitating PPHI's managed GDs
	Other Interested Parties	
1	International Development Agencies, INGOs, and NGOs	**+ve High to Moderate:** Successful delivery of SIHP and better facilities and services might encourage development agencies/social franchises to invest in the health sector in Sindh and expand their projects and work on public private partnership models
2	Social Franchises in PHC and FP	
3	Department of Health	**+ve High:** Strengthening of the DoH, its coordinating structures and agencies for the coordination and management of project activities and strengthening the PPP model
4	Population Welfare Department	**+ve High:** Integration of FP services with PHC services at GDs
	Vulnerable Groups	
1	Displaced persons because of natural calamities or disasters	**-ve High:** Sindh is vulnerable to extreme climate conditions due to climate change. The 2022 floods have already rendered many people homeless and displaced
2	Persons with Disabilities	**-ve Moderate:** If accessibility issues are not addressed in the building design
3	Poor Women/Girls/Children/Adolescents with underlying health issues or experiencing emotional or mental stress	**+ve Moderate:** Consulting health professionals for psychological problems and discussing reproductive health with adolescents are considered social taboos. This might lead to slow uptake of telehealth and counselling services
4	Seasonal Workers	**+ve Moderate:** Follow-ups, counselling and data tracking becomes challenging with this group
5	Religious and ethnic minorities	**+ve High:** No perception exists to suggest that people are discriminated against in health services provision due to their caste, creed or religion, hence impact remains similar as for the community at large

3. Summary of Previous Stakeholder Activities

3.1 Negotiations and Stakeholder Engagement for Sindh Human Capital Investment

Government of Sindh initiated negotiations with the World Bank (WB) on February 19, 2018 to support reforms in the population and health sector of the province under the SHCIP portfolio of the Bank. The visiting Mission of the Bank held meetings with Chief Minister Sindh; Minister for Health and Population Welfare, Department of Health and Population Welfare Department, P&D Board, and the Finance Department. The negotiations revolved around an IDA (Institutional Development Assistance) of US$ 200 million.

A Design and Scope Committee was established under the chair of Minister for Health and Population Welfare with participation from P&D Board; Finance Department; DoH; PWD; PPHI; SELD; Sindh Technical Education and Vocational Training Authority (STEVTA); Works and Services Department. The committee held regular meetings and guided the development of a Concept Clearance Paper (CCP) in year 2019.

3.2 Baseline and Community Engagement at Preparatory Level

In 2019, the Design & Scope Committee advised DG Health to apprise it of the current physical status of the GDs and the relevant community needs. District level health officials went into the field in all the 30 districts at the GD level, recorded the GD status and acquired feedback from the community. This exercise resulted in a database of GD conditions, besides verbal (and informal) update of community concerns.

Based on the above exercise, out of a total 1,093 GDs in the province, 392 GDs have been selected for project support using the following criteria:

a. Located in an under-developed and poor area (arid zone, desert, riverine, hilly area, lower Indus delta, or peri-urban slums)
b. Located at a distance of at least 4 km or more from another functional health facility
c. No presence of Lady Health Workers

The selected GDs are located in 271 different UCs. For year-1 of the project, five districts (Tharparkar, Thatta, Jamshoro, Sujawal, and Kamber-Shahdadkot) have been selected.

Preparatory work for the project started in the year 2018 with the World Bank (WB) mission to explore potential projects related with population welfare, family planning and health. Another WB mission took place in 2019 and a Concept Clearance Paper (CCP) was developed in the same year. The CCP focused essentially on social protection; it also identified the Union Councils (UCs) and Government Dispensaries (GDs) which lacked accessibility and remained under utilized.

During the first round, consultations were held with various institutional stakeholders to inform the project design. Summary of these meetings is provided below.

3.3 FP2030 Roadmap (2021-2030)

FP2030 Roadmap for Sindh was developed through technical coordination of Costed Implementation Plan (CIP). The first phase in August 2020 included virtual consultation with multiple public sectors and

development partners. Discussions centered around CIP implementation, experiences, and lessons learnt. 13 subgroups of Sindh FP2030 Working Group held separate meetings. In the second phase, in 2021, the same stakeholders/subgroups held meetings and shared recommendations. Based on the feedback, the CIP secretariat led by its Technical Advisor, developed a draft FP2030 Roadmap in line with Federal FP2030 Roadmap based on global proforma provided by FP2030 Secretariat, Washington, D.C.

The Draft Roadmap was reviewed by public sector stakeholders: Department of Health, Population Welfare Department, Sindh Education and Literacy Department (SELD), People Primary Healthcare Initiative (PPHI) and other stakeholders in a session chaired by the Minister for Health and Population. The final draft was again shared with all development partners, District Health and Population Officers.

3.4 Assessment of Refurbished GDs in Thar

7 GDs in Taluka Dahili in District Thar were refurbished through the support of UNICEF. An assessment of the developed GDs was undertaken on March 11, 2020. The findings revealed that during the past quarter a total of 100 deliveries took place at the GDs. The visit demonstrated that the utilization of services improved with staff presence. This prompted the further need for medicines, supplies, and ambulance service. The facilities were running successfully as CMWs got residences within communities or at GDs. The assessment supported the viability of the proposed model of SIHP.

3.5 Consultations with NGOs

There are some 28 – 30 NGOs and development partners working on the themes of reproductive health, population planning and MNCH etc. A consultative workshop was held in mid-2019 where almost 100 representatives from these participated. The workshop discussed the success factors of CIP and future plan for the 1000-days health project.

After the bifurcation of SHCIP in 2021, some activities were included in the Public Private Partnership (PP)) mode. These include ambulance service, nutrition supplement, and tele-health. In 2021, another meeting with the mentioned NGOs was held to present the PPP framework and action plan. The key recommendations by the participants were the following:

a. PPP MOU should be legally binding
b. M&E dashboard should be established to record and monitor proper, real time data
c. Provision of Family Planning / Sexual & Reproductive Health services should be part of the PPP contract / MOU
d. Proper and independent monitoring of the project should be carried out.

These recommendations have been incorporated in the project design.

3.6 Stakeholder Consultation for SEP

The current SEP has been prepared after detailed consultations with the Technical Advisor, CIP, who is also the DoH focal person for the project. Furthermore, the following consultation activities were carried out to develop the SEP:

I. 05 number In-Depth Interviews with DHOs, SEPA and development professionals
II. 02 number team meetings with NGOs
III. 01 number Consultative Workshop with CMWs, LHWs, PPHI District Staff, WMO and nurses
IV. 01 number FGD with LHWs

Besides the above, a BHU+ facility at *Nodo,* Sujawal was visited where informal discussions with Medical Officer, lab assistants, nurses, and an expecting mother were held.

The feedback from these consultations, and the relevant responses, are summarized in Table --- below:

Table 2: Stakeholders Feedback from SEP Consultations

Stakeholder	Feedback	Response
CMWs, LHWs, WMO and nurses	Require Universal Health Coverage (UHC) at community and primary health care levels. This includes Reproductive Health (RH); ANC; delivery; PNC; new born care; nutrition, child care, school age child care, adolescent health, infectious diseases, non-communicable diseases. With GDs being revitalized, the primary healthcare users need to be informed of the new facilities and the services being offered Referral slips for ANC/ PNC/FP visits ANC/Immunization Cards Vitamin and mineral supplements Ambulance service with female paramedic in case of delivery or PN management Helpline for emergency	Campaign/ awareness materials/advertisement to be delivered in local languages Under the project one male and one female family health worker (FHW) will be posted at GDs. Other points noted for project design
Community Midwives (CMWs)	Currently, GDs are not 24/7. This limits CMWs role in handling normal delivery cases, transferring the load to BHU plus, secondary and tertiary healthcare facilities. Residence facility for CMWs/LHV near GD or on premises; Hostel facilities during training; Refresher training courses; Training in providing first aid in case of postpartum hemorrhage and other health verticals, especially the use of technology for telehealth services	The project aims at revitalizing GDs and turning them into 24/7 centers for handling normal deliveries in addition to other RMNCAH+N services Other points noted for project design

Stakeholder	Feedback	Response
Community Health Workers	Refresher training; TA/DA allowance for training; Timely provision of primary healthcare/FP or other health products; training in use of technology to assist in telehealth campaigns	Each CHW will have a catchment of 1200 households. They will address primary healthcare problems at the community level through promotive, curative, and rehabilitative services: MNC, FP, prevention and household treatment of pneumonia, diarrhea; Nutritional interventions; Referrals etc. Their ToRs will include the extent of FP services they can provide
Medical Officers GDs/BHUs	Lack of Women Medical Officers	More Women Medical Officers (WMOs) will be hired under the project to manage GDs. Each WMO will have 3GDs under her supervision and will be responsible for coordination with DHO and District Manager, PPHI. She will also be the first point of contact by CMW in case of any medical Emergency
District Health Officer	Main problems include dilapidated buildings, shortage of trained HR, particularly specialists. The requisition and 85 percent of procurement is processed under SPPRA rules, through Central Rate Contract (CRC) by Health Department Karachi. 15 percent purchases are made locally by DHOs. CRC procedures are complex and lengthy and delayed. Often times medicines cost more than prescribed on the CRC list. Other requirements include Ambulance service with paramedic staff; Mobile Clinics; Blood storage units; Qualified medical staff (surgeons, anesthesiologists at THQ and DHQ).	Points noted for project design
PPHI	Partnership between PWD, DoH and PPH is regarded as a best practice.	Under public private partnership, 392 GDs under this project will be handed over to PPHI in a phased manner for sustainability purpose
Social Franchises	These organizations are open to partnerships with government facilities and have expressed interest in providing training and third party monitoring.	Points noted for project design

Stakeholder	Feedback	Response
	FP coverage data by Social franchises is not integrated with DHIS. There is no combined reporting on coverage of FP services, resulting in data gaps	
SEPA	Clearance required under relevant environmental laws for construction Compliance to Sindh Hospital Waste Management Rules 2014	Noted for legal compliance

List of consultations meetings with dates is attached in Annex 1

Ideally more consultations with users and providers of PHC and FP are desirable, but in the event of 2022 flooding most institutional stakeholders are busy in relief and rescue efforts. Similarly, with large swathes of population displaced, reaching out to them for project consultations was deemed inappropriate. Considering the requirements of further consultation meetings, this preliminary SEP will be further updated and validated through Focus groups and consultative workshop with multiple stakeholders within three months of project effectiveness. The plan for such consultations has been provided in the following sections.

4. Stakeholder Engagement Plan & Methodology

4.1 Phased Approach

The project has divided its stakeholder engagement into three phases:

Phase I (Project Preparation): Stakeholder engagement during this phase focused on representatives from line departments, communities and relevant non-governmental organizations. The purpose of stakeholder engagement during this phase was to: ascertain institutional needs; apprise all stakeholders about planned activities/reforms; improve project design; and create synergies.

Phase II (SEP Update and revalidation): As the flood situation in the entire province hindered most stakeholder engagement activities during phase-I, further consultations with increased focus on direct beneficiaries and healthcare provides will be carried out within three months of project effectiveness. This will further improve the project design and implementation arrangements by incorporating perspectives of all stakeholders including the vulnerable groups.

Phase III (Project Implementation): Extensive stakeholder engagement will continue to be carried out during this phase with institutional stakeholders, communities, disadvantaged/vulnerable groups and other interested parties. Table 6.3 provides a summary of stakeholder engagement during this phase along with the corresponding tools and techniques for conducting them. These will be further refined during project implementation.

4.2 Stakeholder Engagement Tools and Methods

Tools, techniques and methods used for engagement largely build on the established communication, notification, and reporting systems that exist amongst the main stakeholders to avoid adding excessive documentation and parallel systems. The focus is to ensure instituting and encouraging a culture of taking feedback from frontline service providers and users, timely reviewing and addressing problems/road blocks through a participatory approach. Avoid delayed notifications or lapses in communication pertinent to project implementation activities and to ensure transparency through dissemination of public documents and public notices using relevant tools and methods.

Table 3: Stakeholders Description

Identified Party	Key Characteristics	Language Needs	Preferred Notification and Frequency	Specific Needs
Affected Parties				
Users of primary healthcare facilities and services in desert, delta, hilly, riverine, arid zones and peri urban areas of 30 districts	These include women of child bearing ages, newborn, children, and adolescent belonging to lower socio-economic tiers	Consultation sessions and other activities to be conducted in local languages	*SEP Finalization Phase* Total 06 consultation events (one each in the 05 districts selected for year-1, plus 01 event in a district from the central parts of the province) with PHC users. 25 – 50 participants in each event *Implementation Phase* Monthly visits by CHWs for PHC and FP services and counselling; promoting and providing referrals to GDs/BHUs Social campaign and awareness raising through events and public advertisements (boards, banners, tele clinics etc.)	Meetings during daytime preferably Female moderators and enumerators for meetings with women Special transportation arrangements for district level meetings
Community Midwives (CMWs)	CMWs are trained in Government Public Health Schools for two years. CMWs are key primary healthcare providers at the UC level. Currently, CMWs at GDs manage the facility and are responsible for providing ANC and PNC. They are also providing services at BHU plus	Local language preferred; Urdu is the other option.	*SEP Finalization Phase* 06 FGDs with CMWs in districts as described above Participation in the Consultative workshop *Implementation Phase* Weekly meetings with Women Medical Officers (WMO) on project orientation, progress, and	Meetings during daytime preferably Female moderators and enumerators Special transportation arrangements for district level meetings TA / DA allowance

Identified Party	Key Characteristics	Language Needs	Preferred Notification and Frequency	Specific Needs
			challenges Monthly reporting to DHO/PPHI through DHIS Some reports of disease surveillance are reported to DHO on weekly basis Project Orientation Meeting together with GRM orientation	
Community Health Workers	CHWs are going to be hired under the project. They are going to be from within communities.	Local language preferred; Urdu is the other option.	*SEP Finalization Phase* 06 FGDs in districts as described above Participation in the Consultative workshop *Implementation Phase* Weekly reporting on household visits by CHWs to CMWs as per the standard form Project Orientation Meeting together with GRM orientation	Meetings during daytime preferably Female moderators and enumerators Special transportation arrangements for district level meetings TA / DA allowance
Family Health Workers (FHW)	FHWs provide FP services including counselling	Local language preferred; Urdu is the other option.	*SEP Finalization Phase* 3 FGDs Participation in the Consultative workshop	Meetings during daytime preferably Female moderators and enumerators for meetings with women Special transportation

Identified Party	Key Characteristics	Language Needs	Preferred Notification and Frequency	Specific Needs
			Implementation Phase Weekly meetings with Women Medical Officers (WMO) on progress, and challenges Referrals to CMW for 1st dose injectable and to BHU for modern contraceptives Project Orientation Meeting together with GRM orientation	arrangements for district level meetings TA / DA Allowance
Medical Officers GDs/BHUs	Medical Officers manage and supervise BHUs. These facilities are being managed by PPHI and provide outdoor medication and preventive care till 2 pm. **BHU plus** are 24/7 facilities providing additional services like lab test facilities, labor room,		*SEP Finalization Phase* 6 In Depth Interviews (IDIs), one in each district as described above Participation in the Consultative workshop *Implementation Phase* Daily, weekly, monthly reporting to PPHI as per DHIS requirements Member of District Implementation Committee that meets monthly Project Orientation Meeting together with GRM orientation	To be updated
District Health Officers	DHO is an overall administrative in-charge of health departments in districts. This office supervises and monitors		*SEP Finalization Phase* 04 IDIs (with DHO Jamshoro, Tharparkar, Kamber-Shahdadkot, and one district from the middle Sindh)	Meeting during working hours with prior appointment

Identified Party	Key Characteristics	Language Needs	Preferred Notification and Frequency	Specific Needs
	preventive, curative and promotive healthcare. It plans and budgets district health expenses. Procures essential and emergency medicines/vaccines. The office is authorize to issue drug license		Participation in the Consultative workshop <u>*Implementation Phase*</u> With on-going construction activities PHC services might be fully or partially suspended. All relevant users and providers (CHWs, BHUs, RHUs) need to be informed through telephone, Whatsapp Participation in District Implementation Committee that meets monthly Supportive supervision and monitoring to health facilities under MERF and PPHI Monitoring all priority health verticals Project Orientation Meeting together with GRM orientation	
PPHI	PPHI Sindh is an autonomous company that manages most BHUs of DoH. About 1100 BHUs including few RHCs, GDs,		<u>*Design Phase*</u> 1 consultative session Participation in the Consultative workshop	Sometimes requires facilitation in procurement of FP services

Identified Party	Key Characteristics	Language Needs	Preferred Notification and Frequency	Specific Needs
	and Maternal, Child Health Centers (MCH) are being managed by PPHI.		*Implementation Phase* MoU/Partnership Contract between PPH and DoH Notification to DHOs regarding the transfer of GDs to PPH Member of District Implementation Committee that meets monthly Project Orientation Meeting together with GRM orientation	
Other Interested Parties				
Social Franchises	These are particularly Family Planning Services provided through organizations like Marie Stopes, Green Star etc. They have stronger quality controls and follow up systems		*SEP Finalization Phase* 01 consultative sessions with social franchises at provincial level *Implementation Phase* Representation in project steering committee Yearly progress sharing events at provincial level	
Private Partners	Ambulance Service and Telehealth services		*Design Phase* 4 IDIs *Implementation Phase* MoUs or contracts Half-yearly progress review	

Identified Party	Key Characteristics	Language Needs	Preferred Notification and Frequency	Specific Needs
			meetings	
SEPA	A regulatory body for Protection, Conservation, Rehabilitation and Improvement of the Environment, the prevention and control of pollution, and the promotion of sustainable development through enforcement of Environmental Laws		*Implementation Phase* Environmental Checklists to be submitted for construction activity	Compliance to Sindh Hospital Waste Management Rules 2014
DoH	DoH has a vast infrastructure of health facilities consisting of GDs, BHUs, RHCs, THQs, DHQs, tertiary and specialized hospitals		*Design Phase* 1 IDIs Participation in the Consultative workshop *Implementation Phase* Setting up Steering Committee and Project Management Unit (PMU) Project Orientation Meeting together with GRM orientation	Technical Assistance
PWD	The Department has been procuring contraceptive commodities to cater to the needs of all public sector stakeholders as well as selected NGOs. The Department houses a flagship program of the		*Design Phase* 1 IDI Participation in the Consultative workshop *Implementation Phase* Requisition to release FP supplies	Technical Assistance

Identified Party	Key Characteristics	Language Needs	Preferred Notification and Frequency	Specific Needs
	Government of Sindh called Costed Implementation Plan (CIP). CIP Secretariat under FP2020/FP2030 coordinates all FP related activities in Sindh in DoH, PWD, PPHI and development partners.		Reporting on DHIS Part of Steering Committee meetings	
Vulnerable Groups				
Displaced persons because of natural calamities or disasters	Majority population is dependent on agriculture as means of livelihoods. Loss of resources and livelihoods pushes them down the economic ladder and makes them vulnerable to diseases and different ailments	Local language and easily understandable modes of communication	*SEP Finalization Phase* 2 or 3 FGDs at relief camps *Implementation Phase* To be updated in the finalized SEP	Meetings to be held at the place of target stakeholders rather than any other place or office
Persons with Disabilities	Their mobility is moderately to severely restricted due to impairments. Some of them might have impairments due to lack of proper nutrition or non-administration of vaccines	Most public facilities lack provisions to facilitate persons with disabilities. Arrange meetings in local languages at a PWD friendly location	*SEP Finalization Phase* 2 consultative sessions with groups representing persons with disabilities Participation in the Consultative workshop *Implementation Phase* To be updated in the finalized SEP	Ramps; tactile flooring for visually impaired; assistive technologies and services
Poor Women/Girls/Children/ GBV survivors	These women can be victims of, malnourishment, patients	Trained and	*SEP Finalization Phase* 2 consultative sessions with groups/experts/organizations	In interviews of FGDs individual GBV

Identified Party	Key Characteristics	Language Needs	Preferred Notification and Frequency	Specific Needs
Adolescents with underlying health issues or experiencing emotional or mental stress	of acute illness, or survivors of GBV Such women not only face physiological problems but also psychological because of which they might be at risk of being outcast by their families.	experienced female subject experts with knowledge of local language and culture to be engaged to conduct stakeholder engagement with this group. Subject expert will be well-informed of available GBV support services.	representing the needs of vulnerable women Participation in the Consultative workshop *<u>Implementation Phase</u>* To be updated in the finalized SEP	experience will not be discussed. This topic should be discussed with women's groups or organization working on the agenda.

5. Stakeholder Engagement Plan

5.1 Stakeholder Influence

Stakeholder engagement activities need to continue throughout the project life, and need to keep specific stakeholder groups updated on relevant information imperative for transparency and disclosure, successful implementation of project activities, provision of means to exchange and propose better ideas on ongoing activities, flag concerns, and stay updated on outcomes.

The proposed engagement plan has been developed keeping in mind stakeholders' stakes in the process and degree of influence.

Table 4: Stakeholders' Influence-Stake Matrix

	DEGREE OF INFLUENCE ←	
	High influence	**Low influence**
DEGREE OF STAKE ↑ **High** / **Low**	Box A: Stakeholders who stand to lose or gain significantly from the project BUT whose actions can affect the project's ability to meet its objectives **CMWs** **CHWs** **FHWs** **Medical Officers** **BHUs** **Taluka Hospital** **District Hospital** **PPHI** **DHO** **DoH** **Ambulance Service** **PWD**	Box B: Stakeholders who stand to lose or gain significantly from the project BUT whose actions cannot affect the project's ability to meet its objectives **Users of PHC and FP services**

Table 5: Stakeholder Engagement and Information Disclosure

Type of Stakeholders	Target Stakeholders	Topics of Engagement	Methods to be used	Disclosure Documents	Roles and Responsibilities
Affected Parties	Users of primary healthcare facilities and services	Awareness raising about PHC, FP, and other health verticals; Usage of PHC/FP/Nutrition provisions, including first FP injection by CHW; Promotion of new GDs and Ambulance Service; Explanation of referral systems and assistance; Complaint or grievance redress	Door to door visits; sharing of campaign/promotional posters in common places in neighborhoods, social media handles; recruitment for awareness campaigns/events/talks/tele clinics	Complaint number/grievance procedures displayed in CHWs health corners, GDs, and BHUs	CHWs will conduct door to visits CMWs/FHWs will provide all necessary medical/FP products and information/campaign materials to CHWs in their weekly meetings
	Community Midwives (CMW)/	Consultation and management of patients; Operational plans and policies; Situational updates and needs; Feedback channel from patients and families; grievance redress related to non-payment of salaries, discrimination, wrongful termination etc.	Direct discussions with WMOs; Monthly reporting on DHIS; Grievance redress	Health data Complaint number/grievance procedures available on DHO website and clearly displayed at GDs/BHUs	CMWs will be managing GDs; They will report to WMOs
	Community Health Workers/ Family Health Workers	Recruitment of CHWs; Training schedules and program; Visit plans; Orientation to new health projects; Refresher training	Notification of vacant posts in newspapers and website. Notification of additional authority, roles and responsibilities through an authorized letter via e-mail, Whatsapp, courier	CHW program compiles data on performa and report it to LHS General staff notification or public notification letters from DHO to be	CMW will supervise a cluster of # CHWs

Type of Stakeholders	Target Stakeholders	Topics of Engagement	Methods to be used	Disclosure Documents	Roles and Responsibilities
			Orientation to LHS and CHWs/FHWs about the project by District Coordinators/Managers of the project	displayed on Notice Board in GDs Complaint number/grievance procedures displayed on Notice Boards	
	Medical Officers GDs/BHUs	Planning, budgeting, organizing, staffing, directing, coordinating, delegating, monitoring, controlling, regulating various functions.	Daily and weekly visits and meetings with CMWs and other GD staff on routine or project related activities; Reporting to PPHI/DHO through DHIs	Monthly report on Health Complaint number/grievance procedures displayed on Notice Boards	PPHI/DHO will be managing and setting targets for Medical Officers/WMOs
	District Health Officer	Operational policies; monitoring; Surveillance of epidemic/pandemic outbreaks;	Monthly coordination with District Committee and District Implementation Unit, and PPHI	Monthly report on DHIS Complaint number/grievance procedures displayed on Notice Boards and on website	DHO reports to DG Health. DHOs to facilitate smooth transition of GDs to PPHI
	PPHI	Project implementation strategy; Evaluation of staffing requirements; forecasting procurement requirements; PHC and FP monthly plans and targets; Challenges	Daily, weekly and monthly meetings of District Manager with BHU/GD staff	Monthly report on DHIS Progress update on website Monitoring and grievance redress reports updated on website Audit reports	PPHI is an autonomous body managed by a Board of Governors
	Department	Project implementation	Meetings of Steering	Project documents;	DoH will coordinate

Type of Stakeholders	Target Stakeholders	Topics of Engagement	Methods to be used	Disclosure Documents	Roles and Responsibilities
	of Health	strategy; Setting up of PMU;	Committees, Coordination of PMU with District Implementation Committees and District Implementation Units	Progress reports and updates; Monitoring Reports; Grievance Redress Report	with the World Bank on project activities
	Population Welfare Department	Project implementation strategy; policy and operational plans and procedures	Meetings of Steering Committees	Project documents; Data on disbursement of FP products	DoH and PWD will jointly implement the project
Other Interested Parties	International Development Agencies, INGOs, and NGOs	Financial or implementation support in healthcare initiatives; public private partnerships; operational plans and technical guidance;	Meetings with DoH and PWD	Memorandum of Understanding; Project Overview; Project Progress Reports on websites Electronic Medical Record (EMR) System	Focal points of interested parties
	Social Franchises in PHC and FP	Partnerships and cost sharing initiatives; distribution of free government FP products through social franchises; support in technical capacity development and third party monitoring			
	Private Partners	Provision of ambulances and telehealth services		Records as determined in MoUs	
	SEPA	Environmental checklist; EIAs	Meetings with DoH (where required with Works and Services Department	Environmental Checklists	

Type of Stakeholders	Target Stakeholders	Topics of Engagement	Methods to be used	Disclosure Documents	Roles and Responsibilities
Vulnerable Groups	Displaced persons because of natural calamities or disasters	Relief and rescue; Emergency services and supplies; Field operational plans and health surveillance; Special measures for high risk patients; Medical camps and mobile health services	Notification from DoH, DHOs and PDMA to respective public healthcare facilities and providers on emergency measures through websites; emails; SMS, WhatsApp Help Centers/Camps in affected areas Virtual Help Advisory Platform/Tele Health Emergency Helpline	Update on relief activities on websites	DoH and PDMA
	Persons with Disabilities	Improving accessibility for persons with disabilities in GDs; Provision of ramps for wheel chairs; Tactile flooring for visually impaired; Basic sign language symbols for hearing impaired	Focus Group Discussions with persons with disabilities and their representative organizations	GD design plans (If required, meetings with Works and Services Department)	DG Health and DG Works and Services Department
	Poor Women/Girls /Children/Adolescents with underlying health issues or experiencing emotional or mental stress	To be updated	Tele health and counselling sessions through 1193	To be updated	To be updated

5.2 Proposed Strategy to Include Vulnerable Groups

The project will take special measures to ensure that disadvantaged and vulnerable groups have equal opportunity to access information, provide feedback, or submit grievances. Government departments, civil society organizations, including NGOs working with identified vulnerable groups will be consulted in this connection. Their engagement will facilitate to factor in opportunities for the identified vulnerable groups. CHWs and CMWs will help to ensure proactive outreach to vulnerable groups through direct interventions, planning telehealth sessions, and coordinating with WMOs and DHOs for specialized programs and initiatives.

5.3 Strategy to Keep Stakeholders Engaged

All stakeholder engagement activities will be informed and regularly updated according to an iterative process of stakeholder identification, analysis and mapping and based on comments received on consultations held. The activities will be based on the various aspects of the project components as outlined in the project description.

6. Roles, Responsibilities, and Resources for Stakeholder Engagement Plan

6.1 Implementation Arrangements

The Environment and Social Safeguards Specialist will oversee the implementation of the project SEP with support from Project Director (PD). The project will also undertake measures for institutional capacity building including for the implementation of the SEP and will include indicators in its monitoring formats for the project.

6.2 Management Functions and Responsibilities

6.2.1 Steering Committee on Support Mechanisms, Oversight and Accountability

A Steering Committee (SC) for Oversight and Accountability for results will be established with highest policy level participation. DoH will be the secretariat for the SC while collaborating partners will be the members in the SC. The SC shall review progress on quarterly basis; review monitoring data, analytical reports and will take decisions for smooth implementation of the project.

6.2.2 Project Management Unit (PMU)

Under the overall supervision of the SC, a PMU will be established. PMU staff will include one environmental specialist and one social specialist who will also act as the focal person for gender related issues. These specialists will lead the process of stakeholder engagement; work with relevant officials to address stakeholders' concerns; supervise the contractors to mitigate environmental impacts mainly during construction work and waste management; flag important social issues, incidence of GBV or harassment to PD or PM for swift action.

6.2.3 District Implementation Unit

DIU will work under the District Implementation Committee. The latter will be chaired by Deputy Commissioner with DHO, DPWO, DM PPHI, DDO RMNCH, DDO Immunization, and WMO as members. This Committee will meet monthly.

7. Grievance Mechanism

7.1 Grievance Redress Mechanism

In compliance with the World Bank's ESS 10, a project-specific grievance redress mechanism (GRM) will be set up by the PMU to handle concerns, complaints, suggestions and questions raised by project affected people and other stakeholders. This will be in line with the requirements of the ESMF. It will specifically address complaints related to the environmental and social performance of the project in a timely manner. In the case of labor related grievances, those will be addressed in accordance with the Labor Management Procedure (LMP), which requires a specific GRM (project workers GRM) to be set up by contractors to handle labor related complaints. The PMU is responsible for ensuring the project workers GRM is functional and consistent with ESS 2 of the World Bank's ESF and should also have established communication channels with the GRM's set up by the contractors, so as to provide recourse to workers who may not have their grievances and/or feedback addressed by the contractor.

In the case of a complaint, the complainant always retains the right to take the matter to the appropriate legal or judicial authority as per the laws of Pakistan as well as provincial laws at any point in time.

- **Set up and Management of Project GRM**

The GRM will be put into place before starting any project activity. It will be proportionate to the potential risks and impacts of the project and will be accessible and inclusive. The project GRM will be set up and managed by the PMU, under the direct responsibility of the Project Director. The PMU will appoint a dedicated staff to manage the GRM. The roles and responsibilities related to the GRM staff and how the community liaison officers will work with the GRM will be detailed and reflected in the updated SEP.

- **Process of Receiving and Resolving Complaints**

In the case of resolution of complaints, the grievance redress mechanism will be in addition to the normal district-level processes that are available to citizens, however, it is the primary mechanism through which all project related grievances must be managed. Dedicated communication materials will be developed to help local residents and providers become familiar with the grievance redress channels and procedures. DoH website will also include clear information on how feedback, questions, comments, concerns and grievances can be submitted by any stakeholder. It will also provide information on the way grievances will be handled, both in terms of process and deadlines.

- **How to file a complaint**

The PMU will provide the channels where residents/beneficiaries/ affected residents can make a complaint by phone, email, letter or in person to the Project Manager or other staff assigned to work on the GRM. A free hotline number will be made before starting any project activities. The project must ensure the availability of all channels and accessibility to the complainant contact. Complaints from the GRM's set up by contractors, if not addressed and resolved at that level will also feed into the overall PMU GRM.

- **Receiving and recording complaints**

On receiving a complaint, the responsible PMU staff will acknowledge receipt to complainant and record the complaint within 1 business days. The person receiving complaints will fill out the complaint form

- **Review complaints or/and questions**

Complaints must be followed up on in 10 (ten) working days with the objective of resolving all grievances within four weeks. The person who is in charge of investigating complaints will gather the facts to understand the nature of the complaint, determine if it is project related, establish its legitimacy and seek to identify possible resolution strategies.

Investigation/follow-up can include site visits, document review, and meetings with parties who can solve the problem. The results of the investigation and response will be submitted for consideration to the Project Director, who will decide what action to take. After a decision is made and the complainant receives the information, the responsible staff will explain the action to be taken in the complaint form as well as details of the investigation and findings and submit a response to the Project Director for signing.

- **Response to complaints**

The complainant will receive notification of receipt of complaint by mail or e-mail. Responses will be made in answer to a question based on the materials of the investigation and, if appropriate, must refer to national/provincial law. The deadline of investigating complaints can be extended to 10-30 business days by the Project Director approval, and the complainant must be informed whether:
a) Additional consultation is needed to respond to a complaint; and
b) Complaints need to be answered by complex information and need to learn additional materials to respond.

If the matter remains unresolved, or complainant is not satisfied with the outcome at the project level, the head of the GRM, may then refer the matter to SC through PD but not directly to SC for a resolution. PAPs have the option to take his/her case directly to the established legal system as provided within the domestic laws.

- **Awareness raising**

Information about the GRM will be provided in an accessible format. It will be made available on the website and will be included in communication with stakeholders.

- **Staff roles and responsibilities**

The Project Director will assign roles and responsibilities to PMU staff and GRM staff. This will be documented in the Project Operation Manual and will be updated regularly. It will include:

- Management of the entire GRM system
- Develop and maintain the improvement of awareness
- Collecting the complaints
- Recording the complaints
- Notification to complainants about receipts and deadlines for reviewing complaints
- Sorting / categorizing complaints
- Observing the entire problems, including the causal relationship between project activities and suspected damage/danger/ disturbance
- Decision making based on the observation
- Processing appeals or ongoing communication to complainants with the aim of resolving the issue peacefully
- Publishing the responses to a complaint (need to be confirmed by the complainant)
- Organizing and applying information delivery and awareness raising campaigns
- Reporting and handling GRM results.

- **Capacity building**

All parties involved in the SEP will attend a workshop that will orient everyone about the Project and appraise all individuals of responsibilities and reporting structures before project activities begin. A specific training will also be held for persons involved in the GRM and a manual will be developed for these users setting out how to classify complaints, where to escalate different categories of grievances received etc.

- **Responsiveness to SEA / SH**

Mapping of GBV services providers that will be conducted for the project will help the identification of a quality GBV service provider that is accessible to complainants in project areas. GRM staff will be trained in GBV issues and on managing SEA / SH related complaints. They will be able to refer the complainants to GBV service provider with strict confidentiality and privacy and will maintain follow up for case resolution. Incident response will follow World Bank guidelines. Procedures for responding to an incident of SEA/SH will also be elaborated on in the action plan as part of the Accountability and Response Framework noted in the Good Practice Note on Addressing SEA/SH risks. All responses to GBV/SEA/SH incidents will be based on a survivor-centered approach. SEA / SH Plan will delineate these steps in detail.

- **Confidentiality and conflict of interest:**

Confidentiality is a fundamental aspect of the project and ensuring confidentiality and accountability is particularly critical in the case of GBV complaints. The GRM within the project ambit will have provision for registering anonymous complaints, however, to ensure the legal basis, it is preferred that complaints are registered with proper identification of the complainants. Nevertheless, anonymous complaints will be treated equally importantly. Furthermore, for SEA / SH related complaints, anonymity will remain the preferred, mode.

The Project Director must ensure there is no conflict of interest in the case of staff involved in investing and resolving particular disputes. With respect to GBV type complaints, a specific approach to dealing with such complaints must be developed in line with the WB GBV Good Practice Note before the GRM is operational which is before any project activities begin. This has been well reflected in the PAD.

The aim is to resolve all grievances within four weeks. Any grievance which is not resolved within that timeframe will be reported in detail in monthly Project Unit report and flagged in quarterly reports to the World Bank. All grievances will be aggregated to track trends for managerial response and also be included in quarterly reports to the World Bank.

7.2 Proposed Institutional Mechanism

The following will be established prior to commencing project implementation activities including pre-construction activities:

- A complaint drop-box to be placed at each selected GD site, to be checked and logged by GFPs on a weekly basis
- Grievance Focal Points (GFPs), which will be the ambassador of change and educated stakeholders on each project site. Two GFPs (1 male and 1 female) will be selected for each sub-project locations and will be community members / health workers who are easily approached by the community
- Public Complaints Register at the Taluka Health Office
- A District Grievance Redress Committee (GRC-District) will be established for each district that will manage GRM aspects for all sub-project locations in each district including decisions to be taken, actions and monitoring of complaints resolution. The District Coordination Committee will steer the GRC functions at the district levels.
- A Grievance Redress Committee (GRC-Central), responsible to oversee the overall function of the GRM at a strategic level including monthly review.

7.2.1 Grievance Focal Points (GFPs)

The GFPs will be literate people from each community or health workers from the selected GD that will assist and facilitate the community members in reporting grievances resulting from project activities.

7.2.2 Public Complaints Register

The DoH will place a Public Complaints Register (PCR) in their offices at the Taluka levels, and issue public notices to inform the public within the project area of the Grievance Redress Mechanism.

The Taluka level DoH office will be responsible to receive, log, and resolve grievances. Given that the female community members have restricted mobility outside of their villages and homes, their complaints could be lodged through GFPs.

7.2.3 Grievance Redress Committee (GRC-District)

A Grievance Redress Committee will be notified under the project for all participating districts. The GRC-District will be chaired by the Deputy Commissioner (DC) for each district. It will have mandatory female members and will include representation from health department, district government, community representatives, civil society organizations and project team. At least two women will be part of the core members of the GRC at district level.

The GRC's phone number, fax, address, email address will be disseminated to the people through displays at the respective DC offices, and at all the project sites of target district. The construction contractor will also display this information prominently at their site offices.

- The GRC will log complaint and date of receipt onto the complaint database and inform the E&S Staff at PMU level;
- The GRC will instruct contractors and GFPs to refer any complaints that they have received directly to the GRC;
- The GRC, with the contractors and GFPs, will investigate the complaint to determine its validity, and to assess whether the source of the problem is due to project activities, and identify appropriate corrective measures. If corrective measures are necessary, GRC, through the GFPs, will instruct the contractors to take necessary action;
- The GRC will inform the Complainant of investigation results and the action taken;
- The GRC will review the Contractors response on the identified mitigation measures, and the updated situation;
- The GRC will undertake additional monitoring, as necessary, to verify as well as review that any valid reason for complaint does not recur.

During the complaint investigation, the GRC should work together with the contractors and GFPs. If mitigation measures are identified in the investigation, the contractor will promptly carry out the mitigation. GFPs will ensure that the measures are carried out by the contractor.

7.2.4 Grievance Redress Committee (GRC-Central)

A GRC will also be established at the PMU level. The GRC will function as an independent body that will regulate the grievance redress process and address grievances that were left unresolved at the GRC-District level or were scaled up. The central GRC will also have specified number of core members, with an option to coopt more members if the need arises. It will comprise of: Environmental Specialist (ES) and Social Specialist (SS) of PMU, Senior Engineers from DoH, Representative of DoH from concerned districts and senior members from civil society in project areas. At least two core members of the central GRC will be women. All efforts will be made to include more than two female members in the central GRC.

8. Monitoring and Reporting

8.1 Involving of Stakeholders in Monitoring Activities

PMU under supervision of the Steering Committee will conduct monitoring of implementation; provide supportive supervision through district and facility level arrangements; will conduct baseline, midline review and end of project evaluation. Other M&E activities will include (a) regular supervision of project construction sites; (b) preparing biannual implementation progress reports; (c) monitoring and verification of project objectives by involving third-party entities; (d) conducting citizens' engagement surveys for ensuring beneficiaries' and communities' satisfaction. Necessary TA support will be provided

to PMU for carrying out the listed M&E activities. Project documents and reports shared by stakeholders (DHOs, PPHI, WHOs CMWs, CHWs) through DHIS will provide necessary reference data for monitoring and evaluation. Discussions on how to converge the new system of MR with the existing data management tools will be discussed and agreed upon in consultation with data management experts.

Moreover, ESCP and SEP require regular consultations with stakeholders. Six-monthly ESCP compliance monitoring reports would be prepared and submitted by the Environment and Social Specialist(s) of the project throughout the project life.

8.2 Transparency, Monitoring, and Reporting

Transparency: Regular policies, procedures, and updates on the GRM system, complaints made and resolved, will be available on the DoH PWD website. This component will be updated every mid-year.
Routine internal monitoring and reporting: The PMU will assess the GRM function on a quarterly basis to:
- Make summaries of GRM results on a monthly & quarterly basis, including suggestions and questions, to the project team and management.
- Review the status of complaints that have not been resolved and suggest corrective actions as needed.

On the quarterly meeting, there will be a discussion and review the effectiveness and use of GRM and collect suggestions on how to improve it.

8.3 Submitting the midterm and annual progress report to the World Bank

In the midterm (semester) and annual implementation reports that are submitted to the Bank, the DoH will include GRM results, which provide the latest information as follows:
• Status of GRM formation (procedures, staffing, awareness raising, etc.);
• Quantitative data about the number of complaints received, the relevant number, and the amount completed;
• Qualitative data about the types of complaints and answers given, unresolved problems;
• The time needed to resolve complaints;
• Number of complaints resolved at the lowest level, rising to a higher level;
• Any special problems solved by procedures/staffing;
• Factors that can influence the use of the GRM / beneficiary feedback system; and
• All corrective actions used.

9. Budget

Implementation of all ESF instruments including the SEP will be financed from the project budget. An estimated budget will be provided in an updated SEP at the start of program implementation. Based on prior experience in similar engagement undertaken by Government agencies, the budget for the SEP finalization is proposed to be approximately USD$25,000. Most of the SEP engagement activities in the ***implementation phase*** are aligned and integrated with project activities The budget for the SEP implementation is proposed to be approximately USD$50,000. The detailed costs, and any specific or

unaccounted for expense/investment in implementation of the SEP will be identified in the review of SEP in three months through further consultations with the executing agencies and included in the project budget under appropriate heads.

Annex One: Consultations

	Organization	Designation	Date
1	CIP, PWF	Technical Advisor	26th August 2022 30th August 2022
2	Marie Stopes	Director Technical Services and Donor Projects	29th August 2022
3	Green Star	General Manager	1st September 2022
		General Manager, Programs	
		Deputy General Manager	
4	DHO	DHO Thatta	2nd September 2022
5	PPHI	CEO	3rd September 2022
		COO	
		Principal Officer to CEO	
6	DHO	DHO Sujjawal	4th September 2022
7	World Bank	Short Term Consultant on Stunting Program	5th September 2022
8	Sindh Environment Protection Agency	Assistant Director	12th September 2022
		Deputy Director	

Consultation with FHWs at DHO, Sujawal, 4th September 2022

BHU+, Nodo, Sujawal

Annex Two: List of Project Districts

District	GD's with 4 KM more distance from BHU/RHC	Uncover Population	GD's Required to Support
Hyderabad	23	168126	5
Badin	43	908490	26
Matiari	16	370033	9
TMK	1	293448	1
T.Allah Yar	34	395959	10
Sujjawal	14	635195	12
Jamshoro	15	97586	15
Thatta	8	628486	8
Dadu	19	540717	10
Sukkur	7	615806	7
Ghotki	14	1089702	10
Khairpur	38	390166	20
SBA	56	1104544	42
N.Feroz	49	374902	19
Sanghar	15	1337056	16
Larkana	22	445939	18
Kashmore	11	637239	8
Shikarpur	19	505374	14
Kambar	26	499570	25
Jecobabad	35	664095	26
Mipurkhas	28	1007906	19
Umerkot	101	514020	21
Tharparkar	374	1068625	33
East	7	1052695	7
West	0	73286	0
Central	3	25275	0
Korangi	0	926265	4
Malir	10	528201	7
Total	**988**	**16898706**	**392**