Meghalaya Health Systems Strengthening Project (P173589)

Stakeholder Engagement Plan

Department of Health and Family Welfare

Government of Meghalaya

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ABBREVIATIONS

ADC	Autonomous District Council
ANM	Auxiliary nurse midwife
ASHA	Accredited social health activist
BMW	Bio-medical Waste
CERC	Contingent Emergency Response Component
CHC	Community Health Centre
CMO	Chief Medical Officer
CTF	Common treatment facility
DH	District Hospital
DMHO	District Medical and Health Officer
DOHFW	Department of Health and Family Welfare
E&S	Environmental and Social
ESF	Environmental and Social Framework of World Bank
ESMF	Environmental and Social management Framework
ESMP	Environmental and Social Management Plan
ESS	Environmental and Social Standard
FPIC	Free, Prior, and Informed Consent
GBV	Gender Based Violence
GHADC	Garo Hills Autonomous District
GoI	Government of India
GoM	Government of Meghalaya
GRM	Grievance Redress Mechanism
HCF	Health Care Facility
HR	Human Resource
HWC	Health and Wellness Centre
ICT	Information and communication technology
IEC	Information, Education, and Communication
IPA	Internal performance agreement
IPF	Investment Project Financing
IPM	Internal Performance Management
IT	Information Technology
JHADC	Jaintia Hills Autonomous District
KHADC	Khasi Hills Autonomous District Council
MHIS	Megha Health Insurance Scheme
MMR	Maternal Mortality Rate
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MSPCB	Meghalaya State Pollution Control Board
NCD	Non-communicable diseases
NGO	Non-governmental Organization
NHM	National Health Mission
NQAS	National Quality Assurance Standards
OHS	Occupation and Health Safety
OOPE	Out-of-pocket expenditure
OSC	One Stop Centre
PDO	Project Development Objective

PHC	Primary Health Centre
PMU	Project Management Unit
PPE	Personal Protective equipment
PPP	Public Private Partnership
RKS	Rogi Kalyan Samiti
SBCC	Social and Behaviour Change Communication
SC	Sub-Centre
SEA	Sexual exploitation and abuse
SEP	Stakeholder Engagement Plan
SH	Sexual harassment
SOP	Standard Operating Procedure
VC	Village Council
WCD	Women and Child Development

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STAKEHOLDER ENGAGEMENT PLAN FOR
MEGHALAYA HEALTH SYSTEMS STRENGTHENING PROJECT (P173589)

1 INTRODUCTION

The Government of Meghalaya (GoM) recognizes that improvement of the health systems is paramount for a citizen-centric fully functional service provision. Recognising the gaps in current services, GoM plans to strengthen the health systems through a series of measures that can not only bring efficiency in operations but also ensure achievement of short term and long-term goals of having qualified competent staff that can sustainably provide quality service delivery. The Meghalaya Health System Strengthening Project (MHSSP) articulates the key measures that the GOM plan to take in strengthening the health system in the state.

The MHSSP is under preparation and in accordance with World Bank's Environment and Social Framework (ESF). In compliance with its requirements under ESS10 on 'Stakeholder Engagement and Information Disclosure', this plan has been developed to guide the engagement of various project stakeholders, including affected persons with the project during its life cycle, spell the strategies and approaches that would be in place to ensure that all stakeholders are informed a priori about all proposed project activities and their impacts in a culturally appropriate manner and mechanisms that would be developed by the project to systematically seek their feedback. ESS10 recognises that effective engagement with the stakeholder can significantly improve the project outcomes and their sustainability through better community acceptance and ownership, enhance the environmental and social sustainability of projects, and hence make a significant contribution to successful project implementation.

1.1 Project Background

The proposed project development objective (PDO) is to "improve management capacity, quality and utilization of health services in Meghalaya; in case of an Eligible Crisis or Emergency, respond promptly and effectively to it". More specifically, the project will improve the quality and responsiveness of health services among public facilities at primary health center (PHC), community health center (CHC) and district hospital levels. This shall be done by creating an ecosystem of increased accountability through intra-governmental Internal Performance Agreements (IPA). IPAs shall be designed both as a management and financing tool for enabling a culture of accountability, which will over time improve utilization of health services. The progress towards achievement of the PDO will be measured by the following results indicators:

a. Percentage point increase in average performance score in targeted administrative units as per internal performance agreement from baseline. (percentage) (*management capacity*)
b. Cumulative number of districts hospitals which are NQAS certified. (number) (*quality*)
c. The percentage point increase in average quality index score for CHCs and PHC from baseline. (percentage)(*quality*)
d. Increase in number of patients utilizing government health services OPD in targeted facilities. (number)(*utilization*)
e. Percentage of claims settled within agreed turnaround time. (percentage) (*utilization*)

1.1.1 Project Components

Component 1. Improving accountability, management and strengthening governance (cost US$ 18 million). This component provides Provision of Performance Incentive Grants to Health

Agencies and Health Facilities to improve governance and management structures. The project envisages IPAs as a tool to infuse new way of operations by moving from input-based financing to RBF. An RBF approach is expected to strengthen the management and accountability relationships between the state- and the substate-level implementing units. Grants to institutions and health facilities would be made available against the achievement of performance indicators specified in IPAs. The IPAs aim to foster a spirit of more accountable government, along with results-based financing, contributing to improvements in management of the system and delivery of quality health services.[1]

The IPAs will be designed to align the objectives of the participating entities. Internal verification mechanisms, governed by IPAs, will ensure regular assessments. An external counter-verification mechanism will be established to validate internal verification results. Additionally, a capacity building vehicle will be prioritized for the implementation of IPA and to build the local institutional capacity to sustain the management capacity and practices beyond the project. The capacity building vehicle consist of "champions" from health department at different level who will play key role in internal assessment of results and provide mentoring support, secondly, the local level institution (academic or think tank) will be identified who will be involved in the project activities as an advisor and mentor the department. The Bank and State will jointly identify local institutions and provide exclusive technical assistance for building their capacity that will be retained in the State.

IPAs will be implemented at the state, district, and health facility levels. Each of these levels will contribute to system strengthening, to improve the health insurance programs and the quality of health services. Entities with which the DoHFW will sign internal agreements are (a) the state-level DMPH, the DHME, their subsidiary departments, and the MHIS; (b) district-level health administrations and district hospitals; and (c) health facilities, at both the primary (PHCs) and first-referral (CHCs) levels.

At the health facility level, this approach will provide flexible resources, strengthening management autonomy of decentralized structures. A system of geographic equity adjustments will be put in place to ensure that the most destitute health facility will have relatively the largest performance budget. To start with a total of 95 health facilties (11 DH, 18 CHC and 66 PHC) has been indetified, indlusing 64 rural primary health centers. Measures that will govern these geographic equity adjustments will include travel time to the state capital, human resources density, poverty scores, and immunization coverage. At the health facility level, the IPA will be focused on key structural quality elements such as planning, budgeting, and coordination; user experience targeting women patients; and core metrics for content of care quality such as knowledge and competency tests of providers. These quarterly metrics, carried out timely and diligently by certified assessors from district and state levels (responsible to their departments, governed by IPAs), will be carefully designed in close collaboration with the client and adjusted incrementally once a year or once in two years.

Implementation will use an iterative adaptive learning approach where attention will be given to identifying and nurturing change agents at each level of implementation. Processes which draw in key interlocutors at each level (health facilities; district health administration; State MOH departmental levels) through purposeful design, will yield tools that will achieve their intent. IPA design will start with PHC and CHCs and DHs, after which district health administration will be targeted. Finally, the IPAs at select State MoH department levels will be designed. These processes will be started during appraisal with virtual tours of health facilities after which a calendar will be created for technical working groups. TWG sessions will start with defining key performance gaps and will share experience

[1] Fritsche, G., et al. 2014. *Performance-Based Financing Toolkit.* Chapter 8, page 165. Washington, DC: World Bank. https://openknowledge.worldbank.org/handle/10986/17194 License: CC BY 3.0 IGO.

from select successful performance enhancement approaches from comparable contexts. Tools and methods will be crafted collaboratively, after which a plan will be created to pilot test and scale these tools and methods. An adaptive learning approach will be used to ensure lessons learned in the pilot will be incorporated before scaling. Attention will be paid to identifying and nurturing change agents at each level.

The performance metrics in the IPA are determinants of improved management capacity and quality of health services. Distinct performance metrics are designed for the levels as per their roles and responsibilities that contribute to enhanced access to and quality of health services. The various metrics in the performance frameworks are designed and weighted using a bottom-up process with the client. The state-level indicators (for directorates) are to improve timely resource allocation to districts and health facilities, for policy reforms in human resources and their deployment, and to ensure procurement and supply of drugs and medical equipment as per the need. District-level performance indicators contribute to improved monitoring and supervision, coordination support for supply of drugs, institutional-level review for biomedical waste, and facilitation of quality improvement and accreditation processes. At the health facility levels, performance indicators are targeted to improve quality of service delivery including content of care quality, patient satisfaction, satisfaction and user experience of women patients, biomedical waste implementation, use of energy efficient resources at the facility level, reporting and documentation, and clinical skills of the medical staff including knowledge enhancement on climate-related diseases and disasters.

The directorates will be supported in identifying existing sector wide gaps in management, delivery, and quality of health services, as well as in coverage and operation of the health insurance program. They will be supported in determining the most suitable approaches to address these gaps, developing action plans, and operationalizing those plans. A first phase of performance-based funding will be provided to the directorates, district-level health offices, eligible subsidiary divisions, and the health insurance program, which will meet preconditions reflecting a minimum level of capacity and interest, including development of action plans with agreed targets and these latter will be a precondition for this first phase of funding. This process will build institutional capacity of the decentralized health administrative units at the state and substate levels in need-based planning and management of health services.

The IPAs will encompass objectives, key results, and indicators reflecting those results, as well as financing tied to the composite performance score of the IPA. Action plans will be defined for accomplishing the results, with implementation of the action plans supported by a first phase of funding, followed by funds transferred based on results. Indicator definitions and reporting procedures will be specified, with reporting aligned to the existing health management information system (HMIS) and other reporting or documentation systems, while the IPA results will be assessed each quarter by certified assessors. Internal and external verification procedures will also be specified in the IPAs. Regular results assessments will be institutionalized, and data availability will be enhanced through the creation of a dashboard.

Though NQAS certification comes with a monetary award, getting health facilities prepared for accreditation has significant up-front costs, and this is where the health facility IPA comes in. The health facility IPA will provide funding based on quality performance. Part of the health facility quality index will be metrics measuring progress on accreditation planning and implementation. Furthermore, low-quality health services have an immediate impact on health benefits, and it seems imperative to tackle this as a matter of some urgency. Also, in times of the COVID-19 epidemic, strengthened attention to infection control and prevention, in general, is urgent. Process quality in the Donabedian sense, the 'content of care quality', which is what happens between the provider and the patient, is significantly related to outcomes of health services.[2] A significant weight within the quality index will come from anonymized health worker knowledge scores.

The achievement of performance indicators reported by the administrative units and health facilities which are parties to the IPAs will be verified in two ways:

(a) An existing pool of human resources who are currently tasked with various Quality Assurance (QA) activities will use the internal verification mechanism. These individuals will be mapped organizationally to departments and units that will be under IPAs. These "champions" will be the "change agents" at different levels in the system will also operationalize and prioritize implementation of IPA in the State.

(b) An external agency will undertake the counter verification of results confirmed by internal verification system. This external agency will independently assess a sample of the reported results as well as the use of financial incentives by different levels.

The IPA is an effective way for all stakeholders to collectively think beyond inputs. Moreover, it promotes defining the results together, compelling health officials at different levels to be more mutually accountable for shared goals. This approach emphasizes working backwards by focusing on desired outcomes, identifying binding constraints, and using financing to unlock those constraints.

Under Component 1, the project will finance the incentives in the form of grants to institutions and health facilities against achievement of results as per the IPA. These grants will be used for implementation of activities that support approved improvement plans to increase the quality of health services and overall accountability in the health system.

Component 2: Strengthening systems to improve the quality of health services (cost US$ 17 million). The investment under this component will: (a) Development and implementation of a quality assurance program including training, certification and quality tracking tools, and investments in the functionality of health services infrastructure, for district hospitals, CHCs and PHCs; (b) Provision of support for infection prevention and control, environmental and energy efficiency measures, and management of resources and biomedical waste at the health facility level; (c) Development of tools and provision of technical assistance including training and outsourcing to improve: (i) human resources supply, planning and management, (ii) in-service capacity-building, and (iii) pre-service education; (d) Strengthening of DoHFW's procurement of medicines and consumables and supply chain management at state and sub-state levels; (e) Development of systems for, and provision of training and technical assistance to, the administrative structures responsible for health system management in planning, management and monitoring; and (f) Provision of support for the management of the Project, including on its technical, fiduciary, safeguards management, monitoring and evaluation aspects. Under this component, the project will also support review of the HR policy to promote women professionals' entry, transition and career advancement across various job roles in the health sector. The component will also incentivize hiring of women professionals through preferential clauses in the PPP contracts. This component involves various information and communication technology (ICT) activities to improve the overall efficiency and will also pilot ICT solutions under innovations. These investments will improve the capacity of the state government health systems to better respond to the ongoing COVID-19 pandemic as well as increase preparedness for future outbreaks.

a. **Develop comprehensive quality assurance programs to improve delivery and quality of health services provided by DHs, CHCs and PHCs.** This will include investments for certification under the National Quality Assurance Standards (NQAS). As part of continuous capacity building, the state will create a pool of trainers to undertake facility-level trainings and mentoring along with a hands-on approach for implementing NQAS. The project will establish a quality-tracking dashboard for monitoring. To achieve quality standards, the project will invest in health service infrastructure to improve functionality. This will include

improvements to water supply, sanitation and electrical power, as well as technical infrastructure like neonatal and paediatric intensive care units.

b. **Support to infection prevention and control, and biomedical waste management.** The project will support improvements in infection prevention and control at the health facility level, including necessary supplies, equipment and training. It will also support development and implementation of a plan for improving management and disposal of biomedical waste generated by both government and private health facilities, in collaboration with the State Pollution Control Board and municipalities. The project will support interventions to make health facilities environmentally friendly and energy efficient. This will include using solar power, conserving water resources through rainwater harvesting and landscaping, and improving public spaces. Along with overall strengthening of the health system to respond to increased burden of disease attributable to the effects of climate change, these project-supported activities will help mitigate immediate aspects of the impact of climate change on the natural environment of the state.

c. **Development of human resources.** The project will improve capacities and management of human resources in order to maximize the **r**eturn on investments in service delivery capacity and quality. The project will address constraints to availability, motivation, and performance of health human resources in three areas, namely (i) human resources supply, planning and management: (ii) in-service capacity building: and (iii) strengthening pre-service nursing education. The capacity of the DoHFW for planning and management of human resources will be strengthened including a detailed enumeration of the human workforce across cadres to map current demand and supply. This will inform development of a human resources for health strategy and a management framework, including a forecasting plan. Shortages in human resources for health will be addressed by contracting-in specialists for hospitals, and outsourcing management of selected PHCs and CHCs under contracts with the private sector. Capacity-building will aim to develop technical and managerial skills and competencies of health cadres. The project will invest in the existing training institutions and state agencies (such as the State Institute of Health and Family Welfare) to deliver continuous medical education. The project will also implement "Low Dose High Frequency (LDHF) Trainings" for health facility staff with the aim of building clinical skills and improving quality of care. Initiatives for improving the skill-mix and distribution of responsibilities of in-service physicians and nurses (task-shifting) will be piloted in selected districts. The project will also strengthen the pre-service education in the General Nursing and Midwifery schools and contribute to upgrading the existing GNM schools to B. Sc college of Nursing.

d. **Strengthening of procurement and supply chain management.** The DoHFW procurement and supply chain management systems will be strengthened to improve the supply of medicines and consumables. The project will support capacity building of state and sub-state level structures involved in procurement and supply chain management, like the State Procurement Board. This will include organizational strengthening, business process reengineering, need-based retrofitting, warehouse renovations to improve storage capacity, and development of monitoring capacity and information systems.

e. **Testing innovations in service delivery through pilot interventions.** The project will support design, development, and piloting of innovative models for outreach and service delivery outreach. Activities may include (i) using tele-medicine to connect PHCs for referral and tertiary care, and (ii) using drones for the purpose of improving the health service delivery such as emergency supplies of drugs and blood units in hard-to-reach areas.

f. **Improvement of planning, management, and monitoring.** The project will strengthen the administrative structures responsible for health systems management. This will include technical support and training for administrators at the state and district levels on planning, management and technical issues, with support by a contracted Project Management Agency (PMA). The project will support knowledge exchange with other states in the region as well as other parts of India on technical and system development innovations and reforms. The project will support integration of existing information systems and development of applications to improve oversight and management of the health system. This will include development of a command-and-control system to foster inter-operability of existing information systems and applications, including the health management information system (HMIS), epidemiological surveillance system, electronic health records, human resources management information system (HRMIS), the MHIS information system, the grievance redressal system, and others.

g. Provision of support for the management of the project, including on its technical, fiduciary, safeguards management, monitoring and evaluation aspects. A Project Management Unit (PMU) embedded in the DoHFW will be responsible for technical, fiduciary and safeguards management, as well as monitoring and evaluation. The project will finance: (i) establishment of a PMU within the Directorate of Health Services along with the necessary technical staff and consultants; (ii) the incremental costs incurred by government agencies in implementing project-financed activities; (iii) establishment of expert groups to provide technical support to the PMU; (iv) provision of training to PMU staff, government staff and technical experts; (v) technical, fiduciary, and safeguards oversight and supervision of project activities in the field, and (vi) monitoring and evaluation of the project at all levels.

Under Component 2, the project will finance: (a) hiring of consultant support; (b) minor civil works in compliance with ESS requirements; (c) goods and equipment; (d) Trainings; (e) hiring of additional human resource (such as hospital managers and other technical staff); and (f) hiring of non-consultancy services for clinical and non-clinical works.

Component 3: Increasing coverage and utilization of health services (US$ 5 million). This component will invest in increasing the coverage of the state health insurance program, strengthen primary care through Health and Wellness Centers, and strengthen community-level interventions and engagement. This will be achieved through: (a) Assessment and strengthening of the Megha Health Insurance Scheme, including its organization and operation systems to improve coverage; and (b) Support for innovation pilots in health and wellness centers and community-level interventions.

(a) **Improving coverage and strengthening institutional capacity of the Megha Health Insurance Scheme.** The scheme will be strengthened to improve population coverage, increase utilization, reduce disparities in seeking benefits, and develop institutional capacity. More specifically, the project will finance strengthening of the scheme design through comprehensive evaluation of processes and service utilization, and review of benefit packages and pricing. It will finance interventions for increasing population coverage and demand for services. These will include community-level interventions, data collection and consultations, for reaching families for enrolment; developing and implementing a communication strategy; and incentives for frontline workers for identifying uncovered households. Organizational infrastructure, systems and capacity, will be strengthened by developing the scheme's management information system; improving operational guidelines and standard operating procedures (such as for empanelment, monitoring and evaluation, anti-fraud management, financial management and fund utilization); building the capacities of hospitals, district and state-level staff to facilitate coverage and operation of the

scheme; improving capacities of the scheme's staff, including learning visits; upgrading its office infrastructure; and expanding the toll-free helpline for the scheme.

(b) **Pilot innovations in Health and Wellness Centers and community-level interventions.** The project will support the state in implementing the national Ayushman Bharat strategy for strengthening Health and Wellness Centres, including strengthening capacity to provide an expanded package of services to encompass primary screening, counselling and referrals for NCDs. The project will pilot innovative strategies in in two districts of the state, in select 20 Health and Wellness centers to improve their service delivery through telemedicine and contracting of service management to non-governmental and private organizations.

(c) **Innovations to enable gender equity**: The project will pilot community-led interventions in an integrated and multi-sectoral approach for women and child development in 100 villages under the selected Health and Wellness Centers. The project will undertake an assessment to identify gender gaps in service delivery and patient experience in select health and wellness centers. This will inform the roll-out of specific parameters to improve the utilization rate amongst women patients, particularly pregnant women. **Project** investments will provide a roadmap for scaling-up of interventions using government funds, integrating elements of ongoing community interventions supported by the National Health Mission. The component will also support intervention services to survivors of violence against women and children. This will be established on a pilot basis as an out-patient department (OPD) of the hospital, with linkages to legal aid agencies, police stations and shelter homes. The objective of this would be to establish intimate partner violence/domestic violence against women and children as a legitimate public health issue.

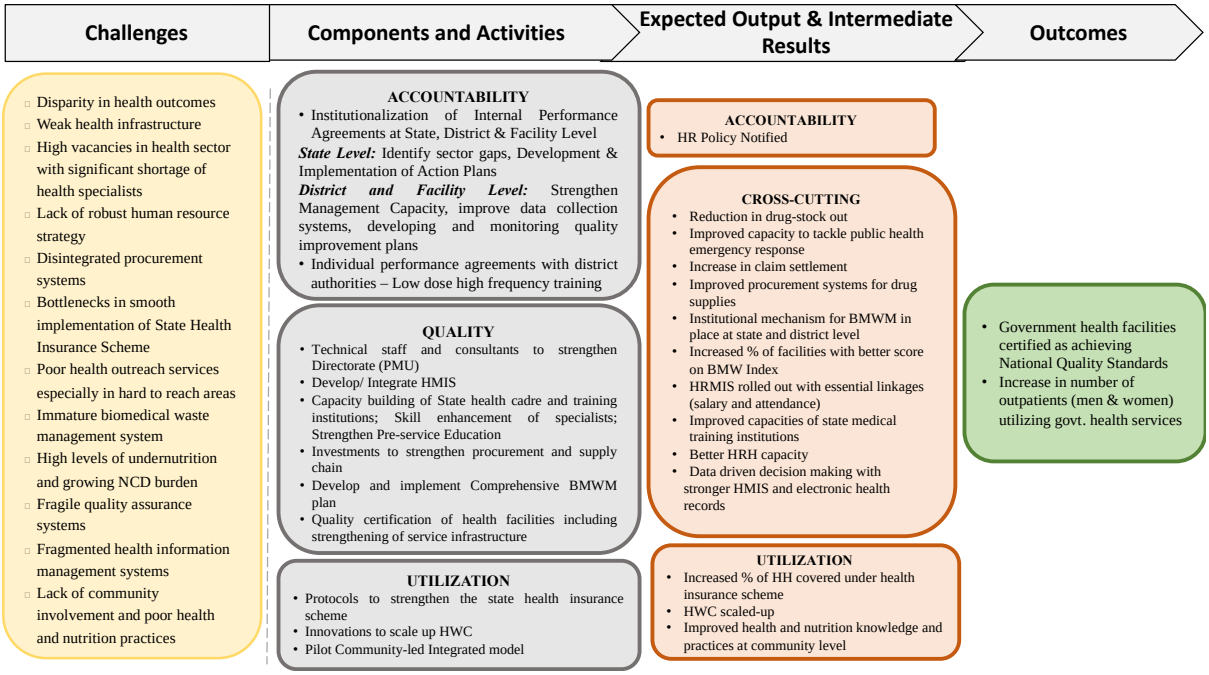
Under Component 3, the project will finance: (a) hiring of consultant support: (b) minor civil works: (c) goods and equipment: (d) training: and (e) hiring of non-consultancy services.

Component 4: Contingent Emergency Response Component (cost US$0 million): Provision of immediate response to an Eligible Crisis or Emergency, as needed.

1.1.2 Project Beneficiaries

1. The proposed project will benefit the entire state of Meghalaya as it aims to strengthen the state public health system. The primary focus will be on strengthening the 12 district hospitals, 23 CHCs and 70 PHCs across the state. Systems will also be strengthened in the Megha Health Insurance Scheme which is currently used by 56 percent families in the State.
2. The project will also benefit the health sector staff, specifically at the secondary and primary levels, by strengthening their capacity and provide them skills training. The investment at the health facility level to improve infrastructure, private sector partnerships, technology solutions, and improved working conditions will improve their efficiency and satisfaction level and provide better quality care.
3. The community level intervention that follows the integrated approach for child development also provide focused health and nutrition service for mothers. This will benefit the women and child through focused intervention.

1.1.3 The Result Chain



1.2 Key Environmental and Social Risks and Impacts

The project does not envisage potential large-scale, significant or irreversible environmental impacts. The project does entail a range of minor civil works for infrastructure repair and rehabilitation, but the risks and impacts associated with these activities (such as noise and dust pollution) will be localized and short-term. The project proposes to develop a strategy and finance primarily capacity building and institutional strengthening including (i) hiring of external consultancy support; (ii) minor civil works; (iii) purchase of goods and equipment; (iv) training of human resources; and (v) purchase of services.

With the improved utilization of health services through the project, the quantity of bio-medical waste will increase. However, the increase of biomedical waste will not be significant. Nonetheless, given that the present bio-medical waste management of the State, the project will invest to improve the overall ecosystem for bio-medical waste management that includes segregation, disinfection, collection and disposable that largely safeguards the environment and contributes in improving the quality of health service and patient safety.

Overall, it is expected that the project will have positive environmental and social impacts, given the project components aims to strengthen the public health function and improve the access to and quality of health service delivery in Meghalaya. The key social risks emerge from the risk of exclusion and access to services given the difficult geographic terrain of the state and especially those living in remote and hilly areas.

1.3 Objectives of Stakeholder Engagement Plan (SEP)

SEP seeks to provide a transparent engagement and open communication between and among the project stakeholders to maximize participation and inclusion for project design, implementation, monitoring and evaluation; enhance project acceptance and improve the environmental and social sustainability. A systematic approach to stakeholder engagement will help DoHFW develop and maintain over time a constructive relationship with the stakeholders throughout the duration of the Project.

Specific objective of this SEP is to establish a systematic approach to stakeholder engagement at project level that will:

- Identify stakeholders and build/maintain a constructive relationship with them to enable stakeholders' views to be considered in project design and environmental and social performance;
- Assess the level of stakeholder interest and support for the project;
- Promote and provide means for effective and inclusive engagement with project affected parties throughout the project life cycle on issues that could potentially affect them;
- Ensure that appropriate project information on environmental and social risks and impacts is disclosed to stakeholders in a timely, understandable, accessible and appropriate manner and format; and
- Provide project-affected parties with accessible and inclusive means to raise issues and grievances and allow DoHFW to respond to and manage such grievances.

1.4 Methodology Adopted in Development the SEP

To inform project design and for development of SEP, consultation with various stakeholders were undertaken including discussions were conducted with key officials in DoFHW. These consultations were done where possible (especially some of those in Shillong) on face-to-face, and otherwise in a virtual manner in relation to main environmental and social aspects of the project. The views of the vulnerable groups are sought through virtual consultations with representative organizations/ institutions and NGOs/ CBOs working with them. This involved:

- Discussion with DoFHW key officials
- Discussion with State pollution control board, Social Welfare and Tribal Development Department, Women and Child Development Department, Education Department, all three Autonomous development Councils (Khasi Hills ADC, Garo Hills ADC, Jayantia Hills ADC) in virtual manner.
- Discussion also happened with Meghalaya Medical Services Association, the larger body of medical professionals in Meghalaya
- Survey of 17 HCFs including 2 DHs, 2 CHCs, and 14 PHCs to collect baseline on key environmental and social indicators using digital methods.
- Consultation with HCFs key Medical officers/ Nurses using one-to-one phone calls about their issues and concerns as well as issues and concerns with 2 DH, 2 CHC, 7 PHC/ UHC and one DMHO.
- Consultation with CBOs (including women groups, elderly groups etc) and NGOs (15 in #s) to voice the concerns of women, youth, elderly, and disabled population.
- Consultation with traditional community heads/ village council chairman(s)/ members to voice the concerns of beneficiaries including poor, vulnerable and marginalised groups living in their village.

The key concerns as voiced by various stakeholder groups are presented in Annex-I, and further informed the ESMF and project preparation by instituting specific measures targeting poor and vulnerable population and those living in remote areas.

 Consultation with Women's group	 Consultations with NGOs – face to face as well in virtual manner

2 STAKEHOLDER IDENTIFICATION AND ANALYSIS

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) persons who may be disproportionately impacted or further disadvantaged by the project as compared with any other groups due to their vulnerable status, and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project are categorized as "**vulnerable groups**").

2.1 Affected Parties

Affected Parties include local communities, community institutions, health care facilities, health care providers etc who may be subject to direct impacts from the Project and includes:

- Community living on target areas of the project
- Community institutions such as Village Health and Sanitation Committees (VHSCs), ASHAs, ANMs in the villages that coordinate with target health facilities kin providing promotive health care and provide linkages to reproductive, maternal, new-born and child health (RMNCH) services
- Target health facilities i.e. target District Hospitals, CHCs, PHCs, and SCs
- Health care workers especially in the target health facilities
- Workers associated with handling, transportation and disposal of BMW
- Department of Health and Family Welfare and all its Directorates

2.2 Interested Parties

The project stakeholders also include parties other than the directly affected communities, including:

- Other line departments and agencies such as State pollution control board, Social Welfare and Tribal Development Department, Women and Child Development Department, Education Department, Autonomous development Councils (Khasi Hills ADC, Garo Hills ADC, Jayantia Hills ADC) etc.
- Elected representatives
- NGOs and CBOs including women groups, elderly groups etc.
- INGOs supporting NGOs/ CBOs in Meghalya on health care, disability, gender, and other such issues
- Media groups and academia
- The public at large

2.3 Vulnerable Groups

It is important to understand and recognise whether project impacts may disproportionately fall on disadvantaged or vulnerable individuals or groups, who often do not have a voice to express their concerns or understand the impacts of a project. And hence, awareness raising and stakeholder engagement with disadvantaged or vulnerable individuals/ groups on health care services in target areas be adapted to consider such groups or individuals' issues and concerns, cultural sensitivities, and to ensure proper understanding of project activities and benefits. This includes:

- Elderly
- People with disabilities
- Women, especially Young women and girls at heightened risk of gender-based violence
- Scheduled tribes (ST), scheduled castes (SC), and communities living in in remote and hilly locations
- Illiterate and poor population especially in rural and remote areas
- Female-headed households, especially single mothers with underage children
- Tribal/ ethnic/ gender minority groups and migrants' workers from other states etc.

2.4 Stakeholder Analysis

Stakeholder analysis is the process of identifying the stakeholder groups that are likely to affect or be affected by the project activities and sorting them according to their impact on the project and the impact the project activities will have on them. Stakeholder analysis is an ongoing process, which may evolve as new stakeholders are introduced to the project. The preliminary stakeholder analysis has identified the various interests of stakeholder groups and the influence these groups may have on the project. The analysis also shaped the design of stakeholder consultation activities and which stakeholders to engage and when.

Table 1: Stakeholder Analysis

Stakeholder Group	Key Characteristics	Stakeholder Interest	Language Needs	Preferred Means of Communication	Specific needs
Community groups including minority groups and public at large	Key primary beneficiary seeking quality health services closer to their village/ town	- Better medical services closer to village - Better medical assistance for gynaecological diseases at the PHC/ CHC - Better RMNCH services closer to village - Better geriatric disease treatment locally - Better medical services for disabled population - Improved diagnostic services	English, Khasi, Garo	TV, Newspaper, Community meetings	Timings based on community convenience
Elderly population and persons with disability	Key primary beneficiary seeking quality health services including geriatric care and with universal access measures being in place at HCFs	– Better medical services closer to village – Better geriatric disease treatment locally – Better medical services for disabled population – Infrastructure supporting universal access for elderly and disabled population	English, Khasi, Garo	Community meetings	Timings based on community convenience

Table 1: Stakeholder Analysis					
Stakeholder Group	**Key Characteristics**	**Stakeholder Interest**	**Language Needs**	**Preferred Means of Communication**	**Specific needs**
		– Improved diagnostic services			
Women, especially Young women and girls	Key primary beneficiary seeking quality health services closer to their village/ town	– Quality health services closer to village – Better medical assistance for gynaecological diseases at the PHC/ CHC – Better RMNCH services closer to village including at SC, PHC, and CHC – Availability of gynaecologists and paediatrician – Improved diagnostic services – such as x-ray, ultrasound and laboratory tests – Gender sensitive Infrastructure provisions such as caring for privacy, separate toilets for women etc.	English, Khasi, Garo	Community meetings	Timings based on community convenience
Poor and vulnerable population	Key primary beneficiary seeking quality health services closer to their village/ town	– Quality health services closer to village – Easily accessible beyond regular OPD hours	Khasi, Garo	Community meetings	Timings based on community convenience

Table 1: Stakeholder Analysis					
Stakeholder Group	**Key Characteristics**	**Stakeholder Interest**	**Language Needs**	**Preferred Means of Communication**	**Specific needs**
		– Improved diagnostic services at affordable cost – Availability of free medicine			
Village Health and Sanitation Committees (VHSCs), Health committees associated with HCFs, ASHAs, and ANMs	Institutions and individuals with community linkage involved in outreach services of health	- Better RMNCH services in the village with improved linkages with PHCs/ CHCs - Improved assistance for gynaecological diseases at the PHC/ CHC	English, Khasi, Garo	TV, Newspaper, Community meetings	Timings based on community convenience
Health Facility staffs including Doctors, Nurses, Paramedics, and other staffs including Workers associated with handling, transportation and disposal of BMW	Main service provider of health services at DH, CHC, PHC and SC level	- Establishing an effective primary and secondary healthcare services with improved quality - Improved health facility infrastructure, supply of medicines, diagnostic services where needed, to serve better - better equipment and technologies - Improved reporting mechanism - Receiving support from superior authorities, especially technical support from general practitioners and specialists	English, Khasi, Garo	Official communication, meetings/ workshops, email, Phone, social media e.g. WhatsApp etc.	Outside OPD timings – preferably in the afternoon

Table 1: Stakeholder Analysis					
Stakeholder Group	**Key Characteristics**	**Stakeholder Interest**	**Language Needs**	**Preferred Means of Communication**	**Specific needs**
Representatives at local governing institutions eg. ADCs, Village/ Town councils, and Traditional Leaders (Dorbar, Nokmas)	Key influencers of public opinion and facilitators of other developmental resources to villages/ towns	- Quality primary and secondary health care services in their area	English, Khasi, Garo	Official communication, leaflets/ booklets etc Meetings/ workshops	Timings based on community convenience
Key officials of Department of Health and family Welfare including NHM, Directorate of Health (MI), Directorate of Health (H&FW), and Directorate of Health (Research)	Main decision makers at State level for provision of various health services in the state	- Quality primary and secondary health care services in the target areas and facilities - Smooth implementation of project activities	English	Official communication, meetings/ workshops	Official working hours
Key officials of other line departments/ institutions involved in provision of associated services e.g. State pollution control board, Social Welfare and Tribal Development Department, Women and Child Development Department, Education Department	Main decision makers at State level for implementation of various schemes and provision of various services in the state	- Quality primary and secondary health care services in Meghalaya -	English	Official communication, meetings/ workshops	Official working hours
Elected Representatives	Main policy makers influencing health services; and key influencers of community opinion	- Quality primary and secondary health care services in Meghalaya -	English, Khasi, Garo	Official communication, Meetings/ workshops	Official working hours

3 STAKEHOLDER ENGAGEMENT PROGRAM

3.1 Purpose of the Stakeholder Engagement Program

The MHSSP project under preparation in accordance with World Bank's Environment and Social Framework (ESF). In compliance with its requirements under ESS10 on 'Stakeholder Engagement and Information Disclosure', this plan has been developed to guide the engagement of various project stakeholders, including affected persons with the project during its life cycle, spell the strategies and approaches that would be in place to ensure that all stakeholders are informed a priori about all proposed project activities and their impacts in a culturally appropriate manner and mechanisms that would be developed by the project to systematically seek their feedback.

ESS10 recognises that effective engagement with the stakeholder can significantly improve the project outcomes and their sustainability through better community acceptance and ownership, enhance the environmental and social sustainability of projects, and hence make a significant contribution to successful project implementation.

This SEP shall serve the following purpose:

- Identify and analyse critical stakeholders of the project. Identify those that are affected and/or able to influence the project and its activities,
- Plan on how the engagement with stakeholders will take place,
- Conduct consultations with project stakeholders and provide reports on the results of the consultations prior the appraisal stage,
- Enhance and/or strengthen the grievance/resolution mechanism for stakeholders making them able to raise their concerns about the project,
- Define reporting and monitoring procedures to stakeholders to ensure the effectiveness of the SEP and periodic review of SEP based on results and findings.

Apart from the requirements under ESS10, this SEP also fulfils the requirements for information disclosure and stakeholder consultation prescribed under two major legislations of the government of India. These are:

- Right to Information Act of 2005
- Environmental Impact Assessment Notification (EIA) of 2006 (including all subsequent amendments) as notified by Ministry of Environment, Forests and Climate Change, GoI

The Right to Information Act, 2005 is a progressive rights-based accountability and transparency enforcement mechanism available to citizens which allows them to seek information related to government programs in personal or larger public interest and mandates the provision of this information within a stipulated timeframe. The Act is implemented in states through the office of the State Information Commissioners and Information officers designated for each public office. It makes the public offices and duty- bearers liable to providing correct and detailed information demanded by the citizen within designated timeframes, with mechanisms for appeals and sanctions if information provided is inadequate or incorrect.

The Environmental Protection Law also recognizes the right of citizens to live in a healthy environment -protected from any adverse environmental impacts and provides detailed protocols and guidance on environment management. It also provides citizens the right to environmental information as well as to participate in developing, adopting, and implementing decisions for managing environmental impacts. It also has provisions for public hearing during the process of project planning to ensure public discussion during project implementation and makes it obligatory for project authorities to incorporate suggestions received from the citizens.

The engagement of stakeholders has already commenced as part of the project preparation. This will continue throughout the project lifecycle, starting as early as possible and continuing throughout planning and installation activities and through the technical advisory components. The nature and frequency of the engagement will be tailored to relevant groups, issues and sub-projects. Details of the planned stakeholder engagement activities (including disclosure and consultation) are included in the following two sections.

3.2 Stakeholder Engagement and Information Disclosure Strategy

There are a variety of engagement methods used to build relationships, gather information, consult, and disseminate project information to stakeholders. This includes formal communication by DOHFW to various stakeholder groups (other than community groups), conduct state level workshop inviting various stakeholders including from civil society, media and academia; and disclosure at DoHFW website. The consultation process will involve inclusive methods, inform about project activities and update, solicit feedbacks, document the process, and communicate follow-up. The timing of stakeholder engagement is broken down by stakeholder and project phase, as provided in Table-2 below. Engagement and consultation will be carried out on an ongoing basis as the nature of issues, impacts, and opportunities evolve.

Table 2: Stakeholder Consultation Process

Target stakeholders	Information to be disclosed	Proposed engagement & disclosure method	Timing of Engagement	Responsible Parties
Community groups including minority population and public at large	Project scope Key project objectives Broad set of project activities E & S documents – ESMF, SEP, ESCP etc.	Community meetings, Surveys	Design Phase Implementation Phase	PMU CMO HCF\
Elderly population and persons with disability	Project scope Key project objectives and Broad set of project activities E & S documents – ESMF, SEP, ESCP etc.	Community meetings, Surveys	Design Phase Implementation Phase	PMU CMO HCF
Women, especially Young women and girls	Project scope Key project objectives and Broad set of project activities E & S documents – ESMF, SEP, ESCP etc.	Community meetings, Surveys	Design Phase Implementation Phase	PMU CMO HCF
Poor and vulnerable population	Project scope Key project objectives and	Community meetings, Surveys	Design Phase	PMU CMO HCF

Target stakeholders	Information to be disclosed	Proposed engagement & disclosure method	Timing of Engagement	Responsible Parties
	Broad set of project activities E & S documents – ESMF, SEP, ESCP etc.			
Health committees associated with HCFs, ASHAs, and ANMs	Project Information Key project objectives and components Broad set of project activities E & S documents – ESMF, SEP, ESCP etc.	Official communication, meetings/ workshops, Surveys	Design Phase Implementation Phase Completion stage	PMU CMO HCF
Health Facility staffs including Doctors, Nurses, Paramedics, and other staffs including Workers associated with handling, transportation and disposal of BMW	Project Information Key project objectives and components Broad set of project activities E & S documents – ESMF, SEP, ESCP etc.	Official communication, meetings/ workshops Correspondence by email, phone, social media tools Surveys	Design Phase Implementation Phase Completion stage	PMU CMO HCF
Representatives at local governing institutions e.g., ADCs, Village/ Town councils, and Traditional Leaders	Project Information Key project objectives and components Broad set of project activities E & S documents – ESMF, SEP, ESCP etc.	Official communication, meetings/ workshops	Design Phase Implementation Phase Completion stage	PMU
Key officials of Department of Health and family Welfare including NHM, Directorate of Hospital and Medical Education (HME), and Directorate of Health Services (DHS)	Project Information Key project objectives and components Broad set of project activities E & S documents – ESMF, SEP, ESCP etc.	Official communication, meetings/ workshops	Design Phase Implementation Phase Completion stage	PMU
Key officials of other line departments/ institutions	Project Information Key project objectives and components	Official communication, meetings/ workshops	Design Phase Implementation Phase	PMU

Target stakeholders	Information to be disclosed	Proposed engagement & disclosure method	Timing of Engagement	Responsible Parties
involved in provision of associated services e.g. State pollution control board, Social Welfare and Tribal Affairs Department, Women and Child Development Department	Broad set of project activities E & S documents – ESMF, SEP, ESCP etc.		Completion stage	
Elected Representatives	Project Information Key project objectives and components Broad set of project activities E & S documents – ESMF, SEP, ESCP etc.	Official communication, meetings/ workshops	Design Phase Implementation Phase Completion stage	PMJU
NGOs/ CBOs; Media and Academia	Project Information Key project objectives and components Broad set of project activities E & S documents – ESMF, SEP, ESCP etc.	meetings/ workshops	Design Phase Implementation Phase Completion stage	PMU CMO

3.3 Strategy to incorporate the view of vulnerable groups

During preparation, the views of the vulnerable groups are sought through virtual consultations with representative organizations/ institutions and NGOs/ CBOs working with them given the Covid19 situation and associated travel restrictions, social distancing and other advisories on community gathering etc. This included consultations with NGOs and CBOs working with women's groups for understanding women's concerns. Similarly, NGOs/ CBOs working with disabled population, youths, poor and vulnerable population and health sector to understand their concerns, consultation with Khasis ADC, Garos ADC and Jayantias ADC is to understanding concerns of tribal population living in different parts of the state including in remote and hilly areas. In addition, consultations with sample HCF staffs were also undertaken to understand the issues and concerns of the vulnerable community and the service providers in a virtual manner during the design phase to inform project design. While these consultations could not be directly with the target population during project design phase and will be undertaken during implementation phase. Consultation will also be conducted as part of the social and behaviour change communication and with patients during visit to HCFs through patient satisfaction surveys to voice their feedback on level of satisfaction as well as areas of improvement.

Additional vulnerable groups on this project may be identified during future stages of community engagement, and the plan will be revised accordingly to reflect this identification of new stakeholders.

The project will inherently benefit vulnerable groups by increasing and improving the access opportunities to the health services in the state. However, the project will need to pay special attention in order to address any potential barriers to the most vulnerable groups to meaningfully participate the in the project including using local ethnic languages such as Khasis, Garo, and Pnar etc. for some of the community engagement activities with local ethnic groups.

3.4 Timelines

The current information on the project timelines are still being discussed and finalised. Hence, the timeline will be updated once the project design is further finalized.

3.5 Review of Comments

Comments, suggestions, clarifications and other information collected will be documented in consultation records, and at the next engagement opportunity, a summary of how they were considered will be reported back to the stakeholder group.

This document includes details of the consultations undertaken as part of the project preparation phase, including key discussion points and recommendations to respond to stakeholder feedback in Annex-I. It also includes a summary of all parties and individuals consulted during project preparation. The project design and the Environmental and Social Commitment Plan (ESCP) of the project will be informed by the concerns voiced by the stakeholders, which will be updated over the project lifecycle.

3.6 Responsibilities for Implementing Stakeholder Engagement Activities

At the State level, PMU at the DOHFW shall have an Environment Safeguard Specialist and a Social Development Specialist. Both these specialists will be responsible for implementation of their respective E&S measures- including implementation of the Stakeholder Engagement Plan. At the district and HCF level, the DMHO and CMO will be responsible for implementing the SEP. To ensure that the stakeholder engagement plan is effective, DoHFW will hire, train, and deploy qualified personnel with good communication skills to undertake the stakeholder engagement, where needed in addition to the PMU personnel. Ensuring placement of suitable staff for social safeguards will be included in the ESCP as one of the commitments. The roles and responsibilities at different level of project implementation is present below.

Agency / Individual	**Roles and Responsibilities**
Project Director	• Approve the content of the draft SEP (any revisions) • Approve prior to release, all IEC materials used to provide information associated with the project (communication material, PowerPoint, posters, leaflets and brochures, TV and radio insertions) • Approve and authorize all stakeholder engagement events and disclosure of material to support stakeholder engagement events
Social Safeguard Specialist and Environmental Safeguard Specialist	• Provide overall guidance and monitoring supervision to the SEP process • Prepare and provide appropriate SBCC, IEC and communication material, information required to be disclosed to different stakeholder categories • Finalize the timing and duration of SEP related information disclosure and stakeholder engagement

Agency / Individual	Roles and Responsibilities
	• Orient the district and HCFs staff on SEP and requirements for its operationalization
District and HCF	• Prepare and customize to district requirements the IEC and communication material provided by the PMU and the information required to be disclosed to different stakeholder categories • Ensure that all material/ strategies developed are culturally appropriate and available in an easily comprehendible form to stakeholders (based on their profile and their information needs). Finalize the timing and duration of SEP related information disclosure and stakeholder engagement • Participate either themselves, or identify suitable representative, during all face-to face stakeholder meetings • Review and sign-off minutes of all engagement events; Maintain the stakeholder database. • Assure participation/ inclusion of stakeholders from vulnerable groups

3.7 Proposed Budget for Stakeholder Engagement Plan

A proposed indicative budget for the stakeholder engagement activities is outlined below:

Table 4: Indicative Budget for SEP*	
Activity	**Proposed Budget (INR)**
SEP Updating and Auditing (consultant)	10,00,000
General Expenses for SEP implementation	50,00,000
Expenses related to Stakeholder Engagement activities (@20 lakhs x 5 year)	100,00,000
Additional services on stakeholder engagement (consultants, other expenses) (@10 lakhs x 5 year)	50,00,000
Total	**210,00,000 ~300,000 USD**
* Note: Separate budget for strengthening GRM system is included in ESMF	

4 GRIEVANCE REDRESS MECHANISM (GRM)

There is no dedicated grievance redress mechanism (GRM) system in place for DoHFW. The existing grievance redress mechanism (GRM) in Meghalaya is:

1. Using the Meghalaya Chief Minister's, WhatsApp platform for public grievance redress (using +91-9436394363 phone no.). People can submit their grievances directly to the Chief Minister's (CM) office using WhatsApp messages and monitored online (http://megpgrams.gov.in/index.htm). It is a step towards solving simple problems being faced by the people where people can lodge complaints/ grievances. The Chief Minister office has a dedicated team to service the grievances including screening, forwarding to particular Department concerned for taking up necessary actions to address the problems.
2. Department of Personnel and Administrative Reforms (DP&AR), government of Meghalaya also have centralised public grievance redress mechanism whereby one can register their grievances online and track the same for its redressal at http://megpgrams.gov.in/index.htm. Grievances received by this online system is then screened and forwarded to respective department/ directorate/ agencies for addressing. The Meghalaya Public Grievance Redressal & Monitoring System (megPGRAMS) is a web based application which facilitates Department /Directorate /District Collectors to receive grievances lodged, forwarding to concerned department /directorate for redressal and promotes easy monitoring of grievances received online / offline or received through the call centre of the Meghalaya Integrated Information Services (MIIS - http://mii.nic.in/). The nodal officer is placed at the MIIS to screen the grievances and forward it to respective department/ directorate/ districts and other officials. The MIIS Citizen Help Desk has been created by the Government of Meghalaya to assist citizens in quickly and easily reporting a problem, requesting a service, asking a question or filing a complaint. A citizen can register his grievance by using any of the following modes: (a) Written Request: Submitting his/her Written Grievance application on paper at any of the DIPR offices located across the state; (b) Online Interface: Submitting the grievance application online using the web interface of the new Grievance Redressal System; (c) Calling Toll-Free Helpline: Citizen can also call a toll-free Grievance Redressal helpline to register his/her grievance with the department; (d) Grievance filed by email - Citizens can email their grievances directly to the Public Grievance Officer(s) on a dedicated email id. This mail inbox will be monitored on a daily basis.

   If citizens provide their mobile number while registering their grievance application, they can get an acknowledgment via SMS containing the Unique Registration Number of their Grievance. They can also check the status of their Grievance request by sending an SMS query containing the Unique Application number.

However, it was felt necessary to establish a project level GRM keeping in mind that the GRM system shall become a dedicated GRM for DoHFW. This will be undertaken in the first six months of the project being effective. Meanwhile the existing GRM system using megPGRAMS or CM's office WhatsApp platform will be used by all stakeholders including general public, project beneficiaries and health care staffs. The project GRM will be supported both by a traditional and technology-based approach, for early resolution of complaints. In addition, at the HCF construction sites, labor specific GRMs will be established and the details of the same is provided in Labor Management Procedure (LMP) (Ref. Annex-I). The detailed composition of the GRM and the processes to be followed by complainants have been elaborated in the SEP. Other social accountability measures such as patient satisfaction surveys, citizen scorecard/ report card or health committees scorecard/ report card will be used for acquiring feedback on performance and recording citizens' recommendations.

4.1 Objectives of GRM

The main objective of a Grievance Redress Mechanism (GRM) is to assist to resolve complaints and grievances in a timely, effective and efficient manner that satisfies all parties involved. Specifically, it provides a transparent and credible process for fair, effective and lasting outcomes. It also builds trust and cooperation as an integral component of broader community consultation that facilitates corrective actions. Specifically, the GRM:

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

Grievances raised by stakeholders will need to be managed through a transparent process, readily acceptable to all affected communities and other stakeholders, at no cost and without any retribution. The GRM will work within the existing national and state's legal and cultural frameworks and will provide an additional opportunity to stakeholders and interested parties to resolve their project specific grievances at the local, project, city or state level. The key objectives of this GRM will be:

- Ensure availability of offline as well as online mechanisms which are simple to use and accessible by all the categories of stakeholders and by people with differing levels of literacy and awareness
- To record, categorize and prioritize the grievances.
- Redress grievances via consultation, information disclosure, action with all stakeholders based on the nature of grievances received
- Inform the stakeholders about the action taken or information sought and ensure that the grievances are adequately addressed and resolved within a specified timeframe
- Provide a system of escalation to the higher level of any grievance that remains unresolved or unaddressed within the stipulated timeframe
- Provide an appellate authority within the project management set-up for handling appeals on grievances perceived as being unresolved by the complainant.

4.2 Roles and Responsibility

The Grievances will be handled at the DoHFW by the concerned official(s) designated for the GRM in the PMU using the mechanism (to be defined while developing) including the one forwarded from CM's public grievance system. The GRM includes the following steps:

Step 0: Raising and registering the grievances using various mechanism including through Help desk, online using internet, email, Walk-ins and registering a complaint on grievance logbook at healthcare facility or suggestion box at the HCFs/ hospitals.

Step 1: Grievance raised is screened and forwarded to respective administrative/ facility level for redressing

Step 2: Grievance discussed at the respective administrative/ facility level, and addressed

Step 3: If not addressed in stipulated period it is escalated to next level at CMHO at the district and finally the DoHFW

Step 4: Once addressed, feedback sent to the complainant

Step 5: If not satisfied, appeal to the other public authorities

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

4.3 World Bank GRS Framework

In addition to the project GM, complainants have the option to access the World Bank's Grievance Redress Service (GRS), with both compliance and grievance functions.

Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit http://www.inspectionpanel.org.

ANNEX-I: KEY ISSUES AND CONCERNS FROM STAKEHOLDER CONSULTATION

Stakeholder Group	Key Issues and Concern	Key Suggestions Received
Meghalaya State Pollution Control Board; Shillong Municipal Board; Jowai Municipal Board	• Absence of Common Bio Medical Treatment Facility. • Intermittent monitoring of BMW of HCFs in all districts. And delayed reporting by the HCFs. Also, updates are inconsistent. Most BMW are not disposed as per the BMW Rules 2016 (amended 2018). • There is a lack of efficient human resource and technical support in maintenance of BMW equipment. • Lack of trained/sensitised municipal workers (BMW rules, environment protection)	• Common treatment facility is an urgent need in various districts and shall be explored. • HCF should have a designated person for BMW management, monitoring and reporting. • HCFs capacity to be built on in-depth understanding of BMW Rules 2016 (amendment 2018) to comply with the requirements • Support Municipal workers in terms of capacity building, information sharing/ refresher trainings etc.
Private Waste Collector – (*The Meghalaya Disposal and Waste Management Society – A Private Waste collector approved by MSPCB, and Health Dept for collecting medical waste – mainly red bags*)	• Waste load is too less for daily collection, and HCFs in remote areas have to wait for few weeks for waste to be collected to a weight that is heavy enough for the expenses spend on transport etc. • No standard fee for transport expenses and for disposal. • In absence of CTF, waste has to be transport to Assam where a private firm receives and dispose in its own plant. • Lack of Waste segregation during collection from HCFs.	• Other medical waste can also be added to reduce the storage time by the HCFs. • MoU should have a fixed rate • Cost of transport will be reduced if the State has its own treatment plant/recycling plant. • Need to ensure that waste is not mixed.
Meghalaya Medical Services Association	• IPHS norms are compromised in terms of human Resource, which impacts quality of services • Medical personnel serving in difficult areas do not receive any incentives or additional support • Quality assurance is hardly done at HCF level • There are HCFs that are neglected for an extensive period.	• IPHS norms need to be understood and uniformly applied • Diagnostic equipment/ services required in remote HCFs. • HCFs in rural areas - DHs, CHCs, should be equipped with screening/ testing equipment for diagnosis and treatment.

Stakeholder Group	Key Issues and Concern	Key Suggestions Received
	• There are well performing HCFs that continue to receive same funding (limited scope for innovation and expansion)	• Living quarters have to be upgraded if Medical Officers and HCF staff have to perform efficiently.
Health Care Facilities - District Hospitals, CHCs, PHCs and UHCs.	• Lack of transparency in percolation of funds from State to Districts and HCFs, resulting in a lack of accountability of HCFs if performance is low • Many HCF buildings (especially the remote PHCs) are constantly facing problems of roof leakages and dilapidated windows, doors and floors. Leakages are so common, that HCFs in remote areas have become used to the seasonal shifting or stopping of specific services for repair. • HCF staff living in callous conditions during the rainy season, some are compelled to leave their living quarters resulting in the absence of 24x7 services. • There are no facilities for treatment of drinking water in many HCFs • Power supply is erratic and in bad condition leading to adverse impact on services to be provided – there have been instances when delivery has been conducted in torch lights • The electrical wiring in many HCFs are so old that computers/ printers/ Xerox machine encounters problems due to short-circuits. In many HCFs even earthing is not done. • Many villages under HCFs are not fully connected by roads to the facilities – especially in remote areas • Single ambulance in the HCFs especially in PHCs are not able to fulfil the transport needs of all patients. People have to hire private vehicle in their village to come to HCFs.	• Districts should be given more flexibility in managing projects, programmes through the HCFs. And utilisation reports to be submitted by HCFs. • Basic infrastructure needs repair, renovation and upgradation including for living quarters and with decent power management in HCFs for improving services. • Mechanism to be developed for additional ambulance/ resource for referral transport to support the HCF in transporting patients. Mapping of HCFs to be done for this and prioritized those which are in dire needs. • Filling human resource gaps is important to serve better. Also, in-service training system needs to be improved for health care providers. • Online data sharing/ documentation, indenting of medicines has been helpful to the HCFs which has reduce their travel time, however, they suffer due to bad network connectivity – any effort in improving network connection can hugely help in accessing the medicine in time and sending documentation and overall improving the quality of services. • Sub centres needs strengthening as being closure to community it can address issue of institutional deliveries.

Stakeholder Group	Key Issues and Concern	Key Suggestions Received
	Public transport is also non-existent in many of the remote areas throughout the day. • Phone and internet network connectivity is erratic in remote areas. Some HCFs in remote areas go for days without network connectivity, especially during bad weather. • Most of the CHCs do not have the complete set of Specialists as required. Lack of Anaesthesiologists in the State has also resulted in most CHCs inability to get their Operation Theatre functioning. Also, inadequate staffing poses challenge across the HCFs. • The Rogi Kalyan Samitis (RKS) at the HCF level have become more significant as its roles and powers are increased. However, awareness about their role and in absence of any capacity building it remains non-functional and have not been able to support the HCF as desired. Also, RKS should have more participation from vulnerable population. • There is no established GRM in the Department that can connect the HCFs in addressing grievances. Also, most HCFs do not have an any Internal Complaints Committee to address sexual harassment in the workplace. • BMW in Urban Health Centres is extremely difficult since they are mostly located in rented locations, they are not allowed to construct sharp pits, soak pits, and deep burial pits. • Most CHCs and PHCs burn their BMW such as PPEs, gloves, and masks etc. Some PHCs bury the same in the deep burial pit.	• RKS membership should be inclusive and requires capacity building in terms of understanding their role and responsibility and functioning of HCFs. • BMW management needs strengthening.

Stakeholder Group	Key Issues and Concern	Key Suggestions Received
	• Except in Shillong, where COVID waste is burnt in the Crematorium, majority of COVID care centre in rural areas burn the waste in municipal grounds/ sites away from the main residential area.	
Rogi Kalyan Samiti (RKS) Members (Bhaitbari PHC, Dangar PHC, Madan Maroid PHC)	• Chairperson of RKS being an Official of the State and is responsible for the Block Development activities, and is also chairing the RKS of other HCFs, hence, it is challenged with time and s/he could barely attend the meetings or visit the RKS and the HCF regularly. • Women members (mostly teachers and Anganwadi Workers) are generally present but are not so proactive given limited knowledge about their roles. • Awareness of HCF functioning is limited among RKS members as well as the role to be played by RKS for smooth and effective function of HCF. • RKS committees meet quarterly or biannually which is less compared to the challenges that the HCF encounters from time to time.	• Include RKS members in planning, review/ update and project implementation meetings. • Role and responsibility of RKS need to be reviewed and members need to be made aware of the same.
CBOs/ NGOs (North East Network; Voluntary Health Association of Meghalaya; Grassroot; Jaintia Hills Development Society; Mih Myntdu Community and Social Awareness Association; Akhil Gandhian)	• Health Infrastructure is very poor especially in remote areas. In most HCFs in remote areas, laboratory, labour rooms, toilets are quite run-down and mostly non-functional. • Manpower is usually not present in the Health Facilities as required. • Institutional deliveries are less due to the inaccessibility of the people to reach the PHC/ CHC on time. • Cases of domestic or sexual violation remains under reported and women continue to have less seeking behaviour when it	• Upgrade to adequate supply of basic amenities such as water, electricity, living quarters to be also upgraded and fit for habitation. • Community engagement to be enhanced- through public hearing and dialogues. • UHCs should be extended with more support in terms of space, resources for emergency, BMW management etc.

Stakeholder Group	Key Issues and Concern	Key Suggestions Received
	comes to their own personal health. rural men who earn on a daily wage basis are less likely to visit HCF, unless they are extremely ill and need hospitalisation. • At places, RKS can be political in nature (community political dynamics), there is less women participation in these committees (women members who are present are usually silent).	• HCF staffs need to be oriented in gender concepts, gender-based violence and relevant issues related to gender. • Soft skills of HCF staffs to be enhanced through sensitising, training and capacity building specially to comfort rural patients. • HCF activities to be assessed through local /village level committees in terms of building transparency and trust. • HCF committees such as RKS should be more inclusive and include differentially abled persons.
Traditional Tribal Village Headmen	• Manpower in the HCF is lacking especially in CHCs. Also, the availability of human resource in HCFs is not at par with the number of patients. • The IEC used for programmes are so difficult to understand and tiresome to read. • Remote places, villages in hilly terrain/ slopes face extreme hurdles in getting to health facility. They mostly rely on traditional forms of medicine. • Though BMW are segregated at source; it is not properly monitored at disposal and HCF has no accountability even if it is not disposed properly.	• Infrastructure and human resource in all HCFs require immediate attention. • Review of essential list of medicines from time to time. • IEC materials must be simple, easy to read, using local language and language that is friendly to women, children, adolescent, community etc. • Any health programmes that are coming to the village should involve committees from the planning stage. • HCF to be accountable for proper disposal of bio-medical waste.
Autonomous District Councils – (1) Khasi Hills ADC; (2) Jaintia Hills ADC; (3) Garo Hills ADC	• Substandard system of Bio medical waste management. • High incidence of early pregnancies and marriages in the communities, especially in the rural areas.	• Common Bio-medical waste treatment facilities to be promoted.

Stakeholder Group	Key Issues and Concern	Key Suggestions Received
	• Traditional system of medicine is yet to be acknowledged and promoted in a sustained manner.	• Integrate the traditional systems of medicines into the larger health care delivery of the State by linking traditional practitioners with HCFs. • Mapping of Traditional Healers in the State to ensure that Traditional Practitioners who receive certification are genuine and people who seek treatment from them are assured accountability. • Adolescent health needs in-depth understanding and research and should result in implementation of a programme which is suitable to rural and tribal youth.
Department of Social Welfare (Women and Child Development, Social Justice and Empowerment, Tribal Affairs and Minority Affairs)	• Networking and linkage with HCFs other than the nearest HCF, yet to be established.	• Training of HCF Staff on gender and gender-based violence needed. • Strengthening of Adolescents health programme to include psychosocial support and coping skills of young people.