Government of Islamic Republic of Pakistan

Environmental and Social Management Plan (ESMP)

For

Temporarily Displaced Persons - Emergency Recovery Project

Economic Affairs Division (EAD),
National Database and Registration Authority (NADRA)
and
Department of Health (Khyber Pakhtunkhwa)

Nov 2020

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List of Acronyms

AD	Auto-Disable
AEFI	Adverse Event Following Immunization
AHO	Asian Humanitarian Organization
BHU	Basic Health Unit
CMR	Complaint Management Register
CNIC	Computerized National Identity Card
CSO	Civil Society Organization
CT	Cash Transfer
CWG	Child Wellness Grant
CFC	Citizen Facilitation Center
DHQ	District Headquarter Hospital
DoH	Department of Health
DRR	Disaster Risk Reduction
EAD	Economic Affairs Division
EA	Environmental Assessment
EIA	Environmental Impact Assessment
EPI	Expanded Program on Immunization
ERG	Early Recovery Grant
ERP	Emergency Recovery Project
ERS	Early Recovery Support
ESMP	Environment and Social Management Plan
FATA	Federally Administered Tribal Areas
FDMA	FATA Disaster Management Authority
FP	Focal Point
GoP	Government of Pakistan
GRM	Grievance Redress Mechanism
GRO	Grievance Redress Officer
HCW	Health Care Waste
IDA	International Development Association
IEC	Information, Education and Communications
IEE	Initial Environmental Examination
IPR	Immunization Performance Report
KP	Khyber Pakhtunkhwa
LHV	Lady Health Visitor
LHW	Lady Health Worker
LMT	Lady Medical Technicians
LSG	Livelihood Support Grant
MGD	Millennium Development Goals
MIS	Management Information System
MIWMR	Monthly Immunization Waste Management Reports
MLM	Mid-Level Manager
MoF	Ministry of Finance

MT	Medical Technician
MTR	Mid Term Review
NADRA	National Database and Registration Authority
NGO	Non-Governmental Organization
NISP	National Immunization Support Project
OP	Operational Policy
OSS	One Stop Shop
PD	Project Director
PDMA	Provincial Disaster Management Authority
PEPA	Pakistan Environmental Protection Act
PKR	Pak Rupees
PMO	Project Management Office
POM	Project Operations Manual
PPE	Personal Protective Equipment
QPR	Quarterly Progress Report
RR &SD	Relief Rehabilitation &Settlement Department
RHC	Rural Health Center
SAFRON	Ministry of States and Frontier Regions
SMS	Short Message Service
TDP	Temporarily Displaced Person
TPV	Third Party Validation
UC	Union Council
VPD	Vaccine Preventable Disease
WB	World Bank
WHO	World Health Organization

Executive Summary

Government of Pakistan (GoP) initiated Temporarily Displaced Persons Emergency Recovery Project (TDP ERP) in the five districts of erstwhile Federally Administered Tribal Areas (FATA) of Pakistan in year 2015, in order to provide support to 340,000 families, displaced due to military operation in the area. The project included provision of cash grants to the persons returning to their homes in erstwhile FATA from temporary camps established in Khyber Pakhtunkhwa (KP) province. The project also included provision of cash grants linked to the child basic health services provided to TDP families. The Environmental and Social Management Plan (ESMP) for TDP-ERP was prepared in 2015 to address the potentially negative environmental and social impacts of project activities.

The World Bank provided US$ 75 million to the GoP initiative under IDA 5719. An additional financing of approx. US$ 114 million was provided to deliver LSG and CWG to all eligible families. Keeping in view the success of the program, TDP-ERP CWG component was extended to remaining two districts of erstwhile FATA i.e. Mohmand and Bajaur. In order to cater extended targets of CWG, a grant of US$ 15 million was provided by MDTF as 2nd additional financing to the project.

This document is the revised version of ESMP required for the 3rd additional financing of the program involving expansion to additional four southern districts of Khyber Pakhtunkhwa province to scale up activities and extend outreach of TDP-ERP. The present Environmental and Social Management Plan (ESMP) has been prepared to address the potentially negative environmental and social impacts of the basic health services to be provided as part of the project.

Background. Pakistan's progress towards human development and the Millennium Development Goals (MDGs) has been a challenge. Despite some improvements, Pakistan's performance against the MDGs in the South Asia Region, especially those that relate to maternal and child-health, needs serious impetus. Routine immunization coverage in Pakistan has stagnated - the proportion of children who are fully immunized has been estimated to be less than 60 percent - and this figure varies considerably across geographic, social and political boundaries of the country. Ensuring strong national routine immunization is the first essential pillar in polio eradication and has been the key to rapid control of polio in many countries.

Following the crisis in five tribal districts of the Merged Areas, the Government of Pakistan (GoP) launched major security operations resulting in displacement of approximately 340,000 families and damage to infrastructure and services. **Starting from 2015, the Government started declaring many areas safe for the repatriation of displaced persons.** Through the FATA Sustainable Return and Rehabilitation Strategy (FSRRS), GoP recognized cash transfers as an appropriate tool to catalyze the return and rehabilitation of the 340,000 displaced families. Against this backdrop, the World Bank was requested to support the GoP launch a program to assist in the early recovery of families affected by the crisis, promote child health, and strengthen emergency response safety net delivery systems in the affected districts of the Merged Areas.

Project Overview. Initially, the program was designed to provide support to displaced population in five merged area districts, namely North Waziristan, South Waziristan, Orakzai, Kurram, and Khyber. Being World Bank assisted program the Temporarily Displaced Persons Emergency Recovery Project (P154278), was allocated 75 Million USD

through IDA credit 5719 and 114 Million through IDA credit 6139. Additionally, 15 Million USD were granted through MDTF during the second additional financing where the program was expanded to remaining two districts of erstwhile FATA i.e. Mohmand and Bajaur, whilst recently 12 Million USD have been allocated under third additional financing for expansion of the program to four southern districts of Khyber Pakhtunkhwa. Moreover, the overall components, design and nature of the program will remain the same and only geographical expansion and scaling up will be undertaken under the third additional financing to cover the adjoining districts of erstwhile FATA and the frontier regions.

So far, the program has provided Livelihood Support Grant (LSG) to approximately 392,000 displaced families, where 657,000 families have received CWG in above mentioned seven districts. Following grants are being provided under TDP-ERP:-

a) Early Recovery Grant (ERG), paid by PDMA and reimbursed under TDP-ERP
b) Livelihood Support Grant (LSG)
c) Child Wellness Grant (CWG).

These project beneficiaries, when returning back to the affected areas received a one-time grant of Pak Rupees (PKR) 35,000 (US$350), based on the criteria of "displaced families having both addresses (temporary and permanent) on their Computerized National Identity Cards (CNICs) from the affected areas of erstwhile FATA", as per the database administered by the Complex Emergencies Wing Provincial Disaster Management Authority (CEW-PDMA), Khyber Pakhtunkhwa and verified by National Database and Registration Authority (NADRA).

The OSSs/CFCs operated by NADRA in collaboration with the PDMA Department of Health (Khyber Pakhtunkhwa), will facilitate the beneficiaries by; a) completing their eligibility and verification checks based on biometric and CNIC information; b) ensuring timely and efficient cash disbursements; c) facilitating health assessment of children and; d) establishing an easily accessible grievance redress system. As part of the Early Recovery Support to beneficiaries, the Bank will reimburse the emergency grants to the GoP, only if a beneficiary family satisfies the conditions set down in the Project Operational Manual (POM). Further, the LSG of PKR 16,000 per beneficiary family will be provided in four equal installments staggered over four months. If the beneficiary family has children under two years of age, the family will then be qualified for additional payments of PKR 12,500, provided in five equal installments for promoting positive health seeking behavior of families for their children and compliance mechanisms as set down in detail in the Project Operational Manual.`

The program has been expanded to the remaining two tribal districts i.e. Mohmand and Bajaur where Citizen Facilitation Centers have been established for delivery of Child Wellness Grant and other agreed services. Keeping in view the success of the project, the stakeholders of TDP-ERP have agreed to expand TDP-ERP to four Southern districts of Khyber Pakhtunkhwa i.e. D.I.Khan, Tank, Lakki Marwat and Bannu where additional sixteen(16) Citizen Facilitation Centers will be established for delivery of Child Wellness package and other vital registration and essential public services to general public. The potential rollout will follow a careful assessment of the intervention with respect to take-up of various services and delivery of benefits.

COVID-19 Considerations: Pakistan is facing severe health and economic consequences from the COVID-19 pandemic. As of October 15, 2020, Pakistan had over 320,000 confirmed COVID-19 cases and over 6,500 deaths. Deterioration of health indicators is expected due to demand-side issues induced by the crisis, such as lower utilization of non-COVID healthcare due to fear of contagion or higher income constraints.

In order to avoid spread of the disease, site staff has been provided safety kits which include masks, gloves, sanitizers, soaps etc at all the OSSs/ CFCs. Upon NADRA's recommendation, EAD decided to reduce the number of beneficiaries to 100/site with following the approved SoP's. The disinfection and sanitization of the sites is carried out on regular basis which including fumigation of cabins, furniture and equipment. Staff and beneficiaries are screened using infrared thermostat gun to check the temperature of those entering the site. Additionally, no staff member or beneficiary is allowed to enter the premises of the site without a mask. Security guards guide beneficiaries in and out of the sites while maintaining the social distancing rule of at least 3 feet between each beneficiary marked by circles on the seats in the waiting areas. Beneficiaries are seated after leaving at least one seat vacant in the waiting area. Beneficiaries are provided with hand sanitizers at the site entry point. For ventilation and fresh air, the windows and doors are kept open.

Key safeguards issues and their mitigation. The original Project triggered OP 4.01 Environmental Assessment and the same is triggered in the AF. Since the proposed AF shall support an expansion of parent project activities, safeguard issues and impacts remain the same as in the original project. To the extent possible, the Project plans to use government lands and more specifically existing BHUs or Tehsil HQs to establish the CFCs. Therefore, as in the original Project, OP 4.12 on Involuntary Resettlement is not triggered, and involuntary resettlement or acquisition of private property is not envisaged. As noted below, the original ESMP remains valid for the Project.

Given the similar type and nature of project activities, the anticipated environmental risks of the project are expected to be same as for original project. These include; decreased effectiveness of vaccine due to disruption in cold chain; inappropriate handling of sharps

and syringes and associated health hazards for the vaccinators; and most importantly, inappropriate disposal of medical waste associated with vaccinations (sharps, syringes, unused vaccines and gauzes) that may result in serious public health issues. To mitigate these potential impacts and risks, the cold chain management protocols need to be strictly followed (Effective Vaccine Management Implementation Plan); only auto-disable syringes need to be used; Personal Protective Equipment (PPE) need to be used by the vaccinators; Hospital Waste Management Rules of 2005, and guidelines need to be effectively implemented to dispose immunization wastes, water filtration units need to be provided at the health facilities where portable drinking water is unavailable. Keeping in view the spread of COVID-19 pandemic, staff has been advised to take extra precautionary measures including social distancing, wearing mask at all the time and use disinfectant before vaccinating the child. Appropriate trainings and capacity building will be carried out for all staff associated with vaccination. All such mitigation measures were included in the original ESMP and satisfactorily complied by the project; and as such will remain unchanged in this revised ESMP. The disinfection and sanitization of the sites is carried out on regular basis. Staff and beneficiaries are screened using infrared thermostat gun to check the temperature. No one is allowed to enter the premises of the site without a mask.

Social issues such as those regarding access to project benefits for eligible beneficiary communities will be addressed by ensuring that the CFCs are established at central locations which are easily accessible by the eligible communities. Signage and announcements will be done in local languages, such as Pushto and Seraiki in addition to Urdu, and pictograms and images will be used, so that eligible communities, regardless of literacy levels, can easily understand the Project and navigate CFCs. Similarly, the project will continue to adopt a gender-sensitive approach by ensuring presence of qualified female staff at all centers, female beneficiaries-only days, and female waiting areas and restroom provision. Grievance Redress Mechanism (GRM) of the project will remain functional and be communicated to the communities so that potential delays in utilization of services can be avoided, and inclusion of eligible communities ensured. Social conflicts, lack of awareness and cultural misconceptions regarding vaccination will be addressed through an effective social mobilization campaign at the community level. The Project will not require land acquisition as existing government buildings, such as basic health units, will be refurbished to function as CFCs. Finally, all CFCs will ensure Universal Access, i.e. disability access, such a ramps and other features so that physically handicapped persons can comfortably visit CFCs and avail services.

ESMP implementation arrangements. While maintaining the overall institutional arrangements intact, overall coordination and monitoring of ESMP implementation will be the responsibility of EAD whereas the on-ground implementation of ESMP will remain the responsibility of NADRA and Department of Health (Khyber Pakhtunkhwa). All the departments have already nominated ESMP Focal Point (FP) to ensure the implementation of ESMP. Owing to the satisfactory performance, EAD focal person will remain responsible for the overall coordination and monitoring, NADRA focal person will be responsible for implementation of social aspects of the ESMP whereas the Health Department (Khyber Pakhtunkhwa) focal person will be responsible for the implementation of environmental aspects of the ESMP. Keeping in view the expansion of project to Southern districts of KP, "Southern Districts Coordinator" (a new position created in EAD PMU as a capacity building measure) will take care of ESMP activities in these districts.

During the project inception and subsequent roll out, deficiency of female staff was faced in merged area districts, however it was addressed with the help of Department of Health (Khyber Pakhtunkhwa), still the issue arises from time to time at various CFCs and needs prompt resolution specifically for the delivery of CWG services which involves presence of mother and child. Similar feedback was received during the consultation meeting held at DI Khan, where a number of participants highlighted the provisioning of female health staff at all centers for processing of female beneficiaries for vital registration and essential public services and

delivery of health awareness sessions for CWG. Separate female waiting areas and female washrooms were established at a few sites (where these facilities were not available previously, as a lesson learnt from the project. Beside these, feedback and suggestions received from the participants have already been addressed and incorporated in the program design and delivery.

Consultations on AF: Two consultations were held to inform key stakeholders about project expansion to southern districts, and solicit feedback on the project. These consultations were held in November in DI Khan and Bannu districts respectively. Detail presentation was delivered by EAD-PMU regarding the program Participants expressed the view that separate waiting areas and washroom facilities be provided to female visitors at CFCs/OSSs, that efforts be made to coordinate with a nutrition program operational in DI Khan district, and that safe disposal of medical waste should be ensured.

Grievance Redress Mechanism. Grievance Redress Counter installed at the CFCs/OSSs have representatives of NADRA who will act as the Grievance Redress Operators (GRO). All complaints, whether received at the counters or forwarded to NADRA, will be registered in the TDP-ERP Complaints Management Information System (MIS). The grievance focal person at the grievance counter will be the initiating authority to address the issues. He/she will forward the complaint to the relevant departments/Stakeholders for resolutions.

ESMP Monitoring and Reporting. In order to ensure effective implementation of ESMP during the proposed initiative, a comprehensive monitoring mechanism has been proposed as part of this document. Under this mechanism, key safeguard aspects of the initiative, namely; vaccine storage and cold chain management, availability of auto-disable syringes, availability and usage of PPEs, availability of safety boxes for disposal of sharps, disposal of hospital wastes in accordance with the Hospital Waste Management Rules 2005 and Immunization Waste Management Action Plans, compliance of COVID-19 related updated SOPs and guidelines issued by Government, as well as of WB and WHO; record regarding the TDPs accessing the OSSs/CFCs, availability of female staff, ramps for disability access, availability of proper signage, establishment of grievance redress mechanism, resolution of complaints and implementation of trainings will be monitored as part of the six-monthly monitoring reports prepared as an output. In addition, environmental audits will be carried out on a six-monthly basis, and a third-party validation will be conducted on annual basis.

ESMP implementation cost. The ESMP implementation cost has been included in the overall project cost estimates which is approximately 22 million for the whole project.

Chapter 1: Background and Project Description

1.1 Introduction

Government of Pakistan (GoP) planned and initiated the Temporarily Displaced Persons Emergency Recovery Project (TDP ERP) in the erstwhile Federally Administered Tribal Areas (FATA) region of Pakistan, in order to provide support to the people displaced from FATA. The project includes provision of cash grants to the persons returning to their homes from the temporary camps established in the Khyber Pakhtunkhwa (KP) province. The project also includes cash grants linked to provision of basic health services to the TDP families.

In line with the environmental legislation of Pakistan as well as the WB safeguard policies, the current ESMP has been prepared as an addendum to parent project ESMP to update the information on new project locations, potential negative environmental and social impacts associated with the health services to be provided as part of TDP-ERP and information on stakeholder consultations.

This ESMP identifies the potential negative impacts of the initiative (i.e. health service provision), and proposes appropriate mitigation measures to reduce if not eliminate these impacts. The ESMP also defines the environmental and social monitoring requirements as well as capacity building arrangements, to ensure that the Plan is effectively implemented.

1.2 Background

A Sustainable Return and Rehabilitation Strategy for FATA. In April 2015, the then Merged Area Secretariat took the lead in developing the Sustainable Return and Rehabilitation Strategy to ensure the progressive and sustainable return of displaced populations. In order to encourage safe, voluntary returns of the displaced population, a comprehensive strategy was developed to provide an enabling environment for FATA returnees. Based on a Post-Crisis Need Assessment, the Merged Area secretariat identified social protection as one of the nine pillars supporting rehabilitation in the region.

The system then in place did not incorporate a systemic response to emergency situations such as the militancy crisis. In addition, the erstwhile FATA Secretariat had little capacity to manage a post-crisis safety net response. As a result, the government requested the World Bank's support in strengthening the early recovery of TDPs returning to erstwhile FATA. Providing returnees with a predictable and regular flow of income over the re-settlement period was and remains critical, to cover basic needs and facilitate livelihood restoration.

The Merged Area districts are lagging behind in terms of child health indicators compared to the rest of Pakistan. In the aftermath of the militancy crisis and with the return of TDP families, the already inadequate child health outcomes have deteriorated further as expected.

1.3 Project Description

Project Components

Component 1: Early Recovery Package for Temporary Displaced Persons.
Component 1 remains unchanged.

One-time Early Recovery Grant (ERG) of PKR 35,000per family and; (ii) a Livelihood Support Grant (LSG) of PKR 16,000 per family in four monthly installments of PKR 12,500 provided each month. These two cash grants are complementary interventions to facilitate the early recovery of TDP families. All registered TDP families from the five targeted tribal districts are eligible for the ERG, irrespective of their destination, to help them cover large initial expenses to restart their lives and livelihood. For families that opted voluntarily return to erstwhile FATA, the LSG will provides a predictable source of income over a limited period of time to help covering basic subsistence needs while livelihoods are being restored. The LSG are delivered through one-stop-shops (OSSs)/Citizen Facilitation Centers (CFCs)currently established in 5x merged area districts.

Component 2: Promoting child health in selected areas of Erstwhile FATA

Component 2 will be scaled-up with increased targets due to addition of four new districts and increased implementation period. Under this component, a selection of child health services are being offered to families with children aged 0-24 months in all seven merged area districts. These services will now be offered to families of four southern districts of Khyber Pukhtunkhwa. The selected services include child health awareness and counseling, screening of children for malnutrition using growth monitoring, immunization services, and referral of complicated cases. Registration of families with children aged 0 to 2 years and periodic attendance of awareness sessions at OSS/CFC is accompanied by a Child Wellness Grant (CWG). The cash grant aims to compensate for the opportunity costs of participating in the health awareness and contingent upon families receiving, counseling sessions and bringing children to health facilities for regular check-ups. A cash grant of Rs. 12,500 is provided in five equal installments for promoting positive health seeking behavior of families for their children. Based on the learning from the initial pilot phase the Government will decide on the roll out to other areas. Human resources and vaccines required for the services under this component will be supplied by the DoH (KP).

Component 3: Strengthening program management and oversight

Component 3 will be scaled up to meet additional project management, supervision, training, and incremental operating costs consistent with the extension of the closing date to June 30, 2024. Additional resources will be added to sub-component 3.2: Enabling Citizen Centric Service Delivery, to support the establishment of sixteen new CFCs and introduction

of additional services including VRS, CRMS, NADRA E-Sahulat platform and other services in four new districts.

This component provides technical assistance to enhance program management, transparency and accountability at the federal, Merged Area Secretariat and local level administration through capacity building, stakeholder consultation, social mobilization and awareness, strategic communication, and monitoring. This component will be implemented by NADRA and has been designed to help the Government to establish a robust system for cash transfer to beneficiary families, with adequate safeguards, fiduciary oversight, accountability and transparency. The main areas of technical assistance include MIS development, hardware provision, communication, outreach and social mobilization, Operational Review, beneficiary surveys, and capacity building. The component finances training and capacity building to staff of the Department of Health (KP) to oversee and deliver services under Component 2, as well as to staff of other stakeholders involved in project implementation and operations.

This component also supports the operational costs related to the establishment, operation, and management of OSSs/CFCs, as well as the costs of setting up and operations of the grievance counters and child health services within each OSS/CFC. The OSSs/CFCs will be managed by NADRA, the project implementing entity. Separate Grievance Counters will be maintained at each OSS/CFC to manage beneficiary grievances and complaints. The component finances NADRA's related costs for end-to-end beneficiary registration based on CNIC data and biometric enrollment, including verifications of payments.

In addition, the component will support administrative, financial management, disbursement, procurement and audit activities related to Project implementation. An overall project implementation unit has been established within the EAD with key technical staff contracted by the project.

The Project Development Objective is to support the early recovery of families affected by the militancy crisis, promote child health, and enhance citizen-centered service delivery in the tribal districts of KP Province.

The project will enhance citizen-centered service delivery through the establishment of CFCs in population centers to serve the entire population of the tribal districts and four adjoining districts. Selected services to be introduced at the CFCs include VRS, CRMS and NADRA E-Sahulat, which will further promote access of beneficiaries to a range of public services. Other services will be introduced as the project is implemented. The additional financing shall promote child health through cash transfers linked to attendance of health awareness sessions to incentivize demand side uptake of critical health and nutrition services to reduce malnutrition and improve uptake of vaccination.

Component 3 will be scaled up to meet additional project management, supervision, training, and incremental operating costs consistent with the extension of the closing date to June 30, 2024. Additional resources will be added to sub-component 3.2: Enabling Citizen Centric Service Delivery, to support the establishment of sixteen new CFCs and introduction of additional services including VRS, CRMS, NADRA E-Sahulat platform and other services in four new districts.

Key changes to the results framework include: (a) an increase in total number of families with children aged 0–24 months attending child health awareness sessions to 1,190,000; (b) Increase in the number of fully functional CFCs to 43; (c) increase in number of services available at CFCs to 6; and, (d) increase in number of times new services (not including LSG and CWG) accessed at CFCS to 1,200,000. Where possible, reporting against indicators will be gender disaggregated.

1.4 Institutional Arrangements for the Project

Owing to the satisfactory performance; the institutional arrangements for the project will remain the same and are as follows as no change has been made in the original design of the program. The Child Wellness Package and CFC component of the program have been expanded to Southern districts with similar arrangements. However a new position of "Southern Districts Coordinator" has been proposed to further strengthen the existing set up and to take care of ESMP activities in the additional districts.

The Economic Affairs Division (EAD) will be responsible for the overall coordination and monitoring of the project. The EAD assumes the responsibility for donor coordination, reporting and for managing the flow of funds to the Payment Service Provider (PSP)' accounts. The EAD prepared project design and implementation plan at the time of appraisal with technical support from NADRA. The EAD also provided the platform for the required coordination of the project with the National Database and Registration Authority (NADRA) and the key government agencies of erstwhile FATA, including the Merged Area Secretariat, Law and Order Department, Return and Rehabilitation Unit, the Health Department (KP) and the Provincial Disaster Management Authority (KP). To ensure effective coordination, a Memorandum of Understanding (MoU) is signed by all the project implementing stakeholders from DoH, PDMA, Payment Service Providers, and NADRA to agree on respective responsibilities and to get the stakeholders consent to translate these responsibilities into implementation in accordance with the Project Operational Manual.

Key decisions and oversight. The Operations Steering Committee, composed of key stakeholders including EAD, Ministry of Finance, M&R Secretariat, PDMA, Department of Health (KP), and Relief Rehabilitation & Re-Settlement Department (KP), which provides overall operational oversight and decision making support in terms of key project outcomes and deliverables. The Steering Committee is convened by EAD on bi-annual basis to update on the project progress and for key decisions that may require from time to time. If need be for any important decisions, EAD can call upon the Steering Committee to provide their input and endorsement as and when required. Furthermore, an Operational Review Committee has also been established, which meets monthly in order to address any project operational issues or decision to be taken. The Project Operational Manual and all key process-based agreements with the stakeholders will also need to be endorsed by the members of the Steering Committee. In addition, the Project Management Unit set up in EAD, will report progress to both the Steering Committee and Operational Review Committee as their Secretariat.

i) **NADRA is the lead technical agency of the project.** NADRA provides all technical and operational support for the field implementation of the project. NADRA's competency is based on the institution's experience gained from the past emergency operations including the earthquake and flood responses, as well as supporting the implementation of BISP. TDP-ERP operational procedures have been fully detailed in the Project Operational Manual (POM) with inputs from EAD, NADRA, Department of Health and PDMA. The POM provides all concerned stakeholders with guidance on implementation procedures along with any necessary training, follow-up support and advice on their respective roles. NADRA's key responsibilities are: development and maintenance of the project MIS;
ii) setting up and operations of One Stop Shops (OSS)/Citizen Facilitation Centers (CFCs)
iii) Acquisition and subsequent verification of biometric data on-site.

Establishment of CFCs/OSSs. The OSSs/CFCs set up by NADRA supports the project implementation and operations in the field for registration, verification and payment of all eligible beneficiaries, as well as provision of child health services for eligible beneficiaries. Establishment of OSSs/CFCs was divided in phases according to TDPs return schedules during the project roll out. The implementation of the OSSs/CFCs by NADRA involved

close coordination and work relationship with the PDMA, DoH (KP) and local/district administration. Suitable office buildings and locations for each OSS/CFC have been identified by PDMA and NADRA, in discussion with the local/district authorities. The child health services were rolled out in four pilot OSSs in the first stage and has been expanded to 27 Citizen Facilitation Centers with a further expansion to Southern Districts of Khyber Pukhtunkhwa through additional 16x Citizen Facilitation Centers (CFCs). The potential rollout will follow a careful assessment of the intervention with respect to take-up of various services and delivery of benefits.

Grievance Redress Systems. The project beneficiaries are able to access the OSS/CFC to address any beneficiary grievance concerning enrolments, verification, ERG, LSG and CWG payments, and the quality of services being provided, as well as information updates. The OSS/CFC are equipped with MIS based grievance redress module managed by NADRA and DoH, partner agencies, that are addressing grievances as per the agreed procedures laid out in the POM. NADRA is keeping a record of the details of cases lodged, resolved cases, pending cases and actions taken for each OSS/CFC and will update the EAD and Operational Review Committee accordingly in a timely manner.

Social Mobilization, Strategic Communication and beneficiary feedback mechanisms. The role of, social mobilization is fundamental to stimulate public demand, motivate people to avail services, educate beneficiaries about their rights and responsibilities not just for the overall early recovery package, but also more extensively for child health services. The Project has adopted a four-pronged approach which is being followed. Firstly, this includes social mobilization and awareness raising at village level especially for women and remote communities through the implementation of a gender-sensitive social mobilization strategy which especially targets village elders, notables, women and those involved in ensuring that children receive health services. Secondly, strategic communications supported through a communications framework (attached as **Annex 1**) for developing a cohesive and consistent project image and enhanced understanding among key stakeholders. A comprehensive beneficiary awareness and mobilization campaign has been implemented to sensitize potential beneficiaries about the early recovery package and child health services prior to the activation of the OSSs/CFCs. Standardized communication guidelines for beneficiary facilitation at the CFC/OSS has also been prepared, including counseling and awareness sessions for the beneficiary families to apprise them on the package of services that are being offered. Finally, beneficiary feedback surveys provide information on stakeholder engagement and outreach.

Chapter 2: Legal and Policy Framework

The ESMP has been developed and updated after reviewing the relevant promulgated environmental legislation and guidelines of Pakistan and the World Bank's safeguard policies. These legislations and safeguard policies, and their relevance to the proposed project, are briefly discussed below.

Pakistan Environmental Protection Act, 1997[7]: The Pakistan Environmental Protection Act (PEPA) is the apex environmental law in the country, and provides for the protection, conservation, rehabilitation and improvement of the environment, for the prevention and control of pollution, and for promotion of sustainable development.

Section 2(xxi) of the Act describes "hospital waste" as a waste medical supplies and materials of all kinds, and waste blood, tissue, organs and other parts of the human and animal bodies, from hospitals, clinics and laboratories. Under this Act the hospital waste has been described as "hazardous waste".

Section 12 of the Act requires preparation of Environmental Impact Assessment (EIA) or Initial Environmental Examination (IEE) before commencement of projects likely to cause adverse environmental effects.

The present ESMP has been prepared in compliance with the requirements of this Act.

Pakistan Environmental Protection Agency Review of IEE & EIA Regulations, 2000: These Regulations define procedures for preparation, review and approval of environmental assessments. The projects falling under any of the categories listed in Schedule-I require preparation of Initial Environmental Examination (IEE) report, whereas those falling under categories listed in Schedule-II require preparation of at detailed study, the Environmental Impact Assessment (EIA).

The proposed project does not fall under any of the categories specified in Schedule-I or Schedule-II of the Regulations and would, therefore, not require preparation of IEE or EIA report.

Hospital Waste Management Rules 2005[8]: These Rules describe the process of hospital waste management in an environmentally responsible manner. A 'hospital', as defined in the Rules, includes a clinic, laboratory, dispensary, pharmacy, nursing home, health unit, maternity center, blood bank, autopsy center, mortuary, research institute and veterinary institutions, including any other facility involved in health care and biomedical activities. These Rules also describe roles and responsibilities of the hospital management/administration.

These Rules are applicable to the proposed project, and the risk and non-risk wastes generated during the implementation of the project need to be handled and disposed of in

[7] The national and provincial laws in merged area are equally applicable after the recent merger of tribal districts into Khyber Pakhtunkhwa Province. The same process has reportedly been initiated and implemented for environmental laws as well. Therefore, all the national and provincial laws discussed in this Chapter are applicable to similar projects elsewhere in the country will be deemed applicable to TDP-ERP as well.

[8] http://environment.gov.pk/act-rules/rHWMRules2005.PDF

accordance with these Rules. The rules describe the process as well as the roles and responsibilities at each level (from primary to tertiary level healthcare facilities) for segregation of the waste, its final disposal as well as monitoring mechanism for the entire process. This ESMP will benefit from the Rules.

WB OP 4.01 (Environmental Assessment): This Operational Policy (OP) requires Environmental Assessment (EA) to be conducted of projects proposed for Bank financing to help ensure that they are environmentally sound and sustainable with an objective to improve decision making process. The present ESMP has been developed in response to this OP.

This OP also categorizes the project in one of the four categories on the basis of the type, location, sensitivity, and scale of the project and the nature and magnitude of its potential environmental impacts. The proposed project has been classified as Category B, since the project activities can potentially have negative impacts on environment and human population, though these impacts are site-specific and can be eliminated/controlled/reduced by implementing properly designed mitigation measures.

WB OP 4.04 (Natural Habitats): This policy seeks the conservation of natural habitats for long-term sustainable development. It supports the protection, maintenance, and rehabilitation of natural habitats and requires a precautionary approach to natural resource management to ensure opportunities for environmentally sustainable development.

The activities under the proposed project are not likely to affect the natural habitat, therefore this OP is not triggered.

WB OP 4.09 (Pest Management): Through this OP, WB supports a strategy that promotes the use of biological or environmental pest control methods and reduced reliance on synthetic chemical pesticides.

This OP is not triggered since the proposed project does not involve usage of pesticides.

WB OP 4.11 (Physical Cultural Resources): This policy addresses physical cultural resources defined as movable or immovable objects, sites, structures, groups of structures, and natural features and landscapes that have archaeological, paleontological, historical, architectural, religious, aesthetic, or other cultural significance.

The project activities do not affect any physical cultural resources, hence this OP is not triggered.

WB OP 4.12 (Involuntary Resettlement: The overall objectives of the Policy include: a) involuntary resettlement should be avoided where feasible, or minimized, exploring all viable alternative project designs; b) where it is not feasible to avoid resettlement, resettlement activities should be conceived and executed as sustainable development programs, providing sufficient investment resources to enable the persons displaced by the project to share in project benefits. Displaced persons should be meaningfully consulted and should have opportunities to participate in planning and implementing resettlement programs; and c) displaced persons should be assisted in their efforts to improve their livelihoods and standards of living or at least to restore them, in real terms, to pre-displacement levels or to levels prevailing prior to the beginning of project implementation, whichever is higher.

No involuntary resettlement is involved in the project hence this Policy is not triggered.

WB OP 4.36 (Forests): This policy seeks the management, conservation, and sustainable development of forest ecosystems and their associated resources essential for lasting poverty reduction and sustainable development.

The project activities does not affect any forest resources, hence this OP is not triggered.

WB OP 4.37 (Safety of Dams): The Policy seeks to ensure that appropriate measures are taken and sufficient resources provided for the safety of dams the Bank finances. However, this OP is not relevant since the project does not involve construction of dams.

WB OP 7.50 (Projects on International Waterways): This OP defines the procedure to be followed for the WB-financed projects that are located on any water body that forms a boundary between, or flows through two or more countries. However, no project components was located on any such waterways, hence this OP was not triggered.

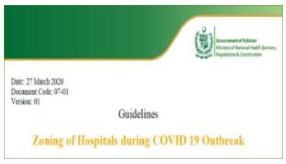
WB OP 7.60 (Projects in Disputed Areas): This policy defines the procedure that needs to be followed in case the Bank-funded project or any of its components is located within any disputed area. Since the proposed project will not be carried out in any disputed areas hence this Policy has not been triggered.

COVID-19 Guidelines and SOPs

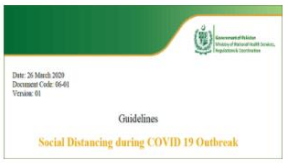
WHO issues advice and updates for the public, including on social distancing, respiratory hygiene, self-quarantine, and seeking medical advice. These are the WHO website: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public

WHO resources include technical guidance on: (i) laboratory biosafety, (ii) infection prevention and control, (iii) rights, roles and responsibilities of health workers, including key considerations for occupational safety and health, (iv) water, sanitation, hygiene and waste management, (v) quarantine of individuals, (vi) rational use of PPE, (vii) oxygen sources and distribution for COVID-19 treatment centers.

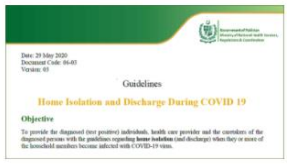
In Pakistan, National Command and Operation Center (NCOC) - https://ncoc.gov.pk/#section2 is the nerve center to synergize and articulate unified national effort against COVID-19, and to implement the decisions of National Coordination Committee. NCOC has issued several SOPs related to COVID-19 and available at https://ncoc.gov.pk/sop.php.



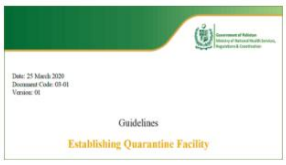
Guidelines for Zoning of Hospitals



Guidelines for Social Distancing



Guidelines for Home Isolation



Guidelines for Quarantine Facility Establishment

Instructions for Testing of COVID

Advisory Disinfectants

Chapter 3: Environmental and Social Impacts Assessment

This section describes environmental and social aspects associated with the project activities. The project activities will remain the same after the 3rd additional financing as the overall design and delivery mechanism of the program will remain the same.

As the project activities under additional financing are similar to the activities (being/) implemented under original project, the environmental and social aspect will remain unchanged and E&S screening procedures and mitigation measures planned for original ESMP are being maintained in this revised ESMP as well; with the exception of risks associate with COVID-19 pandemic.

3.1 Screening of Project Impacts

The substantial activities under the program comprise the following:

i) Completing the eligibility and verification checks based on biometric and CNIC information;
ii) Ensuring timely and efficient cash disbursements;
iii) Facilitating health assessment of children and;
iv) Establishing an easily accessible grievance redress system.

The environmental and social aspects of the proposed activities were identified as under:

- Cold chain management for vaccine effectiveness
- Risk of infections
- Disposal of sharps and immunization waste in general
- Water and soil contamination
- Privacy and gender issues
- Potential for social conflicts
- Accessibility Issues related to One Stop Shops
- Absence of services at facilities
- Availability of competent female staff
- Health and Well Being
- Employment Opportunities

Screening and impacts assessment of the project activities was carried out for adverse environmental and social impacts using a standard impacts assessment matrix is shown in **Table-1**.

Table 1: Environmental and Social Impacts Screening Matrix

Project Component	Environmental and Social Aspect											
	ColdChainManagement	Riskofinfections	Disposalofsharpsandotherwaste	Waterandsoilcontamination	Privacyandgenderissues	Potentialconflicts	AccessibilityIssues	Absenceofservicesatfacilities	Availabilityofcompetentfemalestaff	AccessHealthFacilities	HealthandWellbeing	EmploymentOpportunities
Eligibility and verification Processes	N	N	N	N	0	0	N	N	N	N	N	+2
Cash disbursement processes	N	N	N	N	0	0	N	N	-1	N	N	+2
Health Services for children	-2	-2	-2	0	-2	-1	-2	-1	-2	+2	+2	+2
Grievance redress system	N	N	N	N	+1	+1	N	+1	+1	N	N	N

With the help of the above matrix, interactions of various project activities with various environmental and social aspects have been identified. This interaction has further been categorized with respect to severity of impacts as follows:

Low negative impact (-1)
High negative impact (-2)
Low positive impact (+1)
High positive impact (+2)
Negligible impact (0)
No impact (N)

Accordingly, the less important impacts were screened out from the ones which were more important and required further discussion. As depicted in **Table-1**, the following impacts were categorized as highly negative in severity:

i) Cold Chain Management for Vaccine Effectiveness
ii) Risk of Infections

Disposal of Sharps and Immunization Waste in General
Implementation and following of COVID 19 SOPs at OSSs/CFCs
Accessibility to the proposed facilities and other difficulties for accessing child health services in the absence of formal public transport system
Availability of competent female staff for carrying out the immunization

The impacts categorized as somewhat negative in severity are:

i) Privacy and gender issues during female interaction while undertaking the eligibility and verification checks
ii) Privacy issues and potential conflicts during cash disbursements
iii) Availability of resting, washing and other welfare services at facilities and their continuity
iv) Access to grievance redress system and awareness.

3.2 Environmental Impacts and Mitigations

The impacts of highly negative severity issues are assessed and appropriate mitigation measures have been identified below.

Cold Chain Management for Vaccine Effectiveness

Vaccines need to be stored at recommended temperatures for them to remain effective. Also the quantity to be administered is the key for it to work on a child or a mother. The campaign might not achieve its targets of disease(s) elimination, as well as causing mistrust amongst the communities (occurrence of disease despite vaccination), if the cold chain breaks.

Mitigation

Cold chain management, in accordance to the National Expanded Program on Immunization (EPI) Policy and Strategic Guidelines has to be ensured at all levels. Vaccines shall be stored at standard temperatures in official EPI store only. They should not be stored for more than a period of six months at federal level, three months at the provincial level, one month at the district and fifteen days at the facility level. Standard stock ledger with name of the vaccine, quantity in doses, vial size, manufacturer, expiry date, batch/lot number, date of receive and supply to be maintained at all level and updated regularly. Reconstituted vaccine must be discarded six hours after reconstitution or at the end of immunization session, whichever comes first.

Risk of Infections

The project activities involving administering vaccines using sharps/injections pose a high risk to the health workers as well as the community at large. They can cause epidemics, as well as transfer communicable diseases from a host population to another. Epidemics have an impact on virus genetics, and mutations can be caused. Such mutations can cause imbalance within a particular ecosystem, especially with symbiotic relationships, and can be detrimental to other organisms/species survival. Hence, the issue is both environmental as well as a public health issue.

Mitigation

The risk of infection associated with sharps and syringes can be greatly reduced by ensuring use of WHO pre-qualified Auto-Disable (AD) syringes for conducting vaccination, Personal Protective Equipment (PPE) while handling sharps, provision of information posters at needle exchange places indicating safe handling, and collecting the sharp waste generated during the immunization in dedicated safety boxes for safe disposal.

Disposal of Sharps and Immunization Waste in General

Despite many efforts taken by the government and civil society, medical waste and sharp disposal remains a challenge for the hospital industry and environmental managers. **Box 1** on current medical waste management practices shows that medical waste is not regulated and not always disposed in an efficient manner. The hazards associated with improper waste disposal by any healthcare facility operation are mostly caused by not following the infection control protocols, not using proper personal protective equipment (PPE), and not employing proper procedures for waste collection, transportation, storage, and final disposal. In addition, recycling of medical waste also poses very serious health risks for the workers involved in recycling and also consumers using the recycled products. Moreover, safety of staff handling sharps such as syringes and needles is at risk if proper procedures are not followed. Air and water quality deterioration is another associated potential impact if the waste is disposed by burning and/or burial.

Box 1: Current Medical Waste Management Practices in Pakistan

A comprehensive survey was conducted in May 2007 in all four provinces, Azad Jammu and Kashmir, and Federal capital area. Overall fourteen health care establishments from each respective provinces/areas were included in the survey. One tertiary care hospital in public and private sectors, two secondary care hospitals in both public and private sectors and four first level care hospitals in both public and private sectors were surveyed. A total of 78 health care facilities were studied and data collected. Summary of the findings are detailed as below:

Presence of Health Care Waste Management (HCWM) Team or Infection Control Team	30% of hospital surveyed
Presence of guidelines or internal rules of the health care waste management	40 % of hospital surveyed
Presence of plan for HCWM	27 % of hospital surveyed
Presence of program to assess HCWM	12% of hospital surveyed
Regular trainings on HCWM	23% of hospital surveyed
Awareness about the hazards of Health Care Waste (HCW)	67 % of staff surveyed
Routine health surveillance for the staff	22 % of hospitals surveyed
No segregation for HCW	19% of hospitals surveyed
Segregation of sharps	27 % of hospitals surveyed
Segregation of sharps from infectious waste	21 % of hospitals surveyed
Presence of separate containers for infectious and non-infectious waste	48 % of hospitals surveyed
Presence of properly color coded and labeled containers	32 % of hospitals surveyed

Source: Health Care Waste Management in Pakistan (Khan EA et al.). Environmental Health Unit, Health Services Academy, Islamabad**.

****This is the latest national level information*

Mitigation

Immunization waste is required to be managed in accordance to the legal framework of Pakistan, specified under the Hospitals Waste Management Rules 2005. Auto disable (AD) syringes are recommended by WHO to be used for immunization purposes, and the EPI only procures the AD syringes for its fixed and outreach activities. Safe disposal of these syringes is absolutely necessary from a public health and environmental point of view. Once used, these syringes must be disposed into customized Safety Boxes, as per National EPI Policy as well as WHO recommendations. Current immunization activities are being carried out in accordance to the WHO recommendations, and AD syringes and Safety Boxes are being used. Waste disposal will be carried out by using pit burial method within the Basic Health Unit (BHU)/ Rural Health Center (RHC) facilities. The unused reconstituted vaccines are also disposed in the same manner.

The current practice includes digging an earthen pit of about 1m deep. The medical waste is burnt in this pit and then covered with soil.

Action Plan for Immunization Waste Management. Medical waste (including immunization waste) management across Pakistan remains a challenge, especially at the Tehsil and Union Council levels. As **Box 1** explains, most of the primary level healthcare facilities do not have effective systems and procedures in place, nor have infrastructure to manage and dispose-off infectious waste. Hence immunization campaigns and/or other hospital treatments involving sharps and other infectious wastes, can potentially lead to public health risks, unless the waste is efficiently managed and disposed.

It is proposed under the present project to prepare a comprehensive Immunization Waste Management Action Plan in order to tackle this issue, and suggest workable and practical solutions. A stage-wise breakdown of activities is proposed as under. [9]

- **Stage 1; Documentation of current practices and identification of workable solutions:**
  - Workshops on documenting current practices and systems currently in place for infectious waste management;
  - Identifying best practices from within the country as well as the South Asian region
  - Documenting the results and dissemination to relevant stakeholders in the government, academia and civil society.
- **Stage 2; Agency Action Plans prepared and notified:**
  - District Action Plans to be prepared on the basis of the tasks carried out during the Stage 1 described above
  - Identification of short, medium- and long-term milestones and action points from within the plans
  - Notification of the Plans by the Health Department (KP)
  - Appointment of immunization waste management coordinator in each district.
- **Stage 3; Implementation of the District Action Plans and Immunization Waste Management Systems in place:**

[9] A similar mechanism has been proposed under NISP as well.

- Provision of resources for the short-term actions points of each District plans
- Execution of the plans, especially of the short-term actions that can be dealt with in the project lifetime
- Equipment, systems and procedures in place for immunization waste management, under the monitoring and coordination of Federal EPI Program.

The implementation of the above Plan was completed within first 6-8 months of the project and monitored through the regular monitoring system of the project including the third party validation (described later in the document). The implementation progress reports of the project cover the progress on this Plan as well.

During the recent COVID-19 pandemic, various challenges have been faced in crowd management, controlled mobilization, health & safety of staff and beneficiaries etc. To overcome these challenges, COVID SOPs as issued by Ministry of Health and Sciences in line with the WHO guidelines were implemented in field and strict adherence to the said guidelines and SOPs was ensured to avoid the spread of said virus through NADRA, Department of Health (KP) staff and concerned district administrations. All the staff deputed at CFCs/OSSs is provided with PPE kits and face mask and shields, where sanitizers are placed at entry points. To avoid the spread of the disease, the sites were closed on the instructions of Provincial Government for a period of approx. two months, initially. However, later on the sites were opened and limited number of beneficiaries (100-150/day) were allowed to visit the sites. Moreover, at the entry point, temperature of beneficiaries is checked as per SOP. Beneficiaries are advised to maintain social distance and all sites are disinfected on regular basis.

3.3 Social Impacts mitigation

Access to One Stop Shops (OSSs)/Citizen Facilitation Centers (CFCs)

The terrain of the area, the restricted or limited mobility of women and the absence of a reliable transportation system in the region can adversely impact on the accessibility to OSS. Further, the security situation also creates challenges related to travel.

Mitigation

- This impact has been minimized by identifying appropriate locations for One-Stop Shops/Citizen Facilitation Centers so that a maximum number of people can approach the facility. OSSs/CFCs were selected on supply and demand criteria based upon easy access for most people.
- Awareness campaigns will be carried out to motivate people to travel and an on-spot cash disbursement to further encourage the communities to participate.

Availability of competent female staff

Despite of the physically harsh terrain of the project area and conservative social norms which discourage females to work, NADRA and DoH has deployed female staff at most of the sites.

Mitigation

Competent lady health workers are engaged and special incentives are provided in order to encourage them to work in the project operational area. In addition, comprehensive trainings are imparted to locals in order to develop their skills in undertaking the health service provision activities.

Privacy and Gender Issues

Privacy is a core value in the tribal norm. It is challenging for local women to interact with any outsider male during implementation of the proposed activities. In addition, lack of separate waiting areas and washroom facilities can also discourage the females to access the health facilities, hence, separate female waiting areas and washrooms have been provided at all sites.

Mitigation

The Project ensures that, as far as possible under the circumstances, qualified female staff is present at all the health facilities in order to interact with females accompanying the children for health checkups. In addition, separate waiting areas and wash room facilities are designated for women.

Potential Conflict Issues

Since the project involves distribution of cash grants, chance of conflict at the OSSs/CFCs is a possibility. Mainly, this is likely to occur if people are unaware of the eligibility criteria for receiving cash grants. However, unheard and unsolved complaints against project processes can also lead to conflicts. This can have adverse impact on the overall delivery of services under the project scope.

Mitigation

The Project will undertake a widespread awareness campaign and integrate it within the Social Mobilization process so that communities are fully aware of eligibility criteria and can produce the relevant information to prove eligibility. Further, the Grievance Redress Mechanism established at the OSSs/CFCs is effectively implemented. Local communities are informed about the GRM through awareness material having information on the access and process of GRM including details of means of lodging complaints i.e. GRM counter, telephone and written application by posts. Female staff is available to record complaints and deal with female members of the communities.

3.4 Summary of Environmental and Social Impacts and their Mitigation

A summary of the above-discussed environmental impacts and their mitigation is presented in **Tables 2.**

Table 2: Significant Environmental and Social Aspects and Suggested Mitigation Measures

Project Activities	Significant Aspects	Mitigation Measures
Storage, administration, constitution, reconstitution and temperature control of Vaccines	Ineffective vaccines causing epidemic of the respective disease (e.g. measles, Hepatitis B), and/or increased occurrence of the disease leading to increased (child) mortality and morbidity (e.g. measles, Hepatitis B, Tetanus, TB)	Use of revised National EPI Policy and Strategic Guidelines for vaccine administration, management (including procurement, quality and supply) and Storage Cold chain management, including ensuring that the cold chain does not contain Ozone Depleting substances Provision of trainings on vaccine administration and management to be provided to district health staffs including, but not limited to accredited EPI service providers including vaccinators, nurses, dispensers, Lady Health Visitors (LHVs), Medical Technicians (MT), Female Medical Technicians (FMT), mid-wives, Lady Health Workers (LHWs) and Medical Doctors

Project Activities	Significant Aspects	Mitigation Measures
Immunization activities	Sharp waste generated due to immunization campaigns leading to increased risks of patient to patient infections as well as immunization staff Safety	Ensure use of WHO pre-qualified Auto-Disable (AD) syringes for conducting vaccination. Provision of information posters at needle exchange places indicating safe handling Using personal protective equipment (PPEs) for infection control (procurement of the PPEs will be covered within the project cost) Collecting the sharp waste generated during the immunization in dedicated safety boxes for safe disposal.
		Providing trainings to all relevant stakeholders as per their roles and responsibilities in the process of immunization, on injection safety and disposal.
Medical waste generated as a result of immunization campaigns (syringes, used vaccine vials and safety boxes containing syringes)	Risk of infections and spread of diseases through vectors; contamination of soil and water	Use of the Hospital Waste Management Rules 2005 and National EPI Policy and Strategic Guidelines for proper waste management. Follow sound infection control practices, which includes segregation at source If AD syringes are not available, there should be provision of needle-burners/cutters and/or hub-cutters Staff should use Personal Protective Equipment (PPE) while immunization, and hospital workers should use appropriate PPE when collecting and disposing of medical waste All standard waste containers (available with DoH KP), safety boxes, and waste bags to be collected and sent for pit burial. Ensure that wastes are completely burnt in at least one meter deep pit. After burning the waste, pit is appropriately filled. Conducting monitoring of waste handling, storage and disposal to ensure proper implementation of waste management system.
	Lack of awareness among the project staff, district health authorities and facilities staff, healthcare extension workers, and others.	Development of awareness material Conducting trainings of the project staff and district health authorities and facilities staff, healthcare extension workers on hospital waste management as per their roles and responsibilities. Provision of information posters at waste collection and storage sites indicating safe handling and disposal

Project Activities	**Significant Aspects**	**Mitigation Measures**
Capacity to minimize environmental and social risks associated with the above three Activities	Untrained human Resource	Providing appropriate trainings to all stakeholders congruent with their roles and responsibilities in the project with due consideration of sustainability of project components after its completion.
Access to one Stop Shops	Distance of CFC/OSS for local communities and Inadequate transportation options	Appropriate identification of locations for OSS/CFC, provisions of travel grant, effective disbursement of cash grants.
Privacy and Gender Issues	Absence of female staff and lack of segregated waiting areas	Ensure segregated waiting areas for women and children at CFC/OSS. Engender supply side functions, as far as possible under the circumstances through trainings and provision of female staff as far as possible.
Potential Conflict	Lack of dispute resolution mechanism.	Awareness-raising through social mobilization and communication. Establishment of effective GRM, information dissemination to local communities on the use and process of GRM.
COVID-19 threats	Possible threat of spread of Virus at CFCs	Implementation of SOPs Educating of staff deployed at CFCs Provisioning of PPE kits to Staff Wearing of face masks mandatory for both staff and beneficiaries Controlled Mobilization to minimize risk Reducing processing by 50% at all CFCs Fumigation of sites

The aspect of waste management has been considered as a critical environment component therefore, specific measures for handling such wastes within the facility and by extension workers at community level have separately been proposed and presented in **Tables 3** and **4** below.

Table 3: Handling and Disposal of Wastes for Vaccine Extension Workers at Community level (Mid-wives, LHVs/LHWs, etc.)

Type of Waste	Handling of Material Prior to Use	Handling of Used Material/Waste	Storage/Disinfection of Waste	Final Disposal
Used syringes, Used Gloves	Extension workers/field staff should: Always use WHO pre-qualified AD syringes which cannot be reused EPI allows only WHO pre-qualified AD syringes and these must be used with extreme safety pre-requisites There should not be recapping to avoid accidental pricking. There should not be double/multiple Handling Waste should be segregated at Source Avoid leaving Unpacked syringes/sharps unguarded. In-charge should: Provide posters at needle exchange places indicating the methods of use and cleansing and disposal of waste.	Collect the sharp waste generated in dedicated safety boxes for safe disposal.	Wear gloves when handling the sharps. Discard sharps immediately after us into puncture-resistant safety boxes. Disinfect (him/herself & used equipment) as per Recommended guidelines and procedure.	All containers, safety boxes, and waste bags to be collected and sent for pit burial and burning (pit burning and burial will be carried out by the healthcare facility, e.g., Basic Heath Unit)

Note: For details, please refer to the Pakistan Hospital Waste Management Rules, 2005.

Table 4: Handling and Disposal of Wastes for Tertiary Level Healthcare Facilities (BHUs/RHCs)

Type of Waste	Handling of Material Prior to Use	Handling of Used Material/Waste	Storage/Disinfection of Waste	Final Disposal
Sharps Syringes Gloves Cotton Bandages Cloths Other stuff used in Health assessment procedures	Always use WHO pre-qualified AD syringes and ensure non-Reuse Avoid Accidental Pricking Avoid leaving Unpacked syringes/sharps Unguarded Provide posters and guidelines at visible places Demonstrating Recommended methods of material usage and disposal of Waste	Collect the sharp waste generated in dedicated safety boxes for safe disposal. Collect used gloves, masks, waste cotton, bandages, and other waste contaminated with child's fluids in dedicated bags	Wear gloves when handling the sharps and needle containers. Transfer sharps in puncture-resistant safety boxes Collect and store all infectious materials in separate dedicated bags. Disinfect (him/herself & used equipment) as per recommended guidelines and procedure.	All containers, safety boxes, and waste bags to be collected, buried and burnt using a dedicated pit

Note: For details, please refer to the Pakistan Hospital Waste Management Rules, 2005.

Chapter 4: Stakeholder Consultations

The Project enhances citizen-centered service delivery through the establishment of CFCs in population centers to serve the entire population of the Merged Areas and the four southern districts. Selected services to be introduced during the project period include VRS, CRMS and NADRA E-Sahulat, which will further promote access of beneficiaries to a range of public services. Beneficiary feedback will continue to be obtained through regular annual surveys (qualitative and quantitative and with special focus on women). Results of previously completed surveys provide positive evidence on the program's utility and service delivery.

Consultations were carried out with all stakeholders to ensure better service delivery to all the beneficiaries in general and vulnerable groups (female and disables), in particular. Separate waiting areas have been allocated for female beneficiaries while wheel chairs and ramps have been provided at all sites. Moreover, the locations for establishment of CFCs have been carefully selected with respect to population volume and concentrations so that availability of these services can be made to maximum population.

4.1 Consultations during ESMP Preparation

The formulation of the ESMP benefitted from a wider consultation process with the relevant stakeholders. The process has been useful to gather information and sketch a baseline for ensuring compliance to environmental and social safeguard at operational level(s) through the ESMP. The consultation meetings for the parent project were carried out in July 2015.

The major stakeholders consulted as part of the ESMP preparation were:

- Community representatives Khyber Agency (Local Maliks[10]) and Local Administration (Additional Political Agent) Khyber Agency.
- Female Consultation, Kurram Agency
- NGOs/CBOs/CSOs
- FDMA (Federal Disaster Management Authority)
- Department of Health FATA
- Federal Environmental Protection Agency

4.1.1 Consultation meeting with Community Representatives (Local Maliks) and Local Administration (Additional Political Agent) Khyber Agency:

Khyber district is located in the north of Pakistan; it is bordered with Afghanistan, Peshawar city and the Kurram and Orakzai districts. Khyber district consists of three tehsils i.e. Bara, LandiKotal, and Jamrud. Khyber was previously administrated directly by the Federal Government, through the Governor of the Khyber Pakhtunkhwa Province as its agent, where the then Political Agent (PA) used to be the administrative head of the district who is assisted by the then Additional and Assistant Political Agents (APA)After the merger of erstwhile FATA in Khyber Pukhtunkhwa province, the administrative rights have been shifted to Deputy Commissioner assisted by Additional Deputy Commissioner and Assistant Commissioner.

The district has further three Tehsils; LandiKotal, Jamrud and Bara, with three Assistant Commissioners, seven Tehsildars and a number of other administrative functionaries. The headquarters of the Deputy Commissioner is situated in Peshawar, but has also a Camp Office/Residence at LandiKotal. The Assistant Commissioners have their headquarters in LandiKotal, Jamrud and Bara, respectively.

A consultative meeting was held at Assistant Commissioner office, Peshawar on 02 July 2015 (see photographs in **Annex 2**). Representatives/elders of the local tribes of Khyber Agency participated in this meeting. Initially, the Assistant Commissioner and local elders were briefed on the proposed project prior to seeking their views on proposed interventions. During the consultation, the Assistant Commissioner suggested areas for establishing OSSs for the proposed project which would ensure easy access for all communities.

Local elders consulted during Project preparation belonged to Malik Din Khel, Tori Khel & Kamar Khel tribes. According to the local elders, the community is willing to participate in the basic health services program. They reiterated that in the past such activities were affected by the threat of militancy and not because of unwillingness of the communities. Since the area is now returning to normalcy, the communities are

[10] Maliks are representatives of local communities who are recognized by the political administration as notables and influential.

willing to participate in the vaccination program. The elders also reiterated their support for the project.

Suggestions received from local tribal elders:

- Health facilities must be established at a suitable site so that maximum communities can access the facilities easily.
- If possible, provision of transportation arrangement can further improve the proposed project interventions.
- Mobile health facility should be arranged for remote areas.
- Proper storage arrangements must be done for vaccines, through providing solar refrigerators.
- Female staff must be deployed for the female community members.
- There must be a separate waiting area/room for the females so that local cultural values and norms are maintained.
- Provision of clean and safe drinking water facility should be ensured at all health facilities.
- Separate washrooms should be provided for the females.

4.1.2 Female Consultation

Consultations with women were held in Kurram district of erstwhile FATA through a focus group discussion. The group was informed about the proposed project interventions and scope. All the participants were aware of the importance of the child health and were willing to participate in the child health services component of the project.

The group stated that mostly women take their children to the health facility. However, as per the local customs, the females are always accompanied by a male family representative and are not allowed to go out of the home alone. Local transportation is used to reach the health care facility and usually the health facility covers a large scattered area which is difficult for women to visit several times for their child health checkup. The group agreed that the cash grant will help in meeting their domestic needs of food and basic necessities.

Suggestions for Interventions to improve child health care:

- According to the female community members, the proposed project will be more effective if proper awareness is given to all the community members and especially by involving and convincing the family elders. Similarly, the school teachers can play a vital role in convincing and motivating the general community members because they are considered the most respectable, educated and aware community members.
- The health care services for the proposed project can be improved by providing qualified staff and providing general medicines & equipment's in the existing health facilities. Although women were willing to take their children to the established health facilities, they also suggested that the facilities should be

provided at their door step. This will help to reduce access issues and also ensure larger coverage for the project.

4.1.3 Consultations with NGOs and CBOs

Consultation meeting was held with NGOs/CBOs in FDMA office Peshawar on 1 July 2015. All the organizations which are working or have previously worked in FATA attended the meeting. The participants were briefed about objectives and the scope of the proposed project and discussed a range of issues associated with health service delivery, barriers to immunization, challenges associated with gender, remoteness and marginalization of a community and environmental hazards associated with such campaigns. A list of NGOs consulted is presented in Annex 3.

4.1.4 Consultations with Federal Disaster Management Authority:

Federal Disaster Management Authority (FDMA) is a Federal Government Organization, which deals with Natural or Man-made Disasters in Federally Administered Tribal Areas of Pakistan. FDMA's mandate is to engage in activities concerning to all four stages of Disaster Management Spectrum.

As the most concerned organization regarding FATA, FDMA identifies the most vulnerable communities on need basis and the information is shared with local NGOs/CBOs to obtain funding from donors. NGOs/CBOs require NOC from FDMA prior to working with communities of FATA. FDMA also plays a regulatory role for the NGOs/ CBOs/SCOs to avoid overlapping of services in targeted communities.

4.1.5 Consultations with Department of Health FATA:

According to Deputy Director Health FATA, most of the health infrastructure has been partially or completely damaged due to militancy. Many of the health facilities are also nonfunctional due to unavailability of staff (especially female). Female staff is reluctant to work in FATA due to security concerns. Additionally, FATA is spread over hilly areas and health facilities are not easily accessible. Therefore, monitoring of staff and health units is a difficult task.

The medical supply chain is intact and all the establishments are provided with solar refrigerators for storing of vaccines. The consultation meeting with DD Health FATA discussed the problems faced by local in accessing health facilities. It was also pointed out that the drinking water supply schemes at health units are either missing or damaged and the staff has to fetch water from nearby wells or gravity springs that are not fit for drinking. Similarly, washrooms are damaged or nonfunctional due unavailability of water. This lack of water and sanitation facilities promotes open defecation and causes many communicable diseases especially among children. Solid waste management system is also very poor and traditional one. All the waste produced at health facilities is dumped in the open. There is no proper collection, segregation and incineration arrangement for hospital hazardous waste.

Suggestions of DD Health, FATA, for the proposed project:

- Rehabilitation and reconstruction of the damaged health units.
- Financial support to increase numbers of staff (especially female).
- Improve and ensure easy access to health facilities for targeted communities.

- Provision of water & sanitation facilities in health facilities.
- Provide and install proper solid waste system that is easy to maintain and run by health staff.
- Training and capacity building of the health staff regarding proposed project.
- Quality of work should be ensured in the proposed project and avoid overlapping of services in FATA

4.1.6 Consultations with Federal Environment Protection Agency

A meeting was held with the Director General, EPA on 3rd July 2015 to seek his advice on identifying the environmental issues associated with the project, as well as suggestions for mitigation measures. He identified immunization waste collection and disposal as the primary issue associated with the project and suggested that waste should be managed in line with the Hospital Waste Management Rules 2005. He also highlighted inadequate capacity of medical staff in handling such issues. He did not approve pit burial, since it can lead to groundwater contamination, and suggested incineration as an option for handling such waste.

4.1.7 Consultations with Stakeholders, District Administration, Health Department, Public & Private Agencies at DI Khan (November 4, 2020)

Following the decision to expands the program to southern district of Khyber Pakhtunkhwa Province, a consultation meeting was conducted in DI Khan district on 4th November 2020, followed by FGDs in Bannu district on 10th November 2020. The process has been useful to gather information and sketch a baseline for ensuring compliance with environmental and social safeguard at operational level(s) through the ESMP.

The major stakeholders consulted as part of the ESMP preparation were:

- Representatives of EAD & NADRA
- Local/District Administration
- NGOs/CBOs/CSOs
- PDMA Representatives
- Department of Health, Khyber Pakhtunkhwa
- Representatives of Environmental Protection Agency, KP
- Local Elders
- Local health staff

Detail presentation was delivered by EAD-PMU regarding the program since inception followed by detail discussion. All the representatives actively participated in the consultation meeting and provided positive feedbacks in connection to program achievements in merged area districts (Photos attached at Annexure 3). Also, a positive impact of the program was anticipated by all the participants including stakeholders and district administration representatives regarding the program intervention in southern districts. Participants expressed the view that separate waiting areas and washroom facilities be provided to female visitors at CFCs/OSSs, that efforts be made to coordinate with a nutrition program operational in DI Khan district, and that safe disposal of medical waste should be ensured.

4.1.8 Focus Group Discussions at Bannu District (November 10, 2020)

Focus group discussions were carried out in District Administration office (Bannu District) 10th November 2020 to collect in depth feedback and to take timely measures if any concerns are highlighted regarding the expansion of program to southern districts of Khyber Pakhtunkhwa.

The key participants of FGDs were TDP-ERP stakeholders i.e. representatives of EAD, NADRA, DoH (KP) and PDMA. Also, representatives of local elders, LHVs, district administration and people from different walk of life were included. The program service delivery mechanism, target audience, previous achievements in merged area districts and future intervention of the program were highlighted and discussed. The participants shared a positive feedback regarding the program initiation in southern districts and anticipated a positive and sustainable social and environmental effect in the region.

4.2 Summary of Environmental and Social Concerns during consultations

The environmental and social concerns highlighted during consultations are summarized in **Table 5** below.

Table 5: Summary of Environmental and Social Concerns during consultation

Concerns	Mitigation Measures
Environmental Aspects • No proper solid waste management system • No proper disinfecting arrangements • Poor hygienic condition of the health units • Lack of hygiene awareness and education in staff and community • Unavailability of clean and safe drinking Water • Unavailability of safe sanitation facilities (latrines & drains)	In order to address the concerns mitigation options include effective cold chain management, proper handling and disposal of waste. Details on impacts and their mitigations are given in section 6 of this document.
Social Aspects	
• Unavailability of female staff • Staff training and capacity building on public dealing • Lack of awareness on basic health • Accessibility problems due to poor transportation & road infrastructure • Gender based violence issues • Social problems in case of presence of non-	In order to address the concerns mitigation options include Setting up of OSS at an accessible location, presence of female staff and an effective GRM. Details are given in section5 of this document. Ensure supply side functions are gender sensitive, as far as possible in the circumstances.

local staff	

4.3 Consultations during Project Implementation

Consultations will not be limited to one time interaction during ESMP preparation but will be an ongoing process and would continue throughout project implementation. These consultations will be carried out on a quarterly basis with the stakeholders including but not limited to the local NGOs/CBOs, concerned government departments, local administration and the community representatives for timely updating and subsequent implementation of the ESMP.

The overarching goal of consultations, beneficiary engagement, outreach and communications is to support and facilitate the design and implementation of the FATA TDP-ERP. Stakeholder consultations will take place during implementation through the following means:

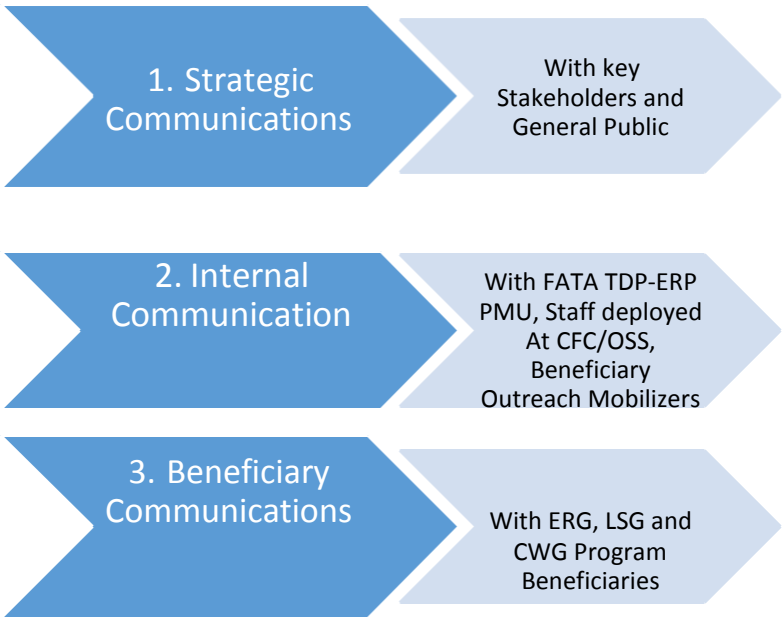
- Social Mobilization at the community level
- Awareness campaign for all stakeholders and
- Formal interactions through periodic workshops, consultation sessions with wider stakeholders especially institutional ones such as other Government Departments, NGOs, CBOs and academia etc.

Consultation Pathways during Implementation:

Social mobilization an integral part of the project. The Project formulated a Social Mobilization Strategy and implemented it through partner organizations. While the primary aim of social mobilization activities is to promote awareness, dispel misconceptions regarding vaccination and promote on-ground solutions to access issues, it will also serve to consult communities on the project's aims and performance. Consultations as part of social mobilization take place at village level. After initial contact, periodic follow up visits are made to elicit a community's views on project activities. These will be communicated to project authorities for follow up and integration in project design. Consultations at community level will target a range of groups including women, religious leaders and local elders. Concerted efforts were made to contact far-flung communities and elicit their views.

Overall communications framework will also be a key pathway for consultations. The Project uses a three-pronged communications platform aimed at **internal and external communications** as shown in the figure below.

Figure 1: Communications Framework and Levels of Engagement



The given framework strives to engage at three levels (**Figure 1**) to undertake an integrated yet differentiated communications. Further details are provided in **Annex 1**.

Workshops, consultation meetings etc: Periodically, the Project will also hold formal workshops to consult a wide range of stakeholders on project activities. Such workshops will involve, NGOs, CBOs, political representatives, academia and research organizations. The workshops will inform stakeholders about project progress and elicit their views on course correction and improvement.

Chapter 5: Grievance Redress Mechanism

A Grievance Redress Mechanism (GRM) has been established by the Project and will remain operational throughout implementation. Grievance redress counters have been established and staffed by NADRA at the One Stop Shops/Citizen Facilitation Centers. NADRA being implementation agency of the program have the responsibility to coordinate with the concerned stakeholders such as Payment Service Providers, District Administration, PDMA and beneficiaries for resolution of grievances related to targeting, payments, quality of services and updating family information, etc. The project includes provision for a 10 percent contingency to attend the grievances of eligible beneficiaries. Grievance counters provide a mechanism for social accountability of the Project. GRM includes the following main categories:

a. **Appeals:** These are grievances related to eligibility where a family member has not been included as "Beneficiary" and he/she feels that he/she fulfils the eligibility criteria of the project. Appeals were mainly linked to exclusion in targeting. These will be lodged by NADRA and forwarded to the respective authority for approvals including local/district administration and PDMA. All the appeals lodged till 30th June, 2019 have successfully been resolved.

b. **Complaints:** These include grievances against the system or processes which have been put in place to assist the applicants/beneficiaries but are not functioning properly or catering to the complainants' needs. These can both include complaints against the enrolment and payment processes, and may also include complaints on behavioral issues, malpractices / bribery etc.

5.1 Grievance Procedure

Grievance Redress Counter, setup at the OSSs/CFCs, operated by representatives of NADRA who act as the Grievance Redress Officer (GRO). All complaints, whether received at the counters or project helpline, are registered in the TDP-ERP MIS in the Complaints section. Every application received is tagged with a reference number and categorized as per the described categories. The grievance focal person at the grievance counter is the initiating authority to address the issues. The system forwards the complaint to the relevant departments/unit for resolutions.

Chapter 6: Institutional Arrangements for ESMP Implementation

Overall coordination and monitoring of ESMP implementation will be the responsibility of EAD, whereas the field level implementation of ESMP will be jointly done by NADRA and Khyber Pakhtunkhwa Health Department. All three departments have already designated ESMP Focal Points (FP) to ensure the implementation of ESMP. The EAD focal person will be responsible for top supervision of ESMP implementation through overall coordination and monitoring. NADRA focal person will be responsible for implementation of social aspects of the ESMP whereas Health Department (KP) focal person will be responsible for the implementation of environmental aspects of the ESMP. Additionally a new position of "Southern Districts Coordinator" has been proposed to further strengthen the existing set up and to take care of ESMP activities in the additional districts the roles and responsibilities of each department are given in the **Table 6** below.

Table 6: Roles and Responsibilities for ESMP implementation

EAD	NADRA FP	DoH FP
• Supervise the implementation of the ESMP • Ensure that the environmental and social focal points are notified by the respective departments. • Ensure the preparation of ESMP monitoring reports. • Coordinate with WB on ESMP implementation related matters.	• Coordinate with focal person of partner hospital/tertiary healthcare unit to ensure implementation of ESMP. • Conduct the monitoring tasks as assigned in Table 7 and maintain all reports and records. • Coordinate and ensure development of training material and implement of trainings sessions. • Commission annual third party validations of partner hospital/tertiary healthcare Unit • Prepare Quarterly Progress Reports (QPR) for ESMP implementation. • Coordinate with the grievance focal person for the follow up and resolutions of grievance.	• Coordinate with focal person of partner hospital/tertiary healthcare unit to ensure implementation of ESMP. • Ensure that cold chain equipment, AD syringes, safety boxes, waste management stuff and Disinfectant equipment/chemicals are being made available to the provinces. •Maintain the record of use of all recommended Equipment • Conduct the monitoring tasks as assigned in Table 7 and maintain all reports and records. • Implement Immunization Waste Management Action Plan • Conduct environmental compliance audit for the Program • Commission annual third party validations of partner hospital/tertiary healthcare Unit • Prepare Quarterly Progress Reports (QPR) for ESMP implementation.

Details of health facilities available in seven districts of erstwhile FATA and four southern districts of Khyber Pakhtunkhwa are given below:-

District Name	DHQ	THQ	CH	BHU	RHC	CD	CHC	type-D	MCH	Teaching Hospital	TOTAL
Khyber	1	0	1	13	0	26	17	2	2	0	**62**
Mohmand	1	0	1	25	3	19	36	0	0	0	**85**
Bajour	1	0	0	19	2	8	11	3	0	0	**44**
Orakzai	1	0	1	23	1	30	6	3	0	0	**65**
Kurram	1	2	1	22	0	47	7	0	2	0	**82**
N.waziristan	1	1	6	16	1	191	61	1	79	0	**357**
S.waziristan	1	0	2	16	0	56	50	3	2	0	**130**
Di-Khan	1	2	2	39	2	36	1	2	7	1	**93**
Tank	1	0	0	18	2	8	0	1	1	0	**31**
Lakki Marwat	1	1	2	27	5	9	0	0	2	0	**47**
Bannu	1	0	0	37	2	50	0	2	3	2	**97**

DHQ: District Headquarter Hospital
THQ: Tehsil Headquarter Hospital
CH: Civil Hospital
BHU: Basic Health Unit
RHC: Rural Health Center
CD: Community Dispensary
CHC: Community Health Center
MCH: Mother and Neonatal Health Care Center

Population of all target districts is also given below:-

Sr. No.	District Name	Population
1	**North Waziristan**	543,254
2	**South Waziristan**	674,065
3	**Khyber**	986,973
4	**Orakzai**	254,356
5	**Kurram**	619,553
6	**Mohmand**	466,984
7	**Bajaur**	1,093,684
8	**DI Khan**	1,627,132
9	**Tank**	391,885
10	**Lakki Marwat**	876,182
11	**Bannu**	1,167,892

Chapter 7: Environmental and Social Monitoring

Table 7 describes the monitoring mechanism based on risks and mitigation measures as per **Tables 3** to **5**, with further guidance from the National EPI Policy 2013. Environmental monitoring during project implementation would provide key information about the environmental and social performance of the project, measured through the effectiveness of mitigation measures. The monitoring would also enable the borrower and the Bank to evaluate the success and/or failures (in environment and social management) of such programs as part of project supervision and to determine corrective actions to be taken when needed. The environmental and social monitoring program for the proposed project is provided in **Table 7** with roles and responsibilities assigned.

NADRA in coordination with the DoH ESM FP will ensure regular monitoring as well as maintain record at the provincial hubs and tertiary healthcare units. Overall responsibility of ensuring compliance against the ESMP will remain with EAD.

Table 7: Monitoring of Key Environmental and Social Aspects and Waste Management Indicators under ESMP

	Monitoring parameters	Monitoring Tool	Frequency of Monitoring	Reporting Frequency	Responsibility
1	Vaccine storage and cold chain equipment management	Temperature Charts Vaccine Vial Monitors (used to monitor potency of vaccines)	Daily monitoring at the facility level	Monthly reporting of district wide assessment of vaccine stores	Cold Chain Technician, and DOH ESM FP
2.	Availability and use of AD Syringes	Inventory and stock lists available at static EPI Centers at Union Council (UC) level (number of AD syringes issued per vaccinator) EPI Tally Sheet (to tally the number of syringes used versus total vaccinated) Daily and Permanent Register maintained by Vaccinators at UC level (to tally the number of syringes used versus total vaccinated) Immunization Performance Reports (IPR)	Daily at the UC level Monthly at the Agency Level	Daily at the UC level Monthly at the Agency level (IPR)	Vaccinators DOH ESM FP
3.	Availability and use of Safety boxes	Inventory and stock lists available at static EPI Centers at UC level (number of safety boxes issued per vaccinator) Immunization Performance Reports (IPR)	Daily at the UC level Monthly at the Agency Level	Daily at the UC level Monthly at the Agency level (IPR)	Vaccinators DOH ESM FP

	Monitoring parameters	Monitoring Tool	Frequency of Monitoring	Reporting Frequency	Responsibility
		Quantities of safety boxes received per health facility (numbers to be recorded Health Facility Waste Management Plan[11])			
4.	Immunization waste disposal including sharps and safety boxes	Timetables and activity sheets describing collection of waste, its quantities and disposal as per Health Facility Waste Management Plan	Weekly	Weekly	Waste Management Officer / Operator of the health care Facility
5	Implementation of Immunization Waste Management Action Plan	Progress on Action Plan; related Documentation	Quarterly	Quarterly	DoH (KP)
6.	Grievance Redress Mechanism	Registered complaints in MIS Resolution of complaints	Weekly	Monthly	NADRA FP
7.	Training sessions	Training Plans Training workshop reports Training Modules Attendance Sheets	Bi Annually	Bi Annually	NADRA Training Coordinator
8.	Access to one Stop Shops	Record of number of people accessing OSS	Weekly	Weekly	NADRA FP
9.	Privacy and Gender issues	Attendance register, Physical verification, attendance of gender-related trainings	Weekly	Weekly	NADRA and DoH FPs
10.	Potential Conflict	Grievance Record	Weekly	Weekly	NADRA and DoH FPs

[11] Hospital Waste Management Plan is required to be developed by each health care facility as per requirements of Hospital Waste Management Rules, 2005, Government of Pakistan.

7.1 Reporting Mechanism

The National EPI Policy 2013 (draft) (**Box 2**) suggests the following reporting structure for the immunization activities:

- Vaccinator shall issue/update vaccination cards, maintain daily and permanent registers, monitoring charts, records of inventories and cold chain maintenance (temperature charts).
- Vaccinator shall be responsible for timely submission of all reports.
- The health facility in-charge shall ensure accurate and timely recording and reporting of provision of child health service performance and diseases surveillance data.
- The EPI Offices shall be responsible for timely collation, verification and transmission of all data/information to all stakeholders and feedback.

For reporting on ESMP compliance, following structure has been placed:

- Monthly cold chain management assessment reports; prepared by DoH ESM FP, these reports describe the efficacy of the cold chain.
- Quarterly Progress Reports (QPR) at Merged Area level; Comprising of inventory checklists, and child health service provision Progress Reports (prepared on monthly basis at the Merged Area level). These QPRs will describe the extent of usage of recommended equipment (AD syringes, Safety Boxes), and provide a tally of number of beneficiaries vaccinated compared to number of equipment issued. These reports will be prepared by DoH ESM FP.
- Monthly reports on Grievance Redress issues including information on access to OSS, gender issues and conflicts, these reports should include the status of resolution of grievances. These reports will be prepared by NADRA ESM FP.
- Regular reports on the EMSP implementation must be included in the project reports to be submitted to the World Bank bi-annually.

Box 2: Monitoring, Surveillance and Reporting as per National EPI Policy and Strategic Guidelines (draft 2013)

Supervision & monitoring

- The local health facility in-charge shall be responsible for supervising child health service provision activities in his/her catchment area and to monitor health indicators, accuracy of data and timely reporting.
- Immunization activities shall be supervised by the district health management team to ensure that every eligible mother and child residing in his/her district/agency is fully immunized.
- At least 30% of district vaccination session should be monitored by district supervisory staff every month.
- A well-defined supervision and monitoring plan should be available at all levels (Federal, provincial, district, sub-district and union council).
- Supervision should be structured, using standard national supervisory guidelines, tools and checklists.
- Health indicators are to be monitored regularly by national, province and district at respective responsible levels.
- Data quality to be monitored at various level using standard tools and mechanisms e.g. DQA, DQS etc.
- Regular review meetings shall be convened on quarterly basis by province and federal EPI cells and on monthly basis by the district.
- Inter-provincial and inter district monitoring activities shall be a regular process of the program at every level.

Surveillance

- The EPI program shall establish a functioning Vaccine Preventable Disease Surveillance system which includes active and passive; sentinel and community based AFP, Measles and NT surveillance system with appropriate laboratory component.
- The program also shall make a functioning Adverse Event Following Immunization (AEFI) surveillance system to ensure vigilance for the National Regulatory Authority.
- Each district must have a District epidemiologist or a designated 'District Surveillance Coordinator'.
- The District Health manager shall be responsible for submission of weekly Vaccine Preventable Disease Surveillance and AEFI surveillance reports. AFP cases to be notified immediately.
- National Expert Review Committees for final classification of AFP cases, Measles cases and AEFIs are to be formulated along with their provincial equivalents.

Evaluation

- Third party evaluation of various features of the EPI program including service provision, coverage, surveillance, communication, monitoring mechanisms, inventories etc. shall be carried out every three years to monitor the progress of the program.

Reporting

- All immunizations given in static center or outreach site or during mobile activities shall be entered in the daily register and routine EPI tally sheet.

- At the end of every session or field activity, data shall be transferred from the daily to the permanent register.
- Only one permanent register shall be made for one union council. Permanent register shall have data of all routine immunization activities in a union council.
- Permanent registers shall have entries of only those children who are permanent residents of that union council.
- Any immunization given to a child resident of some other union council shall be recorded separately. The report shall be sent to the child's union council of residence through a stamp, printed post card to the concerned EDO for onward submission to the concerned center, or through other suitable mechanism.
- Lady Health Workers would be provided a daily register for recording immunization activity provided by themselves in their catchment areas.
- Lady Health workers shall provide immunization activities information to the UC in-charge vaccinators through LHS for recording of the information on the permanent register, and for non-permanent residents for further action, besides transferring it to her diary.
- To review EPI progress, there would be a meeting at the facility level, chaired by the health facility in-charge on the last working day of the month. The meeting shall be attended by the vaccinators, LHV, LHS, LHWs and other health staff.
- Every child or pregnant women immunized for the first time shall be given a vaccination card with appropriate entries and instructions to retain the card.
- If the card is lost; a new card shall be issued to the child/woman with the same registration number after completing all entries from previous vaccination record (permanent register).
- The in-charge of EPI centers in consultation with area vaccinators shall compile all UC immunization coverage reports and surveillance reports.
- VPD surveillance report to be sent in Form B weekly to the EDO (Health) office.
- AEFI surveillance report to be sent weekly along with VPD surveillance report to the EDO (Health) office
- All surveillance reports and immunization coverage reports shall be verified and signed by the health facility in-charges before submission to the concerned Tehsils/Talukas and districts.
- All monthly immunization performance reports for Static Centers, outreach and mobile activities shall be submitted to the district office by 2nd working day of the following month.
- All district reports shall be compiled by the DSV.
- The surveillance reports shall be countersigned by the District Surveillance Coordinator and the EDO (Health) before forwarding to the provincial offices.
- VPD and AEFI surveillance reports to be sent weekly and can be sent electronically to the provincial offices.
- The monthly immunization reports shall be countersigned by the district EPI Coordinator and EDOs-Health and submitted to the provincial offices by 7th of the following month.
- Feedback by district office to the facilities in charges shall be given every month in review meeting to be held at district level under the chairmanship of EDO (H) or his nominee.

Chapter 8: Capacity Development

8.1 Trainings

This section describes the capacity needs and the types of trainings to be conducted in response, in order to minimize/avoid the negative environmental and social aspects associated with the project. The training sessions, along with the learning objectives and the target groups to be focused on, are described in **Table 8**. The trainings will be regularly conducted for the NADRA OSS/CFC and department of health staff. These trainings will developed by the NADRA's training coordinator in consultation with the DoH ESM FP and will based on the WHO's formats/documents.

Table 8: Training Sessions and Schedule

	Training Session	Learning Objectives	Target* Groups	Training Schedule
1.	Vaccine administration, management (including procurement, quality and supply) and Storage	Understanding of WHO standards on vaccine constitution, reconstitution, temperature control, and related issues	OSS/CFC and Concerned BHU staff	As per regular training schedules at the federal and FATA levels, and should be given adequate weightage in curricula of different trainings.
2.	Environmental and Social Hazards associated with Health service Provision	Understanding of environmental issues, social conflicts and abandonments, legal obligations, environmental assessment, infection control, sharps handling, and waste disposal	OSS/CFC and Concerned BHU staff	Same as above
3.	ESMP implementation	Understanding of Implementation requirements and roles and Responsibilities	OSS/CFC and Concerned BHU staff	Same as above
5.	Hospital Waste Management System	Understanding of legal requirements, waste management system, roles and responsibilities, monitoring, reporting and record keeping.	OSS/CFC and Concerned BHU staff	Same as above
6.	Social aspects of child health Service Programs	Awareness about the importance of basic health care and its long term benefits, Understanding the social barriers in accessing health programs.	OSS/CFC and Concerned BHU staff	DoH

	Training Session	Learning Objectives	Target* Groups	Training Schedule
		Provider's attitude towards the women beneficiaries. Development of flexible schedules tailored to the availability of women. Advocating formulation of health teams including male and female members. Developing and adopting gender sensitive behavior.		
7.	Awareness Materials and Advocacy Plans	Communication skills with Communities Types of awareness materials developed and how to use them Appropriate use of the awareness materials	OSS/CFC and Concerned BHU staff	DoH
8.	Grievance Redress Mechanism	Features and functioning of GRM	OSS/CFC and Concerned BHU staff	Before setting up on OSS and during the implementation of project activities.
9	Refresher training on Growth Monitoring	To enhance the capabilities of DoH staff and to ensure proper growth monitoring by staff at all sites	OSS/CFC	Annually, during project operations.

In addition to the above-mentioned project specific trainings, more comprehensive trainings covering a larger audience including the government departments and civil society organizations is also covered under NISP. This project plans to invest into developing relevant awareness raising material according to advocacy component of the project. This material will be produced in Urdu and other regional languages, with minimum words and maximum pictures. It will cover following issues but will not be limited to these only:

a. Posters and pamphlets on general morbidity and mortality risks associated to non-immunization, and/or missed opportunities

b. Posters and pamphlets on relevant environmental and social issues related to syringe and sharps' safety

c. Posters and pamphlets on relevant environmental and social issues related to usage of improperly stored/handled/administered vaccines

d. Posters on AEFI occurrence, recording and reporting procedures

e. Brief guidelines/procedures for hospital waste handling and safe disposal. This would include but not limited to the usage of protective equipment, syringes and sharps disposal, safe disposal techniques for infectious wastes, etc. The Hospital Waste Management Rules 2005 and National EPI Policy 2013 may be used as base documents for developing such brief guidelines/procedures.

f. Posters and display sign for awareness on safe practices.

g. Awareness campaigns through print and electronic media (Radio and Televisions)

Chapter 9: Evaluation of ESMP Compliance[12]

Regular evaluation of effectiveness of ESMP is of prime importance for the overall success of the project, and to ensure that positive impacts are accrued from project activities and outputs. Two types of evaluations are performed for this purpose; environmental audits, and third party evaluation and validation.

Environmental audit is an instrument to determine the nature and extent of all environmental concern of an activity, process, or a facility. The audit identifies and justifies effectiveness of a mitigation measure to address an environmental aspect.

Third party evaluation and validation provide an external, unbiased opinion of progress of the project against its objectives, and short term challenges and gains henceforth. Usually carried out on an annual basis, it helps realign the project as per its ESMP and the impact created due to its implementation. The TPV also covers the implementation status of the Immunization Waste Management Action Plan.

Environmental audits and third party validations will be carried out to evaluate the implementation of ESMP as per the schedule mentioned in **Table 9** below.

Table 9: Activities for Evaluation of ESMP Implementation

Activities	Schedule	Purpose	Responsibility
Environmental Audit	To be carried out six monthly.	To evaluate overall aspects of the project, determine levels of ESMP compliance, determine effectiveness of ESMP as a whole and its various components (e.g. mitigation measures and environmental monitoring responsibilities), and to assess the sustainability of suggested activities at the local (District/Tehsil/UC levels)	NADRA and DoH ESM FP

[12]These evaluations will be aligned with the similar activities for NISP. If appropriate, ESMP evaluation for TDP-ERP will be carried out along with the one for NISP.

Activities	Schedule	Purpose	Responsibility
Third Party Validation (TPV)	To be carried out twice – 4 months before mid-term review (MTR) and 6 months before project completion	To assess the overall impact of the project in terms of environmental and social hazards, AEFI reporting and response, and effectiveness of the ESMP. Implementation of the Action Plan for Immunization Waste Management.	Third Party (Institution/consultants) Preference will be given to the Public Sector Institution/Public Health Academia / Universities

NADRA along with DoH (KP) ESM FP will be responsible for preparing the schedules, setting the scope and scale of the ESMP evaluation activities, developing audit teams, and arrange subsequent financial support. DoH (KP) would be responsible for coordination and supporting the execution of third party validation annually. Services of consultants or professional institutes may be procured for environmental audits and third party validations.

The TORs for third party validation, environmental audit reports and final third party validation findings are submitted to the Bank for review, approval and record.

Chapter 10: Summary of ESMP Actions

The overall action plan for ESMP implementation and the associated timeline is presented in **Table 10** below.

Table 10: ESMP Implementation Plan

Activity	Timeline	Notes/Basis
Implementation of mitigation measures	On a regular basis in accordance with the immunization schedule	Tables 3 to 5
ESMP monitoring	Same as above	Table 7
ESMP implementation reports	Quarterly (to be prepared within one month of each completed quarter)	Section 7.1
ESMP trainings	On a regular basis along with the Overall training program but minimum on a quarterly basis.	Table 8
Environmental audit	Twice a year	Table 9
TPV	4 months before MTR and 6 months before project completion	Table 9

Chapter 11: ESMP Implementation Budget

The cost budget for implementation of the ESMP is provided in **Table 11**.

Table 11: ESMP Implementation Budget

	Activity/Item	Costs (Million PKR)					Total
		1st Year	2nd Year	3rd Year	4th Year	5th Year	
1.	TPV One every year @ 4 million	2	2	2	2	2	10
2	Miscellaneous (Water filtration units etc.)	2	2	2	1	3	10
3	COVID-19 safety measures/ SOP implementation	0	0	0	0	2	2
Total							**22**

LESSONS LEARNED

Keeping in view geographical location and the cultural norms and background special attention and arrangements needs to be established for better facilitation of female beneficiaries as huge influx of female beneficiaries have been experienced in merged area districts, where even a higher turnover of female beneficiaries is expected in southern districts of Khyber Pakhtunkhwa for Child Wellness Grant.

In this regard separate entrance, washrooms and waiting areas shall be allocated for female beneficiaries. Also, provisioning of female staff at citizen facilitation centers is required which gives more confidence to female beneficiaries and give boost to overall turnover and is in line with the local norms and culture. Moreover, the staff to be deployed in southern districts of Khyber Pakhtunkhwa shall have knowledge of local language for better facilitation and guidance of beneficiaries.

Since the project inception, there have been several instances where beneficiaries with disabilities have been received at One Stop Shops/Citizen Facilitation Centers, following to which special arrangements were included during the establishment of CFCs in merged area districts. It is highly recommended that similar arrangements shall be included during the establishment of CFCs in southern districts in order to cater special requirements and needs for beneficiaries/applicants with disabilities at CFCs.

Additionally, it has been learned from past experiences that availability of skilled and trained LHVs/LHWs is key to efficient delivery of CWG services as non-presence of the said staff results into halt of CWG services even in presence of male staff the health awareness session could not be conducted as per the program design, nor the local population is comfortable with the processing of female beneficiaries by male health staff and leads to undesirable situations.

Annex 1: Consultations and Communications Strategy

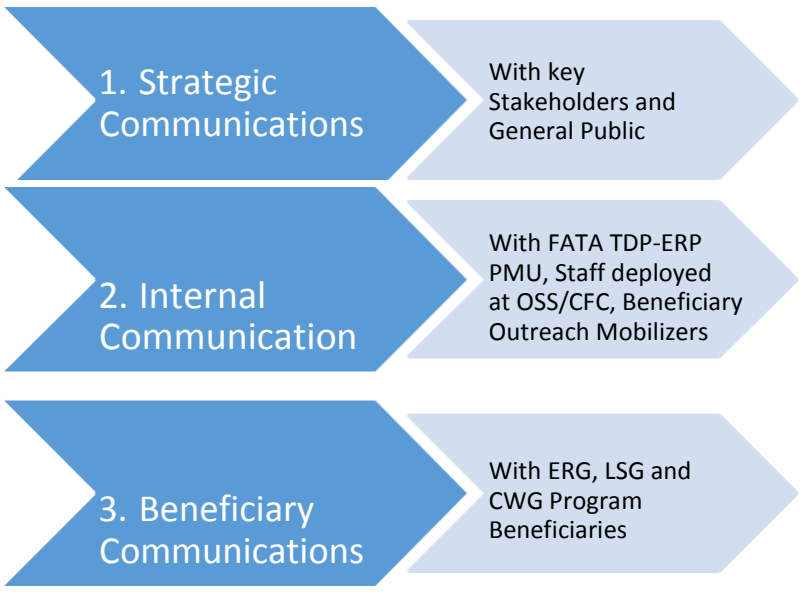
Consultations, Communications, Beneficiary Engagement and Outreach

The overarching goal of consultations, beneficiary engagement, outreach and communications is to support and facilitate the design and implementation of the TDP-ERP. This section sets out to provide the broad framework of the Communications Strategy and its operational features which will ultimately help the project to deliver more efficiently by improving the two-way flow of communication and information for the ERG, LSG and CWG components. The communications and outreach support will be broken up into bite-size core manageable steps to support the implementation of the FATA TDP-ERP project.

A: Communications Framework and Levels of Engagement

As an integral first step, the **overall communications framework** rests on a three-pronged communications platform aimed at **internal and external communications** as shown in the figure below.

Figure 2: Communications Framework and Levels of Engagement



The given framework strives to engage at three levels (**Figure 1**) to undertake an integrated yet differentiated communications:

1. Strategic Communications:

At the strategic level, the communication will facilitate and guide the implementation process through the following key areas (See **Figure 2**):

a) **Branding of the project**: Branding policy and guidelines will be developed in order to communicate a coherent, consistent and credible project identity reflected through all

communications whether key messages, OSS/CFC, communications material as well as interpersonal communication for beneficiary outreach. Branding guidelines will be prepared in coordination with key stakeholders.

Figure 1: Strategic Communications – Key Areas Of Focus

b) Stakeholders' engagement: The communications and outreach is also geared towards coalescing the key project stakeholders to adopt a shared vision of the FATA TDP-ERP regarding policy and implementation mechanisms for administering ERG, LSG and CWG. To this end strategic communications (through coordinated efforts of implementing partners) will identify ways and means to consistently engage national and local level stakeholders for soliciting active support for the FATA TDP-ERP.

Proactive engagement with stakeholders will help addressing their perceptions and motivations to ensure understanding, acceptance and support for the implementation as well as long-term sustainability of the Project. This will be done through various platforms, e.g. Project Steering Committee, engagement with Merged Area Secretariat, DoH (KP), stakeholders' workshops as well as through various consensus-building activities and platforms, which will be mutually agreed upon as part of the communications plan.

The following table summarizes the information needs of each group of stakeholders in relation to the FATA TDP-ERP. This helps in crafting appropriate communications approaches and messages to eventually facilitate better reception of the Project as it gets implemented.

Table 1: COMMUNICATION NEEDS OF FATA TDP-ERP STAKEHOLDERS

AUDIENCE	WHAT DO THEY NEED TO KNOW
Internal Stakeholders	
1. Implementation partners (EAD, NADRA, STEERING COMMITTEE, DoH-KP,	Main features of the FATA TDP-ERP ▪ Project target area(s) ▪ Project objectives ▪ Project duration ▪ Number of beneficiaries in target district(s)

MoF, RR&RD KP , PAYMENT AGENCY etc.)	▪ Selection/eligibility criteria ▪ Project mechanism about , enrolment, verification, and payments for ERG, LSG and CWG and case management modalities ▪ Their role in the Project
External Stakeholders	
2. Beneficiaries	▪ What is FATA TDP-ERP and what is its purpose? Who are the beneficiaries of the Project? ▪ What will the beneficiaries receive in terms of cash value for ERG, LSG and CWG? ▪ What will they have to do to receive it/How do they enroll in the ERG, LSG and CWG? ▪ What documentation is required? ▪ For how long will they receive the cash amount? ▪ How and where will they receive it? ▪ How to deal with payment systems associated with the transfer (e.g. Banks, etc.) ▪ What to do if there are problems in accessing the cash? ▪ What to do in case of a complaint or a grievance? ▪ When the cash transfers will stop? ▪ What is the importance of updating data with information such as new born, change of address, loss of ID cards, etc.
3. Communities & non-recipients/those who are excluded from the Project	▪ What is the eligibility criteria ▪ Who do they contact if they need more information to clarify doubts about their exclusion
4. Policy makers (other than implementation partners), civil society, local players	▪ Main features of the FATA TDP-ERP, including selection and eligibility criteria; mechanisms about enrolment, verifications, payment and case management modalities ▪ Project target area(s) ▪ Their role in the Project
5. General public	▪ What is the FATA TDP-ERP and who implements it? ▪ How does it benefit the TDPs? ▪ What is the eligibility criteria ▪ Transparency checks and mechanisms; technology deployment, spot checks, etc ▪ Programme is backed by the Government of Pakistan

Communication that is strategic and consultative will play a fundamental role in facilitating the objectives of the project with support from stakeholders. A stakeholders' engagement plan will be designed as part of the overall communications strategy.

c) Risk communications and mitigation plan: Considering the geographic scope of the project and nuances of the political economy and audience sensibilities of the implementation area (Merged Area, and Southern Districts of KP), it is essential to develop a common understanding of potential risks and corresponding risk communications mitigation measures, which need to be taken account of during the day to day operations of the Project. To this end, as part

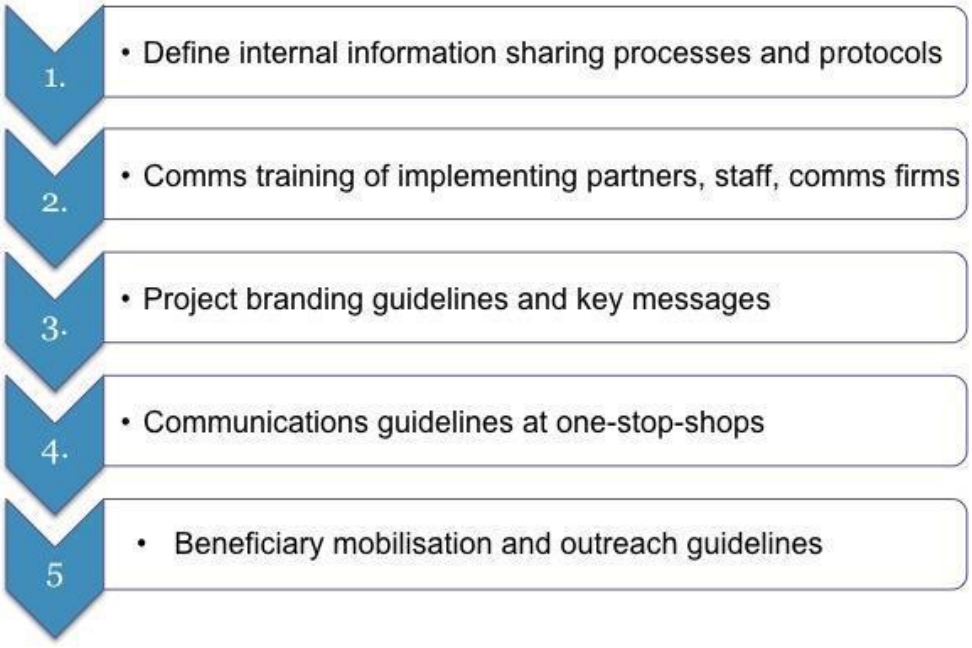
of strategic communications, key risks will be identified from the outset and risk mitigation communication measures will be mutually agreed upon by the key stakeholders to deliver a risk management framework to be used as a standard template through the life cycle of the Project. This will be revisited from time to time to take account of the evolving local realities. Risk management guidelines will be prepared as part of communications plan.

d) Political economy and public image of the project: In order to strengthen the public image of the project, political economy analysis will feed into a proactive media advocacy both at the national and local level. This would further assist in building a constituency for the project through mobilizing civil society and public understanding of the Project in terms of transparency, control and accountability mechanisms. A media engagement plan will be prepared and implemented over the course of the project as part of the communications strategy.

2. Internal Communications:

At the internal level, communications will work towards bringing all the key players in the implementation team on one platform through continuous orientation and training right from the inception phase. It looks at vertical and horizontal information loops between the PMU and operational staff in order to coordinate and facilitate smooth and uninterrupted flow of necessary information about the Project to effectively deliver their roles and responsibilities. The key areas of focus are given in the **Figure 3**.

Figure 3: Internal Communications – Key Areas of Focus



Communications guidelines will be prepared and delivered to orientate staff and implementation teams in the following areas:

i. **Internal communications processes and protocols** were followed by all the stakeholders to bring all key implementation teams on one platform for the ERG, LSG and CWG.
ii. **Communications training of all implementing partners** as well as the Communications and Engagement Firm (s) are conducted during program inception to

identify and clarify key roles and responsibilities in engagement, outreach and communications at various touch points.

iii. **Project branding guidelines and key messages** are shared with all implementing partners so that consistency in communications is maintained across the entire project cycle.

iv. **Standardized communications guidelines for TDP OSS** will be agreed to deliver consistent communications across all OSS, including communications and

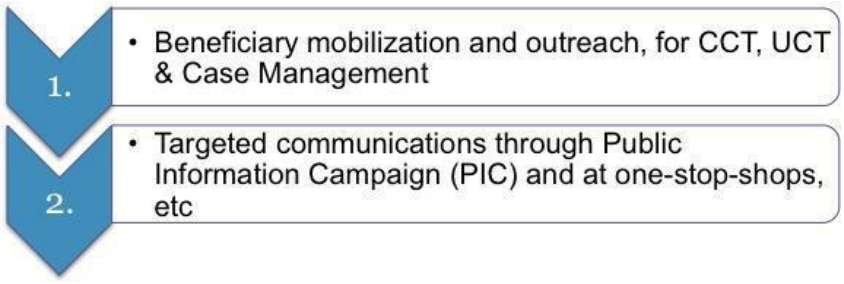
v. Information sharing protocols, project–related FAQs, standard information kit/pack.

vi. **Beneficiary engagement and outreach guidelines** will be prepared separately for ERG, LSG and CWG components outlining key rules of engagement, communications and engagement process to facilitate relevant target audience.

3. Beneficiary Engagement and Outreach

A beneficiary engagement and outreach mechanism will be geared towards informing, educating and mobilizing beneficiaries for ERG, LSG and CWG. This will be a two-pronged model of communications involving targeted communications and beneficiary engagement and outreach as shown in **Figure 4** below.

Figure 3: Beneficiary Engagement and outreach – Key Areas of Focus



Beneficiary engagement for CWG component: Structured advocacy, communication and beneficiary engagement have been fundamental to the success of the CWG component. This mainly involves reaching out to beneficiaries, sensitizing and educating them about the need and overall health benefits of child health services as well as how to avail these services. Long-term behavioral change communication will be embedded through all communications and engagement tools and mechanisms.

The overall objectives of beneficiary engagement are to:

- Sensitize, motivate and educate beneficiaries to understand basic design features of the CWG component.
- Develop awareness about the significance and benefits of routine health services for children as well as understanding of beneficiary rights and responsibilities.

- Mobilize beneficiaries' groups and community leaders to act as conduits for promoting long term health benefits of immunization and behavioral change.

- Support beneficiary awareness to contribute to the overall outcomes of the

FATA TDP-ERP related to enrolment, health services and compliance.

The following section explains the guiding principles for executing beneficiary engagement and outreach:

Table 2: GUIDING PRINCIPLES FOR BENEFICIARY ENGAGEMENT
➢ **Simple, relevant & interpersonal communication** • Information will be expressed as simply and concisely as possible based on the sensibilities of the beneficiaries. • Clear calls to action will be used through inter-personal communication, wherever possible, emphasizing purpose of the project, including needs and health benefits of routine immunization.
➢ **Collaborative & complementary** • Collaboration with program teams and stakeholders will be sought to complement implementation through relevant and timely communication. • Two-way beneficiary engagement and communication channels will be established, such as face-to-face forums and real time information channels for beneficiary engagement e.g. community meetings, focus groups, SMS, interactive voice response (IVR), etc. **a)** Wherever possible, collaboration with other local stakeholders will be used to ensure voice and accountability, both to create greater scale and to reduce costs.
➢ **Embedded & inclusive** • Beneficiary communication will embed and integrate relevant engagement tools and methodologies across the entire process cycle of the FATA TDP-ERP to facilitate an all-encompassing and inclusive communications in a systematic and coherent manner.
➢ **Phased & manageable** ▪ **A phased approach (pre-launch engagement , launch and post-launch)** develops a core set of manageable communications and outreach mechanisms to mobilize, incentivize and educate beneficiaries, particularly about health benefits of routine immunization, process and schedule for getting children immunized and payment modalities. ▪ A mechanism for soliciting continuous feedback from beneficiaries will be embedded within the beneficiary engagement process cycle to gauge effectiveness of beneficiary communication and outreach**.**
➢ **Positive & constructive** • Focus will be on communicating positive impacts of the CWG, however small, to demonstrate that progress and impact is possible.

Operationalizing beneficiary engagement, outreach and communication:

Following steps will guide to operationalize beneficiary engagement, outreach and communication:

i. **Developing Beneficiary Engagement and Outreach Strategy & Guidelines** that embed relevant tools and mechanisms of interpersonal communication at various touch points.
ii. Hiring of a local community/outreach organization for beneficiary engagement and outreach.
iii. Consultation(s) with local complementary programs led by Department of Health, UNICEF, WHO, etc.
iv. Orientation training of local community/outreach organization on beneficiary engagement and outreach strategy.
v. Development of key messages and IEC ((Information, Education and Communications) tools for engagement by the communications and outreach team from NADRA in collaboration with the local community/outreach organization.
vi. Engagement of voluntary support through informal community networks, elders, maliks, mosque imams, etc.
vii. Communication training of LHWs/LHVs/Vaccinators/Staff for CWG beneficiary engagement and outreach campaign, including how to prepare defaulter list of all target age group children.
viii. Activating a pre-launch/forward beneficiary engagement and awareness campaign at community level to inform about routine health assessment, process of CWGs, including activation dates of OSS/vaccination sites, immunization schedule and corresponding payment and compliance modalities.
ix. Mobilizing beneficiaries groups for participation in enrolment and immunization campaign at the OSS.
x. Conducting a post-launch beneficiary outreach campaign to support compliance to vaccination schedule and case management (complaint and appeals) process.

NOTE: Communication for educating beneficiaries about the ERG, LSG and CWG features, process and mechanisms will be an allied & embedded feature of the beneficiary engagement and outreach activities.

Targeted communications through Public Information Campaign for engaging beneficiaries for NADRA's (OSS)/CFCs: This will involve a combination of tools and platforms for extensive dissemination of information through appropriate delivery mechanisms, which will include, but not limited to:

i. inter-personal modes of tactical communication
ii. radio campaign,
iii. SMS targeted messaging for early intimation of immunization schedule and compliance
iv. Information kit/package for the OSS
v. Visually strong information material, etc.

Communications and outreach will individually address all components of the project cycle (beneficiary engagement, registration, verification, biometric verification, payments, immunization, case management, etc.)

B: Implementation Approach for Communication

The communications implementation/action plan rests on three principal implementation approaches:

- An intensive exchange of information through appropriate delivery mechanisms including beneficiary engagement, outreach and communications, and public information campaign
- A drumbeat of messages worked into all activities and materials provides motivational context for the campaign
- A phased activity schedule begins with a core manageable group of activities for immediate impact, which then expands to a menu of high-impact activities as the project picks up.

A comprehensive **Communications Strategy** and Plan (a separate document) **for the FATA TDP-ERP** will also outline roles and responsibilities of Communications and Beneficiary Outreach Team in terms of technical support, terms of reference as well as relevant implementation support required from communications and engagement firm(s).

It is strongly emphasized that the **Communications and Beneficiary Outreach Team** of the FATA TDP-ERP is the custodian of the implementation of communications plan from overall branding to targeted communications, stakeholder engagement support and dedicated beneficiary engagement and outreach. The Communications and Outreach Team works as a well-knit integrated unit under the NADRA PMO along with the technical teams for ERG, LSG and CWG.

Annex 2: Consultation with NGOs/CBOs at FDMA office Peshawar

Consultation Meeting with APA BARA & Local Maliks

Annex 3: Consultation Meetings at DI Khan (04 Nov 2020)

Annex 4: Names of the consultation participants representing NGOs and CBOs (1st July, 2015)

S.No	Name	Organization	Designation
1	Adil	FDMA(FATA Disaster Management Authority)	Operation Officer
2	Hamayun Khan	LHO(Lawari Humanitarian Organization)	Coordinator
3	Adrian Thompson	MSF (Medecines Sans Frontieres)	Project Coordinator
4	Dr. Mian Naveed	MSF (Medecines Sans Frontieres)	Base Medical Doctor
5	Tariq Ali	CDO/SWA (Community Development Organization Swabi)	Team Leader
6	Irshed Ali	HF (Hayat Foundation)	Project Manager
7	IshaqIsrar	HF (Hayat Foundation)	Program Specialist
8	Shaista Bibi	Asia Humanitarian Organization	Grants Coordinator
9	AlamzebQazi	HUJRA (Holistic Understanding for	Program Officer

		Justified Research and Action)	DRR/FSL
10	Amir Saeed Khan	HUJRA (Holistic Understanding for Justified Research and Action)	Program Manager
11	Ashraf Shah	PADO (Peace And Development Organization)	Project Manager
12	Shams Safi	PEACE (Peoples Empowerment And Consulting Enterprise)	Field Coordinator
13	Muhammad Shoaib	PAIMAN	Project Coordinator
14	Kaleem Nasir	LHO (Lawari Humanitarian Organization)	Project Manager
15	Furqan	PADO (Peace And Development Organization)	Project Manager

NGOs working in the Project Area and their interventions

PEACE Organization:

PEACE is currently working in Kurram Agency, Hangu, Dera Ismail Khan and Lakki Marwat on food security for the IDPs communities. They help to improve the nutrition of the malnourished children in FATA as implementing partners of World Food Program (WFP). Extremely Vulnerable Individuals are identified in the screening process followed by service provision through provision of food supplements. PEACE organization also extends their services in order to help the agency Surgeon during Polio vaccination campaigns but has no direct program interventions regarding immunization or Polio vaccination.

HUJRA:

HUJRA organization is working in five (5) districts of KP and North Waziristan in FATA. Their main focus is on cash for work in the affected communities through community active participation. In past livelihood and disaster risk reduction projects have also been completed in Bajaur, Mohmand and Khyber Agency. HUJRA also extended their services regarding immunization vaccinations to Swat IDPs.

LHO (Lawari Humanitarian Organization):

LHO is currently working in South Waziristan on food security & they provide food items to the affected communities at their door step. This practice is very effective but requires extensive field work, which need increase in number of project HR and logistic support with time constraints. LHO has no health-related project at present.

Asia Humanitarian Organization:

Asia Humanitarian Organization works mainly on water and sanitation and NFIs distribution in the areas of return in FATA. Proper hygiene sessions are conducted with affected communities in order to improve the personal, domestic and environmental hygiene. Water supply schemes are rehabilitated to ensure the clean drinking water to the targeted communities. Both household and communal latrines are constructed to reduce the open defecation and help to protect the Diarrhea outbreaks, especially under 5years age children. At present the organization has no direct health related project in FATA.

PAIMAN Alumni Trust (Participatory Approach, Integrated Management, Advancement and their Needs):

PAIMAN is currently working as implementing partner with WFP in distribution of food items in FATA. Affected communities receive food items under the sub categories for food provision as food for education, food for work, food for seeds and food for training.
In category food for education, food items are provided to the school going children. In food for work, community members are engaged in rehabilitation activities and after 12 working days a food package is provided. Similarly, in food for seeds, seeds of different vegetables are provide to community members to improve kitchen gardening, while in food for training female community members are engaged in skills training sessions and after completing five days sessions each members is provided with a food package.

MSF (Médecins Sans Frontières)

MSF Provides humanitarian assistance to populations in need in Health Sector and is providing health care facility to the IDPs and has a functional hospital in Peshawar. Patients are referred from Kurram Agency and Hangu for treatment at Peshawar. MSF has not been granted NOC for the area of return. MSF hospital at Peshawar has the facility of vaccination for children and a proper solid waste management system for the hospital waste and has installed an international standard incinerator in Hayatabad.

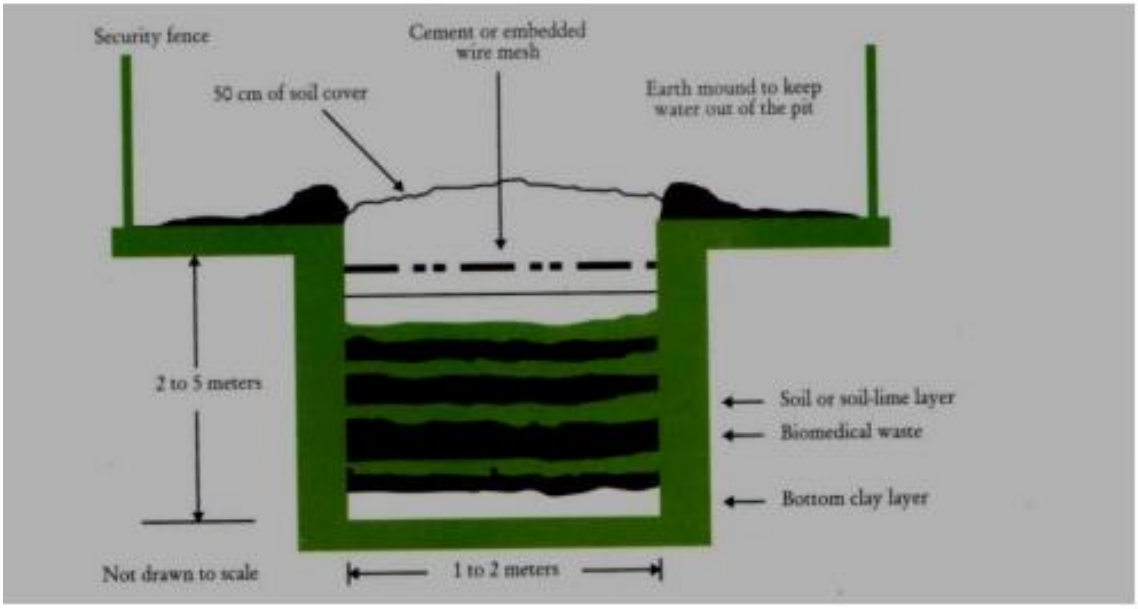
Hayat Foundation: Hayat Foundation started its activities by conducting awareness rising sessions providing the health services to marginalized communities. Hayat Foundation initiated polio campaigns and organized mother care awareness programs in KPK and FATA.

Annex 5: Names of Consultation Participants at DI Khan (November 2020)

Sr. #	Name	Organization	Designation
1	Abdul Haleem	Politician	EX-MPA
2	M. Arshad Khan		Chairman (BoG)
3	Sana Ullah Khan	Environmental Protection Agency	Operation Officer
4	Noor Alam Mehsud	District Administration	Additional Deputy Commissioner
5	Waseem Shirazi	Economic Affairs Division	Program Manager
6	Khawaja M. Allauddin	NADRA	Project Manager
7	Fayyaz Ur Rehman	NADRA	Regional Director
8	Sanaullah Khan	Environmental Protection Agency	Director
9	S.M. Naeem	Social Welfare Department, KP	District Officer
10	Naeem Hasan	NADRA	Zonal AD
11	Raina Gul	CEW-PDMA	GR Specialist
12	Syed Jawad Shah	Department of Health	Health Coordinator
13	Dr. Noman Latif	District Health Department	HoD
14	Dr. Naseem Saba	District Health Department	District Gynecologist
15	Syeda Mehwish Batool	District Health Department	
16	Mussarat Shaheen	District Health Department	LHV
17	Shagufta Naheed	District Health Department	LHV
18	Zahida Parveen	District Health Department	LHV
19	Mujtaba Masood	NADRA	Zonal Officer, NADRA
20	Sidrat ul Muntha	MM Pakistan	District Coordinator
21	Razia Sultana	MM Pakistan	District Coordinator

Pit Burial Design Specifications:

1. A pit or trench should be dug about 2 meters deep and 2 m wide. The pit is covered with a heavy concrete slab that is with an internal diameter of about 200mm.
2. It should be half-filled with waste, and then covered with lime up to 50 cm of the surface, before filling the rest of the pit with soil.
3. Animals should not have any access to the waste burial sites. Covers of galvanized iron/wire meshes may be used to protect the area from trespassing.
4. On each occasion, when wastes are added to the pit, a layer of 10 cm of soil shall be added to cover the wastes.
5. Waste disposal into the pits should be performed under close and dedicated supervision.
6. The deep burial site should be relatively impermeable, and no shallow well should be close to the site.
7. The pits should be distant from habitation and sited so as to ensure that no contamination occurs of any surface water or ground water. The area should not be prone to flooding or erosion.
8. The healthcare facility should maintain a record of the kind of waste sent for deep burial.
9. A permanent Record of the size and location of all burial pits needs to be strictly maintained and displayed at strategic place with due precautions to prevent construction workers, builders and other from digging in those areas in the future.
10. The pit burial place should be fenced and locked to avoid any unauthorized access to the place and also to avoid any health and safety risk for the workers and patients in the healthcare facility.



Schematic diagram of proposed Burial Pit