Government of Islamic Republic of Pakistan

SFG1233

Environmental and Social Management Plan
(ESMP)

For the

FATA TDPs Emergency Recovery Project

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

July 2015

Contents

List of Tables

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
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
PEPA	Pakistan Environmental Protection Act
PKR	Pak Rupees
PMO	Project Management Office
POM	Project Operations Manual
PPE	Personal Protective Equipment
QPR	Quarterly Progress Report
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) is planning to initiate the Temporarily Displaced Persons Emergency Recovery Project (TDP ERP) in the Federally Administered Tribal Areas (FATA) of Pakistan, in order to provide support to the people displaced due to militancy and military operations in the area. The project includes provision of cash grants to the persons returning to their homes in FATA from temporary camps established in Khyber Pakhtunkhwa (KP) province. The project also includes provision of cash grants linked to the child basic health services to be provided to the TDP families. 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 against 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. However, the regrettable deficits in immunization coverage are reflected in the continued incidence of endemic polio transmission and the recent measles outbreaks especially in the security compromised areas, like FATA. As a result, Pakistan remains one of the world's last three polio endemic countries.

Project Overview. The overall program will provide support to displaced population in five FATA agencies, namely North Waziristan, South Waziristan, Orakzai, Kurram, and Khyber, based on the need with agreement of the Bank and GoP. The overall government program will support approximately 336,762 displaced families. Based on other similar programs in the country, it is estimated that majority of the displaced families will be moving back to their respective regions[1] and out of these 64 percent will be accessing the support of the program. Keeping in view the International Development Association (IDA) envelope, a maximum of 120,000 qualifying families can be covered under the TDP-ERP and provided the; a) Early Recovery Grant (ERG); b) Livelihood Support Grant (LSG); and c) Child Wellness Grant (CWG). The project will continue its support to beneficiaries for a period of three years based on the return schedule laid out by the Government of Pakistan. Given that average family size[2] in FATA is 6.5, the total number of beneficiaries will be about 780,000.

These project beneficiaries, when returning back to the affected areas will receive a one-time grant of Pak Rupees (PKR) 35,000 (US$350), based on the criteria of having both addresses (temporary and permanent) on their computerized national identity cards (CNICs) from the affected areas of FATA, as per the current database administered by the FATA Disaster Management Authority (FDMA) and verified by National Database and Registration Authority (NADRA). Only those families who have already been paid

[1] Fata Rural Livelihoods And Community Infrastructure Project Approval Document – World Bank -2011
[2] http://fata.gov.pk/Global.php?iId=35&fId=2&pId=32&mId=13, Government of FATA Statistics -2015

the grant of PKR 35,000 by GoP and included in the FDMA database will be considered by NADRA for registration and verification at the One Stop Shops (OSS) for consequent early recovery cash transfers of PKR 4,000 (US$40) over four months and child health linked cash transfers for each child under two years of age. The OSS operated by NADRA in collaboration with the FATA Government and it's allied departments including FDMA and Department of Health, 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 ERS of PKR 16,000 (US$160) 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 7,500 (US$75), provided in three 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 establishment of OSS will be phased process. The child health services will be rolled out in four pilot OSSs in the first stage. The potential rollout will follow a careful assessment of the intervention with respect to take-up of various services and delivery of benefits. This ESMP may be revised as per the needs and requirements of the rollout OSS.

Key safeguards issues and their mitigation. The potential environmental, social, and public health impacts of the project 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 revised National Expanded Program on Immunization (EPI) Policy and Strategic Guidelines need to be effectively implemented; in particular, 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.

Social issues such as those regarding access for communities will be addressed by ensuring that the OSS are established at a central location which is easily accessible by the communities. Similarly the project needs to adopt a gender-sensitive approach such as presence of qualified female staff at OSS, where possible. A Grievance Redress Mechanism needs to be functional and communicated to the communities so that potential conflicts can be avoided. Social conflicts, lack of awareness and cultural misconceptions regarding vaccination can be addressed through an effective social mobilization campaign at the community level. Finally, appropriate trainings and capacity building need to be carried out for all staff associated with vaccination.

ESMP implementation arrangements. Overall coordination and monitoring of ESMP implementation will be the responsibility of EAD whereas the on ground implementation of ESMP will be the responsibility of NADRA and FATA Department of Health. All the departments will designate an ESMP Focal Point (FP) to ensure the implementation of ESMP. EAD focal person will be responsible for the overall coordination and monitoring, NADRA focal person will be responsible for implementation of social aspects of the ESMP whereas the FATA Health Department focal person will be responsible for the implementation of environmental aspects of the ESMP. All these FPs need to be government officers to ensure government ownership and accountability.

Grievance Redress Mechanism. Grievance Redress Counter will be setup at the OSS and will have representatives of NADRA who will act as the Grievance Redress Officer (GRO). All complaints, whether received at the counters or forwarded to NADRA, will be registered in the FATA 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/unit for resolutions. If the complainant is not satisfied or in case of any unanswered grievances or maladministration the complaints will be referred to the Federal Ombudsman as a last resort.

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, record regarding the TDPs accessing the OSS, performance of female staff, establishment of grievance redress mechanism, resolution of complaints and implementation of trainings will be monitored with regular 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 estimated to be around Pak Rupees (PKR) 12 million. This includes cost allocations for annual third party validation and miscellaneous costs that may be incurred during the implementation of ESMP. This cost has been included in the overall project cost estimates.

Chapter 1: Background and Project Description

1.1 Introduction

Government of Pakistan (GoP) is planning to initiate the Temporarily Displaced Persons Emergency Recovery Project (TDP ERP) in the Federally Administered Tribal Areas (FATA) of Pakistan, in order to provide support to the people displaced from FATA due to the militancy and the military operations in the area. The project includes provision of cash grants to the persons returning to their homes in FATA 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. The GoP is seeking financial support from the World Bank (WB) for this project.

In line with the environmental legislation of Pakistan as well as the WB safeguard policies, the current Environmental and Social Management Plan (ESMP) has been prepared to address the potentially negative environmental and social impacts associated with the health services to be provided as part of TDP-ERP. This ESMP has benefited from the environmental and social assessment recently carried out and the ESMP prepared for the WB-supported National Immunization Support Project (NISP).

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

Overview of social protection in Pakistan. In 2007, the Government of Pakistan endorsed the Social Protection Strategy to Reach the Poor and the Vulnerable, recognizing social safety nets as a key objective of the Poverty Reduction Strategy. In 2008, the Government of Pakistan put in place the Benazir Income Support Program (BISP), a social protection system at the national level supporting the poorest households of Pakistan, which provides cash transfers to approximately 4.9 million beneficiaries. The targeting mechanism of BISP has been utilizing the National Database and Registration Authority (NADRA) that records all adult citizens of Pakistan via the Computerized National Identification Card (CNIC). The NADRA database allows the biometric registration, identification and verification system of social protection beneficiaries. This system was efficiently used not only for the BISP income support program but also for the emergency intervention of the Citizen Damage Compensation Program which provided cash support to approximately 1.1 million affected families of the 2011 floods. There is, however, no current system in place to address the TDP situation and the FATA region has been lagging behind in terms of safety net systems.

A Sustainable Return and Rehabilitation Strategy for FATA. Recently in April 2015, the FATA Secretariat has taken 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 has been developed in order to provide an enabling environment for FATA returnees. Based on a Post-Crisis Need Assessment, the FATA secretariat

identified social protection as one of the nine pillars supporting rehabilitation in the region.

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

Pakistan's progress toward human development and the Millennium Development Goals (MDGs) targets has been uneven. Despite some improvements, Pakistan remains one of the worst performers against the MDGs in the South Asia Region, especially with respect to maternal and child health. Child mortality rates are almost twice the MDG targets. Stunting among children under five remained around 44 percent in the past few decades. Routine immunization of children in Pakistan has also been stagnating. The proportion of children fully immunized is less than 60 percent[3], and this figure varies considerably across geographic, social and political boundaries. The regrettable deficits in immunization coverage are reflected in the continued incidence of endemic polio transmission and the recent measles outbreaks especially in the Federally Administered Tribal Areas (FATA).

FATA is 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 are expected to deteriorate further. Infant mortality is estimated to be as high as 87 deaths per 1,000 live births, compared to 74 throughout the country, and the under-five mortality rate is 104 per 1,000 live births compared to 89 in the rest of Pakistan. In addition, stunting rates in FATA are close to 50 percent and 30 percent of children are classified as underweight4. Child immunization rates also remain extremely low. Only 40 percent of children in FATA are fully immunized with a very large contribution to polio cases within the country5. The situation requires urgent interventions to address both supply and demand side challenges. The National Immunization Support Project (NISP), currently prepared by the Government with Bank support, aims at strengthening immunization systems and access to services to improve immunization coverage nationwide. In addition, the Government has started to address the low polio immunization rates in FATA by providing polio immunization to children of TDP families in camps and at the FATA entry check-points.

1.3 Project Description

1.3.1 Project Beneficiaries

The overall program will provide support to displaced population in five FATA agencies, namely North Waziristan, South Waziristan, Orakzai, Kurram, and Khyber, based on the need with agreement of the Bank and GoP. The overall government program will support approximately 336,762 displaced families. Keeping in view the IDA envelope, a maximum of 120,000 qualifying families can be covered for the complete project cycle

[3] PSLM 2012-13
[4] FATA Development Indicators Household Survey 2013-2014
[5] FATA multi-year immunization plan. For additional details on child health outcomes and socio-economic indicators in FATA, see Annex 5

and provided the; a) Early Recovery Grant (ERG), b) Livelihood Support Grant (LSG) and c) Child Wellness Grant (CWG). All registered TDP families from the five targeted agencies are eligible for the LSG, irrespective of their destination. For families that choose to return to FATA, the LSG will also become available upon return to the original locations and families in the affected Agencies with children aged 0-2 at the time of the project will be eligible for the CWG. The project will continue its support to beneficiaries for a period of three years based on the return schedule laid out by the Government of Pakistan. Given the average family size[6] in FATA is 6.5, the total number of beneficiaries will be 780,000.

These project beneficiaries, when returning to the affected areas will receive a one-time grant of PKR 35,000 (US$350), based on the criteria of having both addresses (temporary and permanent) on their CNICs from the affected areas of FATA, as per the current database administered by the FDMA and verified by NADRA. Only those families who have already been paid the grant of PKR 35,000 by GoP and included in the FDMA database will be considered by NADRA for registration and verification at the One Stop Shops (OSS) for consequent early recovery cash transfers of PKR 16000 ($160) in four installments of PKR 4,000 (US$40) over four months and child health services linked cash transfers for each child under two years of age. The OSS operated by NADRA in collaboration with the FATA Government and it's allied departments including FDMA and Department of Health, 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 child health services and; d) establishing an easily accessible grievance redress system. As part of the Early Recovery Support to beneficiaries, the Bank will reimburse the grants to the GoP, only if a beneficiary family satisfies the conditions set down in the Project Operational Manual (POM). Further, the Early Recovery Support (ERS) of PKR 16,000 (US$160) 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 7,500 (US$75), provided in three 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.

1.3.2 Project Components

Component 1: Early Recovery Package for Temporary Displaced Persons (total estimated cost – US$61.9 million). This component will support the early recovery of approximately 120,000 TDP families from FATA through two unconditional cash grants; (i) a one-time Early Recovery Grant (ERG) of US$350 per family and; (ii) a Livelihood Support Grant (LSG) of US$160 per family in four monthly installments of US$40 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 Agencies 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 choose to voluntarily return to FATA, the LSG will provide a predictable source of income over a limited period of time to help covering basic subsistence needs while livelihoods are being restored. The LSG will be delivered through one-stop-shop (OSS) registration and delivery centers to be set up in FATA through a phased rollout.

[6] http://fata.gov.pk/Global.php?iId=35&fId=2&pId=32&mId=13, Government of FATA Statistics -2015

Component 2: Promoting child health in selected areas of FATA (total estimated cost – US$3.1 million). Under this component, a selection of child health services will be offered to families with children aged 0-24 months in four pilot OSSs which comes to around 40,000 families. 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 will be 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. 7,500 is being proposed to be provided in three 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 FATA DoH.

Component 3: Strengthening program management and oversight (total estimated cost – US$10 million). This component would provide technical assistance to enhance program management, transparency and accountability at the federal, FATA 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 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 will finance training and capacity building to staff of the FATA Department of Health to oversee and deliver services under Component 2, as well as to staff of other FATA agencies involved in project implementation

This component will also support the operational costs related to the establishment, operation, and management of OSSs, as well as the costs of setting up and operation of the grievance counters and child health services within each OSS. The OSSs will be managed by NADRA, the project implementing entity. Separate Grievance Counters will be maintained at each OSS to manage beneficiary grievances and complaints. The component will also finance 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 will be set-up within the EAD with key technical staff contracted by the project.

1.4 Institutional Arrangements for the Project

The institutional arrangements for the project are as follows:

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 and reporting and for managing the flow of funds from the Ministry

of Finance (MoF) to the commercial banks' accounts. The EAD will prepare project design and implementation plan at the time of appraisal with technical support from NADRA. The EAD will also provide the platform for the required coordination of the project with the National Database and Registration Authority (NADRA) and the key government agencies of FATA, including the FATA Secretariat, Law and Order Department, Return and Rehabilitation Unit, the Planning and Development Department, the Health Department, and the Disaster Management Authority. To ensure effective coordination, a Memorandum of Understanding (MoU) will be signed by all the project implementing stakeholders from FATA Secretariat (representing DoH & FDMA), 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, Ministry of States and Frontier Regions (SAFRON), S&M Secretariat, and the allied government departments agencies of FATA which include FDMA, Department of Health, and Return and Rehabilitation Unit, which will provide overall operational oversight and decision making support in terms of key project outcomes and deliverables. The Steering Committee will be convened by EAD every quarter to update on the project progress and for key decisions that may be required. 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 will be established, which will meet on a monthly basis to resolve project operational issues. 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.

NADRA will be the lead technical agency of the project. NADRA will provide 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. NADRA has already developed the proposed project's operational procedures, which have now been fully detailed in the Project Operational Manual (POM) with inputs from the Department of Health. The POM will provide 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 will be: (i) implementation of a comprehensive communications campaign; (ii) further development and maintenance of the project MIS; (iii) setting up and operation of One Stop Shops (OSS) and; (iv) acquisition and subsequent verification of biometric data on-site.

Phased-rollout establishment of OSS. The OSS to be set up by NADRA will support 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. Opening of OSSs will be phased according to TDPs return schedule. The implementation of the OSS by NADRA will involve close coordination and work relationship with the FATA government agencies including the FATA Secretariat. A suitable location for each OSS will be identified by NADRA, in discussion

with the local authorities. The child health services will be rolled out in four pilot OSSs in the first stage. The potential rollout will follow a careful assessment of the intervention with respect to take-up of various services and delivery of benefits. This ESMP may be revised as per the needs and requirements of the rollout OSS.

Grievance Redress Systems. The project beneficiaries will also be able to access the OSS to address any beneficiary appeals concerning enrolments, verification, ERG, LSG and CWG payments, and the quality of services being provided, as well as information updates. The OSS will also include a MIS based grievance redress module to be managed by NADRA and DoH, partner agencies, that will address grievances as per the agreed procedures laid on in the POM. NADRA will also keep a record of the details of cases lodged, resolved cases, pending cases and actions taken for each OSS and will update the 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 will follow a four-pronged approach which will be followed. Firstly, this will include 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 will especially target village elders, notables, women and those involved in ensuring that children receive health services. Secondly, strategic communications will be 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 will be implemented to sensitize potential beneficiaries about the early recovery package and child health services prior to the activation of the OSS. Standardized communication guidelines for beneficiary facilitation at the OSS will also be 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 will provide information on stakeholder engagement and outreach.

Chapter 2: Legal and Policy Framework

The present ESMP has been developed 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] Applicability of national and provincial laws in FATA is not uniform. The Federal Government through the Governor of KP issues notification to enforce any national or provincial law in FATA and such a process has reportedly been initiated for the environmental laws as well. Therefore, all the national and provincial laws discussed in this Chapter and applicable to similar projects elsewhere in the Country will be deemed to be applicable to the proposed Project 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 are not likely to 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 are not likely to 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 proposed 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 will be located on any such waterways, hence this OP is 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 will not be triggered.

Chapter 3: Environmental and Social Impacts Assessment

This section describes environmental and social aspects associated with the project activities, as suggested by the stakeholders as well as the project team.

3.1 Screening of Project Impacts

The substantial activities under the proposed project 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:

i) Cold chain management for vaccine effectiveness
ii) Risk of infections
iii) Disposal of sharps and immunization waste in general
iv) Water and soil contamination
v) Privacy and gender issues
vi) Potential for social conflicts
vii) Accessibility Issues related to One Stop Shops
viii) Absence of services at facilities
ix) Availability of competent female staff
x) Health and Well Being
xi) 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											
	Cold Chain Management	**Risk of infections**	**Disposal of sharps and other waste**	**Water and soil contamination**	**Privacy and gender issues**	**Potential conflicts**	**Accessibility Issues**	**Absence of services at facilities**	**Availability of competent female staff**	**Access Health Facilities**	**Health and Well Being**	**Employment Opportunities**
Eligibility and verification Processes	N	N	N	N	0	0	N	N	N	N	N	+2
Cash disbursements 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

iii) Disposal of Sharps and Immunization Waste in General
iv) Accessibility to the proposed facilities and other difficulties for accessing child health services in the absence of formal public transport system
v) 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 1 m 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:**
  - Agency 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 FATA Health Department
  - Appointment of immunization waste management coordinator in each Agency.

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

- **Stage 3; Implementation of the Agency Action Plans and Immunization Waste Management Systems in place:**
  - Provision of resources for the short term actions points of each Agency 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 will be completed within first 6-8 months of the project and will be 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 will cover the progress on this Plan as well.

3.3 Social Impacts mitigation

Access to One Stop Shops (OSS)

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 can be minimized by identifying appropriate locations for One-Stop Shops so that a maximum number of people can approach the facility. OSSs will be selected on supply and demand criteria which will be based upon easy access for most people.
- In addition a travel grant will be provided to meet the travel costs.
- 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

Due to the physically harsh terrain of the project area and conservative social norms which discourage females to work, competent female staff is either reluctant or unavailable to work in the area. Absence of competent staff can adversely impact the effectiveness of child health service activities.

Mitigation

Competent lady health workers should be engaged at higher costs and special incentives in order to encourage them to work in the project area. In addition trainings may be 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 may also discourage the females to access the health facilities.

Mitigation

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

Potential Conflict Issues

Since the project involves distribution of cash grants, chance of conflict at the OSS 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.

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 OSS will be effectively implemented. Local communities will be 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 should be 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),

Project Activities	Significant Aspects	Mitigation Measures
		Medical Technicians (MT), Female Medical Technicians (FMT), mid-wives, Lady Health Workers (LHWs) and Medical Doctors
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 containers, safety boxes, and waste bags to be collected and sent for pit burial 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	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

Project Activities	Significant Aspects	Mitigation Measures
	extension workers, and others.	per their roles and responsibilities. Provision of information posters at waste collection and storage sites indicating safe handling and disposal
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 OSS for local communities and inadequate transportation options	Appropriate identification of locations for OSS, 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 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.

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 non-pierce able 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, eg, 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 non-pierce able 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

4.1 Consultations during ESMP Preparation

The formulation of the present 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 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 Agency is located in the north of Pakistan; it is bordered with Afghanistan, Peshawar city and the Kurram and Orakzai agencies. Khyber Agency consists of three tehsils i.e. Bara, Landi Kotal, and Jamrud. Khyber Agency is administrated directly by the Federal Government, through the Governor of the Khyber Pakhtunkhwa Province as its agent, Political Agent (PA) is the administrative head of the agency who is assisted by Additional and Assistant Political Agents (APA).

The Agency has three sub-divisions; Landi Kotal, Jamrud and Bara, with three Assistant Political Agents, seven Tehsildars and a number of other administrative functionaries. The headquarters of the Political Agent is at Peshawar, but has also a Camp Office/Residence at Landi Kotal. The Assistant Political Agents have their headquarters in Landi Kotal, Jamrud and Bara, respectively.

A consultative meeting was held at APA 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 APA and local elders were briefed on the proposed project prior to seeking their views on proposed interventions. According to the APA, the security situation is good and still improving in Khyber Agency. During the consultation, the APA 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 Agency of 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.

4.2 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-local staff	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 section 6 of this document. Ensure supply side functions are gender sensitive, as far as possible in the circumstances.

Concerns	Mitigation Measures
• Low numbers of health facilities • Unavailability of mobile networks and CNIC for female community members	

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.

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:

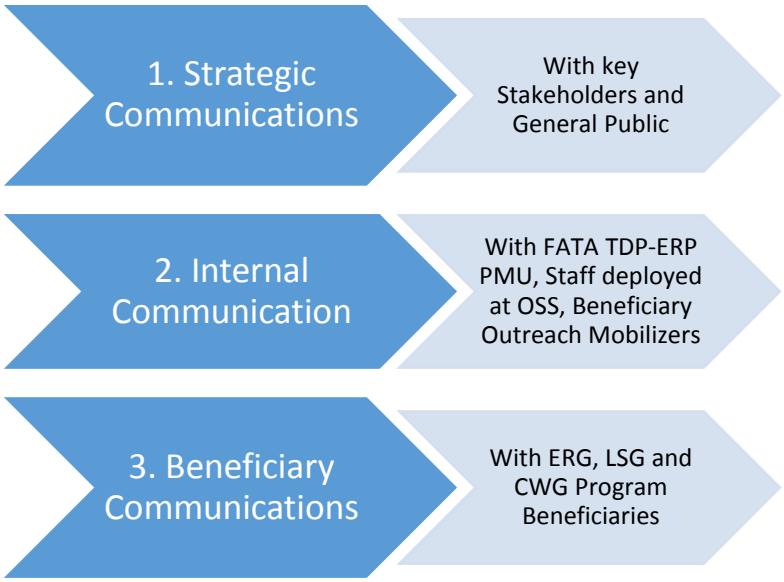
- Social Mobilization at the community level
- Awareness campaign for all stakeholders and
- Formal interactions through periodic workshops, consultation sessions with wider stakeholders especially institutional ones such as other Government Departments, NGOs, CBOs and academia etc.

Consultation Pathways during Implementation:

Social mobilization is an integral part of the project. The Project will formulate a Social Mobilization Strategy and implement it through partner organizations. While the primary aim of social mobilization activities will be 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 will take place at village level. After initial contact, periodic follow up visits will be 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 tribal elders. A concerted effort will be made to contact far-flung communities and elicit their views.

Overall communications framework will also be a key pathway for consultations. The Project will use 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, and 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) will be established by the Project and remain operational throughout implementation. Grievance redress counters will be set up and staffed by NADRA at the One Stop Shops. NADRA will have the responsibility to coordinate with the concerned stakeholders such as Payment Service Providers, District Administration and beneficiaries to resolve 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 will provide a mechanism for social accountability of the Project. GRM will include 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 will be mainly linked to exclusion in targeting. These will be lodged by NADRA and forward to the respective authority for approvals including FATA Secretariat and FDMA.
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.
c. **Updates:** These include grievance related to updates in the family information, such as update of CNICs after marriage, etc.
d. **Referrals:** The GRM will also include a referral system to ensure that all grievances or appeals that concern the government's larger development program under the R&R are being redirected to the government's existing complaint mechanisms.

5.1 Grievance Procedure

Grievance Redress Counter, setup at the OSS, will be operated by representatives of NADRA who will act as the Grievance Redress Officer (GRO). All complaints, whether received at the counters or forwarded to NADRA, will be registered in the FATA TDP-ERP Complaints MIS. Every application received will be tagged with a reference number and will then be categorized as per the described categories. Every application or petition will be acknowledged through standard acknowledgement slips or a copy of the receipt which should be dispatched to the complainant within 3 days of receipt of complaint or handed over to person at the time of receipt for complaints submitted in person. 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/unit for resolutions. If the complainant is not satisfied or in case of any unanswered grievances or maladministration the complaints will be referred to the Federal Ombudsman as a last resort.

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 FATA Health Department. All three departments will designate 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 FATA Health Department focal person will be responsible for the implementation of environmental aspects of the ESMP. 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.

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) Quantities of safety boxes received per health facility (numbers to be recorded	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
		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	FATA DoH
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 proposed:

- Monthly cold chain management assessment reports; prepared by DoH ESM FP, these reports will describe the efficacy of the cold chain.
- Quarterly Progress Reports (QPR) at FATA level; Comprising of inventory checklists, and child health service provision Progress Reports (prepared on monthly basis at the FATA 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 Immunization Waste Management Reports (MIWMR) at FATA level. These reports will describe the collection, management and disposal of immunization waste, including the quantities as well as the protocols being maintained. 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, prior to the supervision missions.

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/agency, 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 and FATA 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 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 and concerned BHU staff	Same as above
3.	ESMP implementation	Understanding of implementation requirements and roles and responsibilities	OSS 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 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 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 and concerned BHU staff	DoH
8.	Grievance Redress Mechanism	Features and functioning of GRM	OSS and concerned BHU staff	Before setting up on OSS and during the implementation of project activities.

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 suggested 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 provides 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 will also cover the implementation status of the Immunization Waste Management Action Plan. The ToR of the TPV will need to be cleared by the WB.

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 (Agency/UC levels)	NADRA and DOH ESM FP
Third Party	To be carried out	To assess the overall impact of the	Third Party

[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
Validation (TPV)	twice – 4 months before mid-term review (MTR) and 6 months before project completion	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.	(Institution/consultants) Preference will be given to the Public Sector Institution/Public Health Academia / Universities

NADRA along with DOH ESM FP FATA 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. FATA DoH 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 will be 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	
1.	TPV One every year @ 4 million	2	2	2	6
2	Miscellaneous (Water filtration units etc.)	2	2	2	6
Total					**12**

Annex 1: Consultations and Communications Strategy

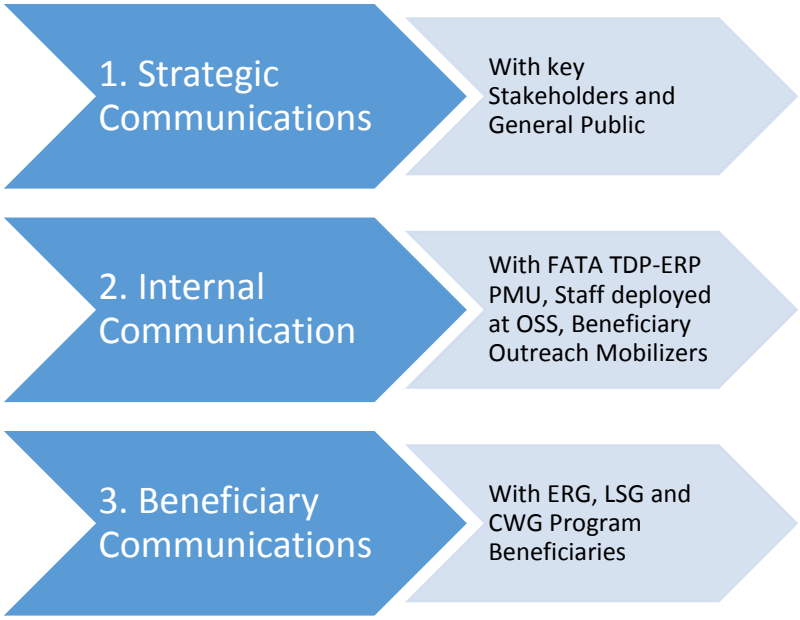
Consultations, Communications, Beneficiary Engagement and Outreach

The overarching goal of consultations, beneficiary engagement, outreach and communications is to support and facilitate the design and implementation of the FATA 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, 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 FATA Secretariat, DoH FATA, 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,	▪ Main features of the FATA TDP-ERP ▪ Project target area(s) ▪ Project objectives ▪ Project duration ▪ Number of beneficiaries in target district(s)

MoF, FATA SECRETARIAT, 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? ▪ 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 (FATA), 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

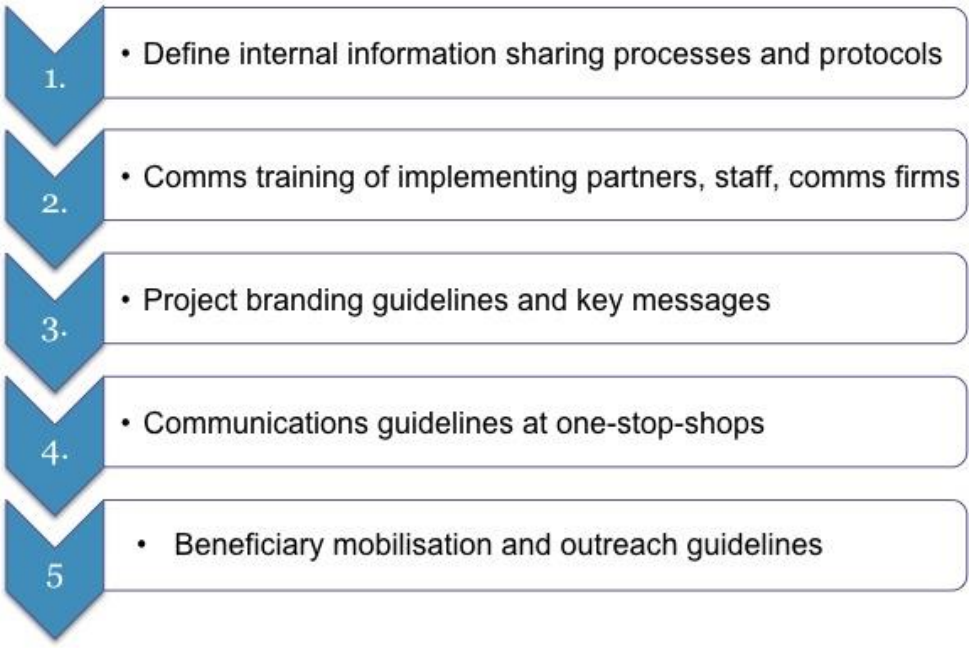
stakeholders to deliver a risk management framework to be used as a standard template through the life cycle of the Project. This will be revisited from time to time to take account of the evolving local realities. Risk management guidelines will be prepared as part of communications plan.

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:

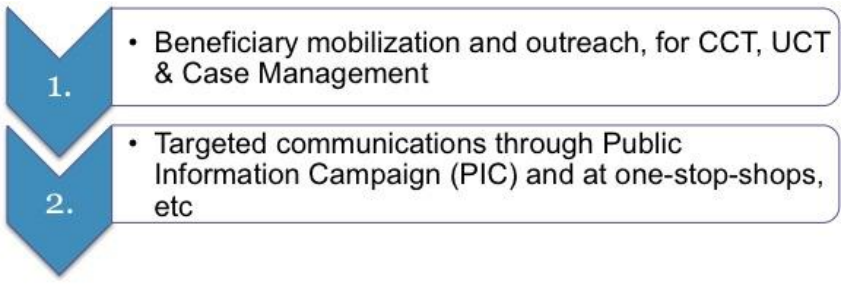
i. **Internal communications processes and protocols** to be followed by all to bring all key implementation teams on one platform for the ERG, LSG and CWG.
ii. **Communications training of all implementing partners** as well as the Communications and Engagement Firm (s) will be conducted during inception to identify and clarify key roles and responsibilities in engagement, outreach and communications at various touch points.

iii. **Project branding guidelines and key messages** will be 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 will be fundamental to the success of the CWG component. This will involve 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 changeSupport 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 One-Stop-Shops (OSS): 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 will be 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 will work 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: Names of the consultation participants representing NGOs and CBOs

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	Ishaq Israr	HF (Hayat Foundation)	Program Specialist
8	Shaista Bibi	Asia Humanitarian Organization	Grants Coordinator
9	Alamzeb Qazi	HUJRA (Holistic Understanding for Justified Research and Action)	Program Officer 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 (Medecins Sans Frontieres)

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.