Ministry of Health
Democratic Socialist Republic of Sri Lanka

Sri Lanka Primary Health Care System Strengthening Project-2 (P181564)

-Draft -

Stakeholder Engagement Plan (SEP)

[March 28, 2024]

Contents

1. Introduction and Project Description

The program development objective of the project is to improve utilization and quality of Primary Health Care (PHC) services across all districts of Sri Lanka. The project builds on the World Bank's experience in supporting the ongoing Primary Health Care Systems Strengthening Project – Phase 1 (PHSSP-1), as well as recent analytical and advisory work, inlcuding mid-term assessment of the PHSSP-1, an analysis of emergency prepardeness and health sector efficiency gains in Sri Lanka, and an assessment on the impact of the economic crisis on health financing systems.

PDO Level Results Indicators are:

- Proportion of women 35-45 years who tested positive for cervical cancer, followed up in a timely manner as per guidelines and protocols.
- Percentage of registered patients at PMCIs (disaggregated by men and women) diagnosed with hypertension effectively managed and followed up.
- Percentage of registered patients at PMCIs who are over 35 (disaggregated by gender) screened for NCDs and receiving timely diagnosis and follow-up.[1]

The project will support:

Component 1: Increased availability of Primary Medical Care Institutions (PMCI) across all nine provinces of Sri Lanka: The minimum capabilities of PMCIs encompass five aspects: (i) minimum presence of trained personnel (two medical officers and one nursing officer per PMCI); (ii) a basic set of diagnostic instruments and equipment; (iii) a minimum stock of essential medicines that meet national quality standards; (iv) basic laboratory investigation capabilities, either with an on-site laboratory or through a network with a designated apex laboratory; and v) capacity for emergency care provision. Component 1 aims to strengthen the capabilities of over 1000 Primary Medical Care Institutions (PMCIs) across Sri Lanka's nine provinces, enhancing their ability to provide comprehensive primary healthcare services. Drawing from insights gained from previous PSSP activities, which enhanced the capacities of 550 PMCIs, pivotal activities will be extended to all 1,087 PMCIs nationwide, with adaptations and expansions as necessary, aligning with Sri Lanka's national PHC reorganization strategy. Additionally, project investments will be tailored to broaden and strengthen the array of services offered, ensuring an integrated approach to primary healthcare with a focus on NCD prevention and management programs, as well as readiness for climate related emergencies and other emerging challenges. The Sub-Components are:

Sub-component 1.1. Ensure minimum capabilities of Primary Medical Care Institutions (PMCIs), including special focus climate-resiliency and on availability of key equipment, supplies, medicines, and laboratory testing/transport capacity : To augment the capacity and operational efficiency of

[1] NCDs include hypertension, diabetes, cervical cancer and breast cancer (to be confirmed by MoH)

PMCIs to meet the above minimum capabilities standards, the project will focus on several key activities, such as updating the national essential medicine list for PMCIs, implementing national e-procurement system for medicines and medical supplies, procuring medicines, medical supplies and laboratory reagents, improving supply chain management, adopting information systems for clinical management and supply chain management, ensuring facilities are climate resilient, conducting necessary upgrading and refurbishment of PMCI facilities, procuring sample transport vehicles and setting up sample transfer mechanism to designated apex laboratories, and transport of wastes to a nearest hospital with incinerator facilities.

Subcomponent 1.2: Ensure availability of primary health workers at PMCIs: To address constraints in human resources for health, the financing under this subcomponent will ensure that the existing personal emoluments for frontline health workers are paid in full on a predictable and time-bound basis.

Subcomponent 1.3. Expand the PMCI package to include mental health, geriatric care, emergency care, care for GBV survivors, and preparedness for future climate disasters and pandemics: While PMCIs in Sri Lanka already provide comprehensive basic PHC services, this subcomponent will support activities to enable PMCIs to provide an expanded package of PHC services to address the growing NCD burden (including mental health) and care needs for aging populations, and pandemic and climate-related disaster risks in Sri Lanka. Among the different types of PMCIs, divisional hospitals level A (100+ bed capacity) and B (50-100 bed capacity) will be equipped to provide emergency care, rehabilitation, palliative care, geriatric care, mental health services, and care for GBV survivors, with necessary civil works and refurbishments to support these enhancements.

Component 2: Strengthen the quality of clinical and person-centered care at PMCIs through human resources capacity building, integrated care platforms, and governance systems for quality assurance: In addition to the availability of inputs, their quality and person-centeredness can also drive increased utilization and positive health impacts. While component 1 focuses on the availability of services, particularly related to structural elements (equipment, medicines, human resource availability), component 2 focuses on the quality and person-centeredness of care. Specifically, this component includes emphasis on capacity building of available human resources for health (HRH), scaling up of platforms to facilitate coordinated and integrated care across facility types and geographies (especially when natural disasters affect one region and there is massive inflow of patients that requires support from healthcare facilities/personnel in regions not or less affected) and strengthening of governance systems for quality assurance at the facility level.

The Sub-Components are:

Subcomponent 2.1: Capacity building of human resources for health: This subcomponent aims to ensure that health care providers across all PMCIs are adequately supported and capacitated to provide clinical care that is responsive to citizen needs and expectations as well as natural disasters and pandemics, and in alignment with best practices for clinical and interpersonal care quality.

Subcomponent 2.2: Scaling up of integrated care platforms: Care coordination and integration is crucial for both efficiency and improved health outcomes, and this subcomponent includes the design and implementation of a referral and back-referral system.

Subcomponent 2.3: Strengthening of governance systems for quality assurance. Ensuring high-quality clinical and person-centered care provision requires robust quality assurance architecture and practices. Therefore, this subcomponent will involve updating and developing tools and guidelines for PMCI quality management, including introduction of systems to institutionalize consistent and well-documented clinical audits, incident reviews, and near-misses, among others.

Component 3: Strengthening health promotion, community empowerment and citizen engagement: Although improved capacity and quality of care at PMCIs will enhance the availability of curative care service, it alone does not guarantee utilization of services and improvements in health outcomes. Further, the scope of PHC goes beyond what is provided by PMCIs, including prevention, promotion, risk factor management and behavior change particularly during climate-related disasters, which draws attention to demand-side issues. In addressing this aspect, component 3 will focus on the demand-side through health promotion, community empowerment and citizen engagement, and strengthen the interface between communities and PMCIs.

Subcomponent 3.1: Health promotion and NCD risk factor management (US$ 10 million). Given the escalating NCD burden, addressing both prevention and treatment is imperative. Primary healthcare services, offered by entities like the Medical Officer of Health unit and PMCIs, play a crucial role. Given low awareness among the public, particularly regarding the services available at PMCIs, this sub-component will also support development and implementation of strategies like a comprehensive social and behavior change communication strategy to raise public awareness of available preventive and curative services at the PHC level (including awareness about the care options at PHCs during climate related emergencies, to enable them to make informed choices and access care when needed).

Subcomponent 3.2: Strengthen citizen engagement for preventive and curative care (US$ 10 million). The community engagement guideline was developed under the PSSP at the national and provincial levels and resulted in the introduction of 'Friends of the Facility Committees (FFCs)' at each of the PMCIs. FFCs include members from the facility and community (including women members) and involve regular meetings, with the aim of soliciting feedback from the community and ensuring service responsiveness especially for women, children, and disadvantaged populations. Similarly, 'Grievance Redress Mechanism (GRM)' was established at each PMCI following the community engagement guidelines to receive and respond to public feedback on health service availability and suboptimal standards through web, telephone, SMS, or other communication channels. These two mechanisms serve as the cornerstones of citizen engagement at PMCIs. Thus, this sub-component will include: (a) strengthening and expanding FFCs and GRM at all PMCIs; (b) revision of community engagement guidelines to include community empowerment strategies; and (c) developing and implementing strategies/guidelines to strengthen linkages between FFCs (at PMCIs) and mother support groups (MSGs) or any other village level platform(s). Further, the community engagement guidelines will be expanded to include people with disabilities and older adults.

Component 4: Project Management and Monitoring and Evaluation. This component will finance activities related to project implementation management, capacity building, monitoring and evaluation (M&E), and operations research related to the project. Key activities include (a) project management, reporting, and supervision; (b) technical support for procurement activities, financial management (FM), and environmental and social sustainability activities; (c) learning and knowledge exchange; (d) M&E and impact evaluations, (e) capacity building related to NCD management; (f) surveys and operations research; as well as (g) institutionalization of a national excellence award.

Project beneficiaries: The direct project beneficiaries will be the citizens of Sri Lanka and health care providers working in the public health sector. The largest impact is expected among people accessing Primary health care services in the nine provinces, especially adult men and women who are screened for, diagnosed with and treated for NCDs and people accessing primary health care services. In particular, the primary users tend to be the poorer segments of the population, including vulnerable groups such as elderly, women headed households, physically disabled and those in need of palliative care. While most of the

project's systems and institutional strengthening activities will take place at the national and provincial levels, supporting community-level activities will also be prioritized. The project will ensure that all PMCIs have the services, capacitated human resources, medicines and supplies required to provide care to members of the population, including those living in areas that are most prone to climate induced events. Project will also target the geriatric population (>60 years of age) (both men and women) who have a greater chance of having severe or catastrophic health incident due to NCDs or any other shocks. The project will not only cater to those already actively seeking primary care in Sri Lanka, but also include measures to increase population awareness of and demand for care at PMCIs, including care for GBV survivors and mental health.

Project implementation arrangements: The Ministry of Health (MoH) will be the primary organization from the GoSL responsible for implementing the project, while the Ministry of Provincial Councils, Local Government Sports (MPCLGS) will provide oversight, coordination and has authority over the Provincial Councils for provincial-level project activities. The MoH is responsible for setting policy and standards and updating protocols for strengthening the PHC system with the aim of streamlining access to high quality people-centered health services, increasing efficiency of these services, and ensuring a continuum of primary care for people throughout their life course. It is also responsible for M&E of the performance of the sector including the PHC system, using administrative data and period surveys.

MPCLGS oversees the nine provincial departments of health services as part of the Provincial Ministries of Health that are under the authority of the Provincial Councils, and are responsible for adopting protocols, planning and implementing the PHC reorganization and strengthening activities per the set standards. The MoH and the MPCLGS will work closely in project implementation structures and directly with the provinces and their department of health services in coordinating, monitoring, and reporting on project implementation. The provinces will receive funds through and report to the MPCLGS. The MPCLGS has the necessary authority to ensure that the loan funds are transferred to the provinces on a Grant basis, that the provincial authorities provide the necessary progress and financial reports and undertake the other necessary responsibilities in participation of the project.

A Project Management Unit (PMU) has been and will consist of the key positions - Project Director, Deputy Project Directors (MoH and MPCLGS), Project officers, Procurement Specialist, FM Specialist, Environment and Social Specialist, Accountants (MoH and MPCLGS), Internal Auditor, M&E Officers (MoH and MPCLGS),Communication and Information & Communication Technology (ICT) officers, Provincial Project Managers, Provincial Project Officers and Regional Project Coordinators, as well as other relevant administrative and technical support staff. The addition of designated provincial and regional project staff to the project management structure given the intensity of the health sector change supported by the project, the additional responsibilities for coordination and reporting on project-level performance in addition to the regular duties, and the level of effort and time expected to convene the stakeholders. Specific job descriptions and responsibilities for each position will be established. The staffing structure is based on this high level of effort required to manage the substantial stakeholder and technical risk, but will be reviewed and updated from time to time to ensure that the staffing is consistent with the workload and requirements.

Project's Environmental and Social Risks:

The environmental risk of the proposed project is assessed to be "moderate" given the Health and Safety risks associated with minor civil works of existing PMCIS including refurbishments and rehabilitation of additional

Health Care Waste (HCW) due to improving quality and increased services across all districts of Sri Lanka. Key environment risks associated with minor civil works includes souring, transport and storage of construction materials, generation of dust, noise, disposal of construction debris and excavated materials, pollution from fuel and lubricants, soil erosion and pollution of surface and ground water resources, generation of solid and liquid wastes, health and safety issues for construction workers and public. However, since the scale of construction is minor, the program will pose limited risks during the construction stage. The potential negative impacts envisaged during the operational phase of the project are related to the generation, handling and disposal of health care waste (HCW). Improper management of HCW could cause various H&S concerns for the HCF staff, waste collectors, patients, and nearby communities and risks to the environment through several routes of contamination including open dumping, burning and mixing with storm water runoff causing widespread pollution and spread of diseases. Therefore, an Environment and Social Code of Practice (ESCOP) will be developed to manage Environment and social impacts during minor civil works while Health Care Waste Management Plan (HCWMP) will be developed taking into consideration the collection, handling, storage, disposal of HCW. The project will also invest in implementation of solar energy systems at PMCIs to improve energy efficiency and energy security. These would generate electronic and hazardous waste at their end-of use stage which could potentially contaminate the soil, surface, and groundwater. In addition, refurbishment of existing waste water treatment facilities will be carried out to manage liquid waste generated from improved laboratories.

The social risk of the proposed project is assessed to be "low". The project expects to benefit the entire population, specifically, those with NCDs, cervical cancer, and mental disabilities, and the elderly; and by strengthening citizen engagement and existing grievance redressal/feedback mechanisms. No involuntary land acquisition or resettlement related impacts are expected as the project will only support minor civil works such as renovations & refurbishments of existing PCMIs. Key social risks associated with the project includes: a) community and occupational health and safety related risks and impacts from minor civil works including disturbances to ongoing clinics, b) potential sexual exploitation & abuse (SEA) and sexual harassment (SH) risks due laborers entering hospital premises, though labor influx is minimum as the civil works are minor in nature ; c) exclusion related risks especially to elderly, people with disabilities and bedridden patients living in remote locations due lack of equitable & universal access to information, health services for these groups, d) risks associated with assuring data protection and privacy of patient records during storing and processing by the e-health information management system (IMS) and e) forced labor risks, which is considered low since supply of solar panels does not contribute to achievement of core components of the project. Associated risks & impacts related to civil works, including health, safety and SEA/SH risks can easily be managed following a proper ESCOP and adopting a SEA/SH prevention Code of Conduct (CoC).

In addition, the project will strengthen the existing SEA/SH service provision at PMCI level and ensure adequate referral pathways. Exclusion related risks will be mitigated through the delivery of targeted essential services including home-based care services and ensuring universal access for vulnerable groups who experience mobility challenges and engaging the Friends of Facility Committees (FFCs) to support and reach out to these groups. Data protection and privacy risks will be mitigated by complying with key national legislation related personal data protection and computer crimes during the implementation of the e-health IMS. Forced labor risks with solar panel suppliers will be addressed by enhanced procurement mitigation measures, requiring additional declarations from suppliers and prior review by the Bank.

2. Objectives & Brief Summary of Previous Stakeholder Engagement Activities

2.1 Objectives of Stakeholder Engagement Plan

The Stakeholder Engagement Plan (SEP) is prepared for the Sri Lanka Primary Health Care Systems Strengthening Project-Phase (PHSSP) (P181564) in accordance with the requirements of the World Bank's Environmental and Social Framework (ESF) and in particular with the Environment and Social Standard 10 (ESS10) on Stakeholder Engagement and Information Disclosure. Stakeholder engagement refers to a process of sharing information and knowledge, seeking to understand and respond to the concerns of potentially affected or impacted individuals and groups, and building relationships based on trust.

The purpose of the present SEP is to explain how the various stakeholders relating to the project will be engaged throughout the project lifetime and which methods will be used as part of the process. The SEP also outlines the responsibilities of the PMU, other relevant government, and private institutions in the implementation of stakeholder engagement activities, including the ways in which the PMU will communicate with stakeholders; the mechanism by which people can raise concerns; provide feedback; and/or make complaints about the PMU, other implementing partners and the project itself. SEP will identify stakeholders and mechanisms through which they will be included in the engagement process as part of project preparation and implementation and will serve as a record for the engagement process during the project preparation period.

2.2 Brief Summary of Previous Stakeholder Engagement Activities

Several missions were conducted from January 22 - 30, 2024, February 12 - 16, 2024, March 11 - 22, 2024 with World Bank to prepare the project. The mission held discussions with the Ministry of Finance, Ministry of Health and MoH authorities at Provincial level, including consultations with regional health directors and PCMI staff. During the mission the following was discussed and agreed: (i) the financing mechanism; (ii) project objectives, components, and the component cost allocation; (ii) the allocation of the funds between the Recipient Executed and Bank Executed parts, the corporate cost recovery, and supervision costs; (iii) the proposed results framework/indicators, and (iv) the project's implementation and oversight arrangements.

In addition, consultations are being conducted with other stakeholders, including representatives from the MoF, MoH authorities (Secretary, Director General, Directors, Hospital Directors, Regional Health Directors and PHC staff), patients visiting PMCIs, Friends of Facility Committees and non-governmental organization working with vulnerable groups. Given below are findings from the initial consultations conducted. Findings from additional consultations will be included in the final version of the SEP.

Stakeholder consultations with key government counterparts
Meeting Objective: To understand the availability systems in place to manage E&S risks and impacts of project activities. **Participants:** Dr. Kamil Prabhaswara MOPL RDHS Nuwara Eliya, Dr. Gimhani MOPL RDHS Gampaha¸ Dr Arundathi Udeshika MOPL RDHS Puttalam, Dr. Alaghai Lathaharan CCP PDHS Eastren province , , Dr Gamini Dissanayaka MONCD RDHS Kandy, **Facilitators :** Mr. Hasitha Karawita Mr. Pradeep Jayawardana Senior M&E (Primary Health Systems Strengthening Project), **Date of consultation:** Session 1 (15th Feb, 2024) and Session 2 (16th Feb, 2024).
Key Findings

Outreach to Vulnerable group

- Institutionalize home-based care to vulnerable groups such as people with disabilities, elderly and bedridden patients.
- Palliative care (both at hospital premises and community outreach) needs to be strengthened in a standardized manner.
- If community outreach (home base palliative care) is expanded/strengthened the Public Health Nursing Officer needs to be given more incentives and facilities (bike/scooter) to carry out their duties.
- DHs should also introduce a cadre position for Public Health Nursing Officer.

Citizen Engagement for E&S Compliances

- FFCs can work with Hospital Director to coordinate to ensure that civil works do not disrupt clinic days.
- FFCs have also monitored and supervised some civil works under PSSP. Therefore, explore possibility of utilizing FFCs to assist with monitor, supervision of minor works at PCMIs.

Grievance Redress Mechanism

- Strengthening of awareness on National hotline for GRM at PCMI level is required.

Environmental & Social Compliance Monitoring

- Contractors that are below National Level C will require capacity building training on Environment and Social Compliance requirements. Small contractors are not aware of the Environment and Social compliance requirements, such as OHS, safety and PPE requirements.
- Civil works should be managed and planned to avoid PMCI clinic days for Pregnant women and Cardiology unit clinic days.
- Infection control nurse at PMCI can also be given the responsibility of monitoring civil works.

Healthcare Waste Management & Optional ESMPs

- Strengthening and standardization of SOP guidelines for laboratory services at the national level is required.
- HCWM and palliative care (both at hospital premises and community outreach) needs to be strengthened in a standardized manner.

Energy efficiency

- As HCF's electricity usage quite high, it will be beneficial and efficient if renewable energy sources (solar), lighting (sensor lights, energy efficient lighting) can be introduced to the facilities.

3. Stakeholder Identification and Analysis

For the purpose of the SEP, stakeholders of the proposed Project will be divided into the following core categories:

1. **Affected Parties** : impacted or likely to be impacted directly or indirectly, positively or adversely, by the project, identified as most susceptible to change associated with the project, and who need to be

closely engaged in identifying impacts and their significance, as well as in decision-making on mitigation and management measures.

2. **Other Interested Parties**: may have an interest in the project, including individuals or groups whose interests may be affected by the project and who have the potential to influence the project outcomes in some way.
3. **Vulnerable/Disadvantaged Groups**: persons who may be disproportionately impacted or further disadvantaged by the project(s) as compared with any other groups due to their vulnerable status and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project.

Engagement with all identified stakeholders will help ensure the greatest possible contribution from the stakeholders toward the successful implementation of the project and will enable the project to draw on their pre-existing, expertise, networks, and agenda. It will also facilitate both the community's and institutional endorsement of the project by various parties. Access to the local knowledge and experience also becomes possible through the active involvement of stakeholders.

Table 1: Stakeholder identification and Classification

Affected Parties	Other Interested Parties	Disadvantaged and Vulnerable groups
• Ministry of Health (MoH) • Ministry of Provincial Councils, Local Government Sports (MPCLGS) • Regional Directors of Health Services (RDHS) • Divisional Hospitals (Category A, B.C) • Primary Care Medical Institutes (PMCI) • Public Health Inspector (PHI) • Public Health Nurse Officer (PHNO) • Poorest households and patients from low-income households who may have or are at risk of NCDs • Households who have lost their livelihoods/incomes • Elderly, Persons with Disabilities • Cancer patients and patients that require palliative care. • Women, pregnant mothers and children from low-income families with nutritional issues vulnerable to GBV/ SH	• Ministry of Finance, Economic Stablization and National Policies (MoF) • Provincial and Local Government level councilors • Sri Lankan Citizens and their civil society organizations • Health Promotion Bureau (HFB) • Information Community Technology Agency (ICTA) • Public health care workers (Doctors, Nurses, Midwives) • Communities in close proximity to PCMIs • Family Health Bureau (FHB) • Friends of Facility Committees (FFCs) • Non-governmental / civil society organizations (NGOs/CSOs)	• Poorest households and patients from low-income households who may have or are at risk of NCDs • Elderly, Persons with Disabilities. • Cancer patients and patients that require palliative care. • Living in vulnerable areas such as in estate sector, underserved urban settlements, and remote rural locations & Vedda communities. • Women, pregnant mothers and children from low-income families with nutritional issues vulnerable to GBV/ SH

3.1 Affected Parties

"Affected Parties" are, persons, groups and other entities within the Project Area of Influence (PAI) who are directly influenced (actually or potentially) by the project and/or have been identified as being most susceptible to change associated with the project, and who need to be closely engaged in identifying impacts and their significance, as well as in decision-making on mitigation and management measures.

Table 2 provides an assessment of the project's risks and impacts on individuals, groups, and other stakeholders that may be directly or positively or negatively affected by the project. The assessment further extends to analyse the level of influence that these different stakeholder groups can exercise over the project preparation and implementation processes.

Table 2: Project's impact on affected parties and their level of influence

Project affected parties	Description of Impacts	Level of Impact	Level of Influence
Ministry of Health (MoH)	MoH accountability and institutional capacity will be improved and will be responsible for the design and implementation of project activities while safeguarding the social and environmental sustainability.	High	High
Ministry of Provincial Councils, Local Government Sports (MPCLGS)	Will benefit through institutional capacity and will be responsible for implementation of project activities at Provincial level through Provincial Health Ministries. Benefit from streamlined e-procurement systems.	High	High
Regional Directors of Health Services (RDHS)	Will benefit from ability to perform required medical services to patients with access to equipment, drugs, laboratory services, streamlined systems for better coordination with higher level facilities, improved HR policy, access to quality management tools. Furthermore, there will be long-term savings on energy consumption due to introduction of solar systems and e-bikes.	High	High
Divisional Hospitals (Category A, B.C)	Benefit by being able to provide better medical services, improved and streamlined e-procurement capabilities, and improved personal health record systems.	High	Medium
Primary Care Medical Institutes (PMCI)	Improved capacities of PMCIs to provide comprehensive primary care, improved screening of NCDs, drugs and equipment. Able to better monitor its services with special attention to quality of services and community engagement.	High	High
Public Health Inspector (PHI)	Benefit from access to training on NCDs, geriatric and mental health care , ability to perform tasks at divisional level in an efficient manner.	Medium	Medium
Public Health Nurse Officer (PHNO)	Benefit from access to continuous professional development through improved HR policies, better access to quality management tools, and improved coordination of care and service provision between PMCIs, community outreach programs and high-level facilities. Able to provide	Medium	Medium

Project affected parties	Description of Impacts	Level of Impact	Level of Influence
	improved services to elderly, disabled and palliative care through access to equipment , tools for mobile health service delivery.		
Poorest households and patients from low-income households who may have or are at risk of NCDs	Benefit from access to improved medical services at PMCIs and improved efficiency in preventive and curative care through screening of NCDs by trained medical professionals, access to required drugs, laboratory facilities.	High	High
Households who have lost their livelihoods/incomes	Benefit from access to improved medical services at PMCIs and improved efficiency in preventive and curative care through screening of NCDs by trained medical professionals, access to required drugs, laboratory facilities.	High	High
Elderly, Persons with Disabilities	Benefit from access to trained PHNOs and medical staff who are better equipped to address preventive and curative health issues faced by this segment.	High	High
Cancer patients and patients that require palliative care.	Benefit from access to trained PHNOs mobile services, access to drugs and medical services.	High	High
Living in vulnerable areas such as in estate sector, underserved urban settlements, and remote rural locations & Vedda communities.	Benefit from improved awareness, community outreach programs that promote information of available health services at PMCIs, requirement to seek medical care for prevention or to address prevalent NCDs. Benefit from access to quality health care facilities at PMCIs.	High	High
Women, pregnant mothers and children from low income groups.	Ability to benefit from improved nutrition and healthcare management due to change in communal perceptions. Reduce the vulnerability for GBV/ SH and benefit from enhanced GBV/SH services.	High	High

3.2 Other Interested Parties

"Other Interested Parties" constitute individuals/groups/entities that may not experience direct impact from the project but who consider or perceive their interest as being affected by the project and/or who could affect the project and the process of its implementation in some way. Table 3 presents the multiple interests of other parties and their level of potential influence over the Project.

Table 3: Interest of other parties and their level of influence over the project

Other Interested Parties	Description of Interests	Level of Interest	Level of Influence
Ministry of Finance, Economic Stablization and National Policies (MoF)	To enhance the efficiency, quality and transparency of the MoH. Reduce number of patients seeking services from secondary and tertiary care hospitals & shift bulk of the patients with minor conditions to less costly PHC level, hence improving the health system efficiency.	High	High
Provincial and Local Government level councilors	To ensure quality, accountability, transparency and efficiency of Provincial Ministry of Health , RDHS , MOH and PMCI performance at district level.	High	Medium
Health Promotion Bureau	To understand their responsibilities, areas for engagement and technical support to the project to implement the communication activities of the project.	High	High
Sri Lankan Citizens and their civil society organizations	Participate in ensuring health service provision and Provincial, District and Divisional levels, specifically PCMIs are implemented in a transparent, accountable manner.	High	Low
Information Community Technology Agency (ICTA)	Design, develop and manage the Electronic Management Information Systems and health related digital databases for procurement, patient records.	High	Medium
Public health care workers (Doctors, Nurses, Midwives)	Access to training, medical equipment, drugs, laboratory services, improved HR policies and management tools to increase efficiency, transparency and accountability in health care system.	High	High
Communities in close proximity to PCMIs	Benefit from access to well equipped PCMIs, improved health coverage. Sense of ownership to the health facilities available to their community and interests to enhance quality of primary health care services their community.	High	Medium
Family Health Bureau (FHB)	Oversee, monitor and manage complaints of an SEA/SH nature received during project implementation.	High	Medium
Friends of Facility Committees	To enhance efficiency of citizen engagement processes, work with PCMIs to raise awareness, support communication, receive and address grievances and complaints received from project activities.	High	Medium
Sri Lankan Citizens	Receive information on PCMI strengthening and available services	Moderate	Moderate

3.3 Disadvantaged / Vulnerable Individuals or Groups

"Disadvantaged/Vulnerable Groups" are persons who may be disproportionately impacted or further disadvantaged by the project(s) as compared with any other groups due to their vulnerable status, and that

may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project. They would include the following groups.

1. Poorest households, communities in remote rural locations (i.e. Veddas, plantation communities), and low income communities in both rural and urban settings.
2. Poorest households and patients from low-income households who may have or are at risk of NCDs
3. Cancer patients and patients that require palliative care.
4. Elderly, Persons with Disabilities

Table 4: identifies the communication methods and resources required for the engagement of disadvantaged/vulnerable persons and groups in the project.

Stakeholder Group	Key Vulnerability/disadvantage	Preferred means of notification/ consultation	Additional Resources Required
Poorest households and patients from low-income households.	• Lack of access to information and access to services at PMCI . • Lack of access to trained medical staff. • Lack of access to basic drugs for treatment of NCDs etc. • Lack of access to laboratory services.	• Awareness programs facilitated through FFCs, individual and group meetings. • Through GNs/PHIs. • Through television programs, radio & news papers. • Through SMS / Whatsapp groups.	• Printed Posters & Brochures & awareness raised by PMCIs. • Targeted television, radio programs & & Newspaper, Social Media, Website. • Support from NGOs/CSOs
Poorest households and patients from low-income households who may have or are at risk of NCDs	• Lack of access to information on the available services at PCMIs. • Access to primary health care facilities limited, lacks knowledge on services available.	• Awareness programs facilitated through FFCs, individual and group meetings. • Through GNs/PHIs. • Through television programs, radio & news papers. • Through SMS / Whatsapp groups.	• Printed Posters & Brochures & awareness raised by PMCIs. • Targeted television, radio programs & & Newspaper, Social Media, Website. • Support from NGOs/CSOs
Elderly, Persons with Disabilities	• Distance from nearest PCMI, difficulty with mobility, unable to afford transport to access primary health services. • Lack of access to information, medicines, and essential medical services	• Awareness programs facilitated through FFCs, individual and group meetings. • Through GNs/PHIs. • Through television programs, radio &	• Printed Posters & Brochures & awareness raised by PMCIs. • Targeted television, radio programs & & Newspaper, Social

		news papers. • Through SMS / Whatsapp groups.	Media, Website. • Support from NGOs/CSOs
Cancer patients and patients that require palliative care.	• Lack of transport facilities and distance to PCMI. • Unable to access nearest PCMI due to their advanced stage and are physically unable to travel. • Lack of access to palliative care, and access to primary health services.	• Awareness programs facilitated through FFCs, individual and group meetings. • Through GNs/PHIs. • Through television programs, radio & news papers. • Through SMS / Whatsapp groups.	• Printed Posters & Brochures & awareness raised by PMCIs. • Targeted television, radio programs & & Newspaper, Social Media, Website. • Support from NGOs/CSOs
Living in vulnerable areas such as in estate sector, underserved urban settlements, and remote rural locations & Vedda communities.	• Lack of awareness about available health services at PMCIs, • Lack of access due to high transport costs and distance to nearest PCMIs.	• Awareness programs facilitated through FFCs, individual and group meetings. • Through GNs/PHIs. • Through television programs, radio & news papers. • Through SMS / Whatsapp groups. • Communication using culturally appropriate methods.	• Printed Posters & Brochures & awareness raised by PMCIs. • Targeted television, radio programs & & Newspaper, Social Media, Website. • Support from NGOs/CSOs
Women, pregnant mothers, and children from low-income groups.	• Poor knowledge on nutritional and personal healthcare management • Higher vulnerability for GBV/SH impacts	• Awareness programs and establish safe community based systems to support vulnerable individuals.	• Printed Posters & Brochures & awareness raised by PMCIs. • Targeted television, radio programs & & Newspaper, Social Media, Website. • Support from NGOs/CSOs

4. Stakeholder Engagement Program

The SEP provides an opportunity for all-inclusive approach in project preparation, planning, implementation and monitoring processes. It is geared toward ensuring meaningful and a wide consultative process guided by World Bank's Environmental and Social Framework (ESF), particularly ESS-10.

4.1 Proposed Strategy for Information Disclosure

Information disclosure and consultation processes will continue with affected parties, other interested parties and vulnerable groups during (i) project preparation, (ii) project implementation, and (iii) project operational phases. A variety of methods such as group consultations, individual consultations, and interviews through different offline and virtual medians such as emails, telephone and conference calls etc. and communication through printed and electronic media, appropriate to the target audience, will be used for information disclosure and consultation.

During project preparation and planning, information related to project scope and schedule will be shared with project affected persons and other stakeholders during consultations. The Project will also provide up-to-date information on the websites of MoH, MPCLGS and other the relevant stakeholder agencies.

At the appraisal stage, safeguard instruments including Environmental and Social Commitment Plan (ESCP), and the SEP prepared for this project will be disclosed on the websites of MoH, MPCLGS and related agencies and on the World Bank's external website, after their clearance by the GoSL and the Bank. Additionally, copies of the referenced documents will be kept at the MoH and MPCLGS for public reference. Any changes to the approved ESCP, and SEP would have to follow the same clearance/ approval procedures and disclosure.

During project implementation, sub-project specific safeguard instruments will be publicly disclosed in-country. The documents and plans to be disclosed include:

- Environmental and Social Commitment Plan (ESCP)
- Stakeholder Engagement Plan (SEP)
- Monitoring activities undertaken as per ESCP and SEP
- Project quarterly reports and annual reports

Translations of executive summary of all documents prepared by the project in Sinhala and Tamil will also be made available to the public through the websites of MoH and MPCLGS. Information can also be disseminated through digital platform (where available) like Twitter, WhatsApp/Viber groups, and traditional means of communications (TV, newspaper, radio, notices, phone calls and e-mails) with clear description of mechanisms for providing feedback via mail and / or dedicated telephone lines. All channels of communication need to clearly specify how stakeholders can provide their feedback and suggestions.

Table 6: provides a plan for information disclosure during project preparatory, implementation and operational periods.

Table 6: Communications / Information Disclosure Plan

List of information to be disclosed	Proposed methods	Timetable/ Location Dates	Target stakeholders	Responsibility
Project preparation and planning phase				
• Scope of the project • Project implementation arrangements including partner agencies and their roles and responsibilities • Project beneficiaries and anticipated impacts • Environmental and Social Commitment Plan & Stakeholder Engagement Plan • Grievance redress mechanism including places to report sexual harassment, and gender-based violence • Arrangements for project monitoring & reporting	• Websites of the MoH, MPCLGS and other relevant departments • Pre-arranged workshops/seminars • E-brochures printed in English, Sinhala & Tamil • Printed reports • Newspaper advertisements in English, Sinhala & Tamil	Three months prior to the commencement of the project and will continue throughout the project period	Affected parties, other interested parties and vulnerable groups	PMU MOH MPCLGS PMCI HPB
Project implementation phase				
PMCISs equipped with minimum capabilities across nine provinces: • Screening of adult population for risk factors • Availability of trained staff (doctors and public health nursing officers) • Minimum set of operational diagnostic equipment and tools available at PCMIs, • Minimum availability of essential drugs and lab test capacity (on-site or through networked/contracted pharmacy or laboratory), • Meeting of national quality and safety standards • List of PMCIs with basic infrastructure in place for connecting to the e-health information management system. **Improved supply chain management**	• Websites of the MoH, MPCLGS and other relevant departments • Pre-arranged workshops/seminars • Brochures printed in English, Sinhala & Tamil • Notices at PMCIs and other health facilities	Continuously and as and when they are ready	Affected parties, other interested parties and vulnerable groups	PMU MOH MPCLGS PMCI HPB

• E-procurement expanded to connect all PMCIs with central procurement system • Development of guidance and directives to abide by e-procurement system at national and provincial level. **Improved Quality of Care** • Improved primary health care cadres competencies on NCDs, elderly care, mental health care and pandemic/climate disaster preparedness. Strengthening of national in service platforms (online and face to face training). • Quality management tools and guidelines for PMCIs – clinical audits, patient experience improvement, grievance redressal • FFC policies, guidelines and their activities available. • Grievance redress mechanism including places to report sexual harassment, and gender-based violence • Summary outcomes of stakeholder consultations and feedback received				
Project operational phase				
• Project's achievements, drawbacks, challenges, any remedial measure adopted • Feedback from project beneficiaries and other interested parties on project's impacts • Project management information, procedures for open-competitive bidding, procurement opportunities, contract awards etc.	• Websites of the MoH, MPCLGS and other relevant departments • Pre-arranged workshops/seminars • Brochures printed in English, Sinhala & Tamil • Printed reports • Newspaper advertisements in English, Sinhala & Tamil	Continuously and as and when they are ready	Affected parties, other interested parties and vulnerable groups	PMU MOH MPCLGS PMCIs

4.2 Proposed Strategy for Consultations

The project will continue to consult the project affected parties; other interested parties and the vulnerable and disadvantaged groups, specifically on themes listed below, in order to elicit their views and feedback. Individual and group meetings, mini-workshops/focus group discussions, satisfaction surveys, social media, etc. will be used to facilitate the consultations on the following:

1. Strengthening the participation of disadvantaged/vulnerable groups in project cycle
2. Improvements to PMCI infrastructure, services and access to essential medicines.
3. Introducing and strengthening of the e-health information management system
4. Improved supply chain management – expansion of e-procurement capabilities at PMCIs.
5. Certification systems for quality care at PMCIs
6. Expansion and strengthening of Friends of Facility Committees.
7. Operation of the Grievance Redressal Mechanism
8. Availability of adequate SEA/SH services at PMCI level.
9. Capacity building trainings for the staff of relevant agencies
10. Stakeholder satisfaction on project processes, deliverables and outcomes and impacts

Table 7: Strategy for Stakeholder Consultations

Target stakeholders	Topic(s) of engagement	Method/s used	Location/frequency	Responsibility
Project preparation and planning phase				
• Ministry of Health (MOH) • Ministry of Provincial Councils, Local Governr and Sports (MPCLGS) • Ministry of Finance, Economic Stablization National Policies (MoF) • Information and Communication Technology Agency (ICTA) • Family Health Bureau (FHB)	• Project's scope, key deliverables and anticipated impacts • Project implementation arrangements and resource allocations • Environmental and social requirements of the project (inclusion of vulnerable groups, stakeholder engagement, information disclosure, community health & safety measures, consultations, grievance redress mechanism).	Consultative workshops/seminars/meetings with ppt. presentations, and a document summarizing the key aspects of the topics to be covered	Prior to the project's commencement MOH	MoH MPCGLS PMU HPB PMCIs
Project Implementation Phase				
• Representative of all project affected parties listed in Table 2 • Representatives of other interested parties listed in Table 3 • Representatives of Disadvantaged and vulnerable groups listed in Table 4	• Project's scope, key deliverables and anticipated impacts • Project implementation arrangements and gaps, drawbacks and challenges • Strengthening project's environmental and social requirements (inclusion of vulnerable groups, stakeholder engagement, information disclosure, community health & safety measures, consultations, grievance redress mechanism) • Citizens' engagement and project monitoring	Consultative workshops/seminars/meetings with ppt. presentations, and a document summarizing the key aspects of the topics to be covered (in local languages) Baseline surveys for disadvantaged and vulnerable groups	At project's commencements and later bi-annual.	MoH MPCGLS PMU
Project Operational Phase				

• Representative of all project affected parties listed in Table 2 • Representatives of other interested parties listed in Table 3 • Representatives of Disadvantaged and vulnerable groups listed in Table 4	• Review and monitor the establishment and functioning of project's outputs, outcomes, and impacts • Feedback on project's operational modalities, project's outcomes and impacts. • Implementation of Operational ESMPs.	Consultative workshops/seminars/meetings with ppt, focus groups discussions, key person interviews, feedback surveys,. presentations, and a document summarizing the key aspects of the topics to be covered	Periodically during project's operation phase.	MoH MPCGLS PMU

4.3 Proposed Strategy for engaging Vulnerable Groups

Table 8 presents a strategy for the engagement of vulnerable and disadvantaged groups in consultative processes.

Table 8: Strategy for the engagement of Disadvantaged/Vulnerable groups

Disadvantaged/Vulnerable Groups	Strategy
• Poorest households and patients from low-income households. • Households who have lost their livelihoods/incomes	• Conduct consultations to identify their issues and constraints for participation in project activities , access to information, primary health care facilities. • Support them to acquire or have access to PCMIs and available health care services. • Provide through easy to understand communication materials information on available services, access to information, GRM etc.
• Living in vulnerable areas such as in estate sector, underserved urban settlements, and remote rural locations & Vedda communities.	• Conduct group consultations to identify their potentials/constraints for participation and representation • Work with Divisional level health care providers to develop strategy for outreach programs, information disclosure. • Ensure meaningful participation and consultation with Vedda communities in a culturally appropriate manner, and ensure availability of mechanisms by which IPs can raise concerns or seek redress.
• Elderly, Persons with Disabilities • Cancer patients and patients that require palliative care.	• Conduct individual/groups consultations to identify constraints for their participation • Develop a strategy ensuring their inclusion and participation in project processes and benefits.

5 Resources and Responsibilities for Implementing Stakeholder Engagement Activities

5.1 Resources

Resources required for implementation of the stakeholder engagement plan would include costs of information disclosure and stakeholder consultations, and the cost of the grievance redress mechanism. The project cost tables and annual work plans and budget shall allocate costs for specific information disclosure and stakeholder consultation activities including: preparation, printing and dissemination of information materials, communications, and costs of stakeholder consultation workshops, and grievance redressal procedures.

The detail breakdown of the budget will be annexed at the point the final SEP is disclosed.

5.2 Management Functions and Responsibilities

The project will be implemented by MoH and MPCLGS. A Project Management Unit (PMU) will be established for implementation of the project. The PMU will be headed by a Project Director (PD) who will be designated by the MoH. The PMU is responsible for overall implementation of the project ensuring that all environmental and social safeguard requirements are met in accordance with the requirements of the World Bank's Environmental and Social Framework. A staff from the PMU will be designated as the focal person for Environmental and Social, who will be responsible for the overall coordination, implementation and monitoring of the SEP including the GRM.

The roles and responsibilities of the different stakeholders in SEP implementation are described in Table 9.

Table 9: Responsibility of SEP implementation

Entity/Person	Responsibility
Project Director	• Ensure that all project activities are undertaken as per SEP • Undertake stakeholder and public consultations • Provide feedback to stakeholders • Provide information on environmental and social requirements to stakeholders • Provides oversight to the project's Grievance Redress Mechanism • Give information on GRM of the project to all stakeholders.
Focal person for Environment and Social.	• Ensure that the consultants hired is informed regarding the provisions of the SEP; • Ensure relevant stakeholder engagement activities in SEP are implemented in a timely manner; • Support PD in GRM operations • Give information on GRM of the project to consultants and stakeholder involved.
Health Promotion Bureau	• Support the design of communication tools and products on PMCI services. • Ensure the communication material is universally accessible allowing people with disabilities can understand. • Support in the development, dissemination and implementation of communication campaigns related to PMCI services.
Key staff at PMCIs	• Engage with key stakeholders, support in consultations, information dissemination activities and implementation of the GRM.
Friends of Facilities communities	• Engage with communities to take information about PMCI services and relay necessary information back to PMCIs to improve service delivery.

6 Grievance Redressal Mechanism (GRM)

The Environment and Social Specialist will be responsible for the implementation and operation of the grievance redress mechanism for the project. The PMU will be responsible for the operation of the Grievance Redress Mechanism (GRM).

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

- Provides affected people with avenues for making a complaint or resolving any dispute that may arise during the course of the implementation of projects;
- Ensures that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants;
- Supports accessibility, anonymity, confidentiality and transparency in handling complaints and grievances;
- Avoids the need to resort to judicial proceedings (at least at first);

PHSSP will build upon the health sector wide GRM established by the MoH through support from PSSP and the COVID-19 project that is operated by the MoH to address all issues related to health care services in the country, which will be further strengthened and utilized under the PHSSP. The GRM is operated by a dedicated MoH unit which was established in 2019 with guidance of the Additional Secretary for Medical Services of the Ministry of Health appointed at the time. This Call Centre at the national level accepts complaints through a dedicated hotline (1907), in addition via email, SMS, social media and regular letters. The GRM has the capacity to collect grievances, suggestions and complaints incoming from any possible source in the country (e.g. grievance hotlines, Presidential Administration, Prime Minister's Office, Parliament and other political establishments, various organizations, health sector employees, citizens and the media); examine each complaint and refer to relevant authorities; follow up with regards to the investigation process; provide feedback to complainants; carry out analytical work related to past and ongoing complaints.

A four tiered system is operated at national, provincial, district and PMCI levels as follows:

- Tier 1:(MOH/Divisional level) Primary, Secondary, Tertiary Medical Care Institutions – these include all hospitals, hospitals where cases are treated and isolation/quarantine centers
- Tier 2 (District level): Regional Director of Health Services (RDHS)
- Tier 3 (Provincial level): Provincial Director of Health Services (PDHS)
- Tier 4 (National level): Grievance Coordinating Unit (GCU) manned by two Medical officers, two development officers, public health management assistant, and health assistants (Support Staff).

THE OPERATION OF THE PSSP GRM

Step 1: Grievance submission

- ✓ Grievances can be submitted at each of the four tiers of the GRM. This includes anonymous grievances.
- ✓ At the national level, the GRM Unit at the MoH operates a call center, which typically serves as a first respondent for all complaints. The call center staff registers the complaints and directs them for investigation to relevant authorities at sub-national levels. The call center accepts complaints through a dedicated hotline (1907), phone calls, email, SMS, social media, and regular letters.

- ✓ At the sub-national levels, grievances are accepted by the GRM focal points verbally, in writing via suggestion/complaint box, through telephone, mail, SMS, social media (WhatsApp, Viber, Facebook), email, website, and via the 'Friends of Facility' committees.

Step 2: Grievance registration:

- ✓ Grievances are recorded and classified based on the type and subject of complaints. Complaints are registered at the GRM level in which they were submitted, and the GRM focal points then direct them for investigation. Reports regarding all incoming complaints are also provided to the GRM Unit at MoH.

Step 3: Grievance investigation:

- ✓ Grievance investigation by relevant authorities and response to complainant within 7 days.

Step 4: Complainant's response:

- ✓ The complainant either confirms that the grievance is closed or requires to taker further steps to address the grievance. If the grievance remains open, the complainant is given the opportunity to appeal to the MoHIMS.

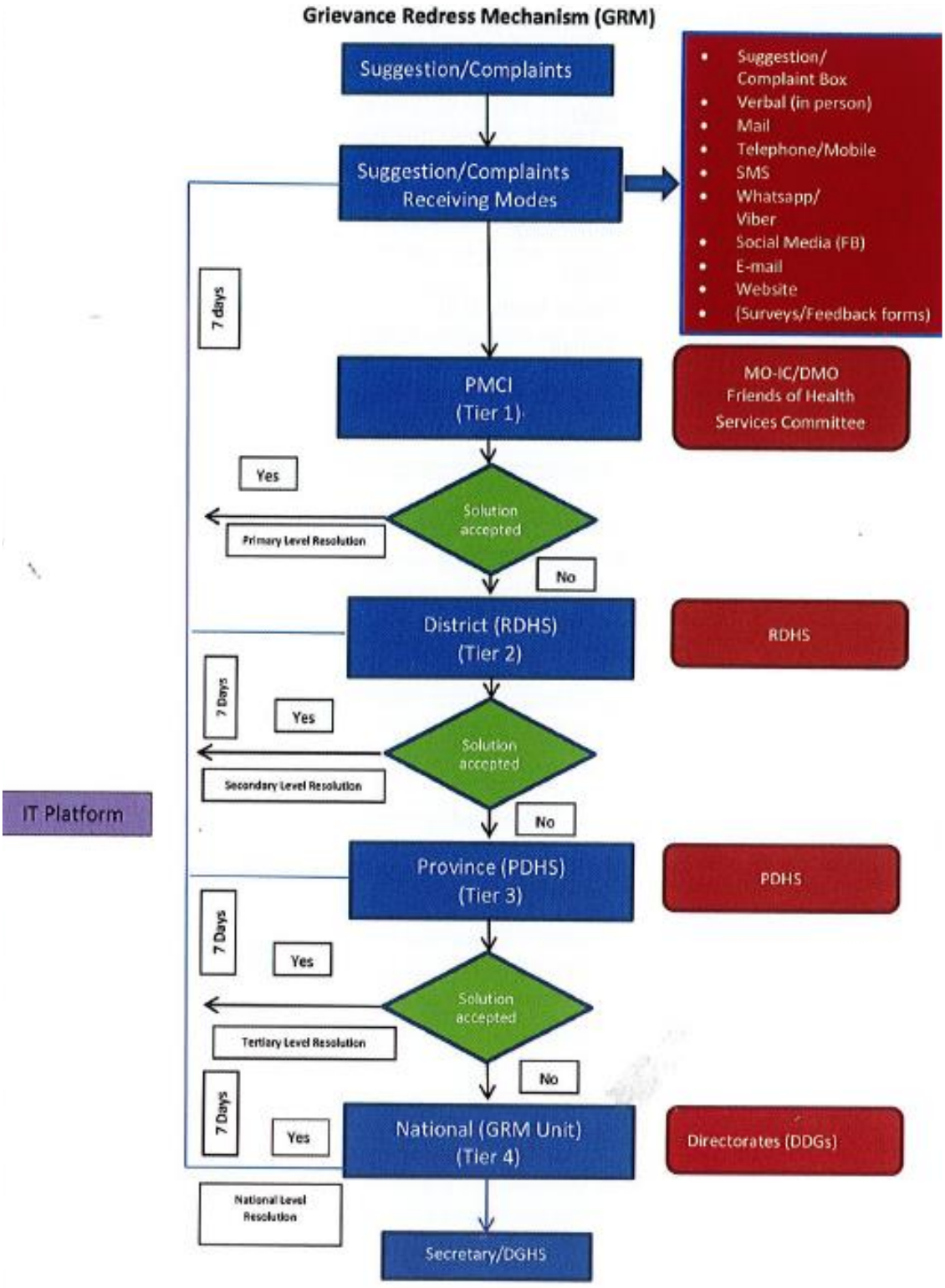
Analytics:

- ✓ Quarterly reports that include a summary of complaint types, actions taken and progress made are submitted for the review of focal points at levels, including to RDHS, PDHS, DGS and to the secretary of MoHIMS. Reports are currently shared by various GRM stakeholders via email, but in the future will be easily available online through the digital GRM platform.

Appeal:

- ✓ Once all possible avenues of redress are exhausted and if the complainant is still not satisfied then s/he would be advised of their right to legal recourse.

This GRM system has effectively managed to receive and resolve a large volume of complaints/enquiries that ranged from quality of medical services, drug availability, service availability and accessibility, lack of medical facilities and equipment, medical needs , medical negligence, misconduct and employee relations (i.e. transfers, salaries, promotions etc). This nationwide GRM has been able to address any health related issue to date. Under the project, more awareness of the GRM will be done at every PMCI and among communities accessing PMCI services.


Grievance Redress Mechanism (GRM)
Suggestion/Complaints
Suggestion/Complaints Receiving Modes
Suggestion/ Complaint Box
Verbal (in person)
Mail
Telephone/Mobile
SMS
Whatsapp/ Viber
Social Media (FB)
E-mail
Website
(Surveys/Feedback forms)
7 days
PMCI (Tier 1)
MO-IC/DMO
Friends of Health
Services Committee
Yes
Solution accepted
Primary Level Resolution
No
District (RDHS) (Tier 2)
RDHS
7 Days
Yes
Solution accepted
Secondary Level Resolution
No
IT Platform
Province (PDHS) (Tier 3)
PDHS
7 Days
Yes
Solution accepted
Tertiary Level Resolution
No
7 Days
Yes
National (GRM Unit) (Tier 4)
Directorates (DDGs)
National Level Resolution
Secretary/DGHS

Handling Gender-Based Violence (GBV) Issues

- ✓ At PMCI level, SEA/SH cases will be handled by specialists providing medical health services and when necessary will be referred to Mithuru Piyasa operating at base hospitals. These doctors have been trained on mental health counselling, identifying patients who may be experiencing some form of GBV.
- ✓ Mithuru Piyasa, established as one stop GBV crisis centres by the FHB of MoH provide services to victims of gender base violence (GBV) and related issues at home, workplace etc., screening cases, referring for counseling or any other specialized areas services. Mithuru Miyasas have been established in Base Hospitals in the country.
- ✓ Mithuru Piyasa's also operates a GBV hotline 070 26 11 111 where anyone can report SEA/SH incidences and receive necessary support. Any SEA/SH related complaints reported to the National Health-sector GRM will also be referred to Mithuru Piyasa's for necessary response.
- ✓ Health workers at PCMI level will be trained with the basic skills to respond to disclosures of GBV, in a compassionate and non-judgmental manner and know to whom they can make referrals for further care to specialized SEA/SH services at Mithuru Piyasa's.
- ✓ Further, the GRM will also have in place processes to immediately notify both the MoH and the World Bank of any GBV complaints related to the project, with the consent of the survivor. Survivor confidentiality should be always protected to prevent any risks of stigmatization and reprisals against the survivor
- ✓ The project will also educate the public that the GRM can be utilized to raise concerns or complaints regarding the conduct of medical officers, especially related to GBV and SEA/SH issues. Thus, the existing GRM will also be strengthened with procedures to handle allegations of GBV/SEA/SH violations.

The GRM will follow the following guidelines when SEA/SH are received:

a) Only three elements related to a SEA/SH allegation will be recorded: (i) the allegation in the survivor's own words; (ii) if the alleged perpetrator is, to the best of the survivor's knowledge, related to the project; and, if possible, (iii) the age and sex of the survivor.

b) the GM operator will report minimal information to the implementing agency, which in turn informs the Bank task team. This information should be along four lines: (i) the nature of the case; (ii) if the case is project-related; (iii) age and sex of survivor (if available); and (iv) if the survivor was referred to services.

c) Finally, the GBV complaints or allegations made to the project GRM will be referred to the GBV service providers that have been identified, regardless of the perpetrator's identity.

7. Citizen's Engagement Mechanism

The "Friends of Facility Committees" (FFCs) represent an innovative CE mechanism that has been introduced as part of PSSP. FFCs are established in attachment to Primary Medical Care Units (PMCI) and District Hospitals, in order to serve as a direct link between PMCIs and the communities they serve.

Each FFC is comprised of a chairman, coordinator, treasurer, and several committee members, who are typically well-reputable members of the local community. The chairman is typically a medical doctor, and other committee members are reputable local community members (religious leaders, lawyers, engineers,

etc.) that are invited to serve on the committee by the chairman.

FFCs serve as a bridge between the PMCI and local communities and fulfill variety of functions. First, they assist the PMCI to tailor its services to the needs and priorities of the local community based on feedback obtained from the community. Second, they raise the awareness of local communities regarding available medical services and the importance of various medical treatments and procedures. Further, they handle grievances or complaints raised by community members, help PMCIs to mobilize resources, monitor the performance of various PMCI services, ensure the proper maintenance of equipment, and generally contribute to the optimal functioning of PMCIs and community health overall.

As of March 2023, 309 FFCs are active in Sri Lanka, established in pursuance of guidelines developed by the MoH in 2019. Committee members are all volunteers and they are not paid for their services, yet they are provided with capacity building activities. Each FFC follows its own objectives and action plan, and has regular communication among the various FFCs through WhatsApp groups. There is also a general WhatsApp group for all FFCs in the country, and also separate groups for each of the committees.

The PSSP has undertaken a range of activities to support the establishment of FFCs. It has developed training materials for the committees, and it specifically encourages women to take leadership roles in them. The M&E officer of PSSP closely monitors the activities of the different committees, and collects information on issues that they identify.

Under the PHSSP, FFCs will be further capacitated through trainings to provide tangible skills and tools to enhance FFC performance and introduce systems to monitor FFC activities to capture the key outcomes and learnings to enhance PMCIs approaches to community outreach. The project will build-in mechanism to obtain feedback from patients to assess the quality and satisfaction of the PMCI services offered. Accordingly, the project includes two BF indicators: Percentage of PMCIs conducting annual patient experience surveys using standardized tools and b) Percentage of PMCIs with active Friends of Facilities committees.

8. Monitoring and Reporting

8.1 Involvement of Stakeholders in Monitoring Activities

The project will establish multiple mechanisms for monitor and evaluate the SEP implementation. They would include the following arrangements: (i) overall monitoring and evaluation by the PMU; and (ii) engagement of the project affected parties, other interested parties, and disadvantaged /vulnerable groups, to monitor and report on the adequacy and usefulness of (i) information disclosure programs; (ii) consultations; and (iii) stakeholder engagement activities via their participation in individual/group consultations, and in the GRM.

The project will use a variety of methods and tools for monitoring and evaluation. They will include review of project documents and progress reports, stakeholder interviews and group discussions, feedback surveys, site visits etc. Focal person for Environment and Social at the PMU will coordinate and facilitate documentation of the monitoring and evaluation results and outcomes including the maintenance of records of all consultations and meetings conducted with stakeholders, types of information disclosed, issues and

concerns raised at consultations/meetings, public comments/feedback received for disclosed documents, informal feedback, decisions made, and reporting back to the stakeholders.

8.2 Reporting back to Stakeholder Groups

The results of the stakeholder engagement activities including results and outcomes of monitoring and evaluation of SEP implementation will be reported back to the stakeholders through website and/or formal communications. The PMU will collate all monitoring and evaluation results and produce bi-annual reports to be submitted to the World Bank. SEP monitoring will be part of the project monitoring reports submitted.

Annex 1 – Stakeholder Consultations related to Environment and Social

Consultation Notes

Project Name: Sri Lanka: Primary Healthcare System Strengthening Program (PHSSP)
Meeting Name: Stakeholder consultations with key government counterparts
Meeting Objective: To understand the current operations of PMCIs/ PMCU in relation and environmental and social management.
Dates of consultations: Session 1 (15th Feb, 2024) and Session 2 (16th Feb, 2024).

Participants
1. Dr. Prabhashwara – RDHS Nuwara Eliya 2. Dr. Gimhani – PSSP Project Coordinator, Gampaha district. 3. Dr. Ramya Hettiarachchi – RDHS Gampaha 4. Dr. Udeshika – RDHS Puttalam 5. Hasitha Karawita – Environmental Specialist – SL COVID-19 Emergency Response and Health Systems Preparedness Project

Discussion Points		
General / Operational	**Environmental Management**	**Social Management**
<u>Primary Medical Care Institutes (PMCIs)</u> • Constitute of Primary Medical Care Units (PMCUs) and Divisional Hospital (DH) OPD services. • PMCIs are governed by the provincial health departments. • There are approximately 1070 PMCI's island wide. • Responsibilities: - Waste management procedures. - Clinic staff carries out social compliances. - Key Staff: Hospital Director, Infection control nurse, Micro-biologist Pathologist **<u>Procurement</u>**	**<u>Environmental Social Health and Safety (ESHS)</u>** • The Environmental and Occupational Health Directorate is responsible for all aspects related to ESHS. • They are the main department which circulates guidelines, policies, action plans, SOPs for PMCUs. • M&E of ESHS is carried out at the district level. **<u>Healthcare waste management (HCWM)</u>** • There is a National Action Plan on HCWM, however the specific procedures and process is district specific.	**<u>Land and involuntary resettlement</u>** • Extensions, minor civil works etc. under PSSP-1 was done in hospital premises or land owned by MoH. • There was no private land acquisition or involuntary resettlement in PSSP-1. **<u>Grievance Redress Mechanism</u>** • Encouraged maintaining suggestion boxes. GRM is available at different levels, and complaints are handled depending on issues at different levels. • GBV/SEA/SH related complaints are not handled at PMCI level. This is handled by

• Projects above 50 million are Mega projects. • Provincial focal points oversee procurement. • Unable to define budget of minor civil works. Some are carried out via budgetary allocations and some through the Ministry. • The PMCIs that had Friends of the Facility committee (FFC) have been able to support PMCIs through their own fundraising (e.g. developing of jogging facilities etc.) **Civil works** - **Minor civil works process** • Hospital Directors can make decision on contracting, but decisions are based on budget allocation and authority limits. • Minor civil works in PSSP-1 included extensions, renovations, Health Care Waste Management (HCWM), water and sanitation facilities, laboratories (new and refurbishments). • A team of engineers, (Mechanical, Electrical, civil) carry out the necessary works (design etc.). Within the team there aren't any designated E&S officers. • A Medical Officer (MO) monitors civil works under the supervision of an appointed Consultant Community Physician (CCP) • The standard procedures and operations are discussed at inception with the guidance of the engineering team. There aren't specific E&S guidelines that are followed during civil works implementation. **dequate hospital infrastructure** • Some hospitals lack universal access systems (ramps etc.)	• HCWM has improved, however there are gaps due to unavailability of equipment (i.e. incinerators) in PMCUs. • Clinical waste is transported health care facilities with incineration facilities (i.e. Base Hospitals or Divisional hospitals). • There is a lack of dedicated vehicles for clinical waste collection from PMCUs. • There is a knowledge gap observed in the labour community operating incineration facilities. • Due to lack of incineration facilities/ waste transfer facilities some of the health care facilities (HCFs) still practice open burning. • Effluent treatment and monitoring need to be enhanced. **Laboratory facilities** • PSSP-1 supported the establishment and refurbishment of laboratories. A Standard Operating Procedure (SOP) is developed by the Hospital Director taking into the procedures and operations of that PMCU/PMCI. • The hospital director supervises the SOP at the Regional level. Public Health Inspector (PHI) monitors it at the PMCI/PMCU level. • A national level standardized SOP is not available.	PHM supervisor, goes to MOH, Family services also gets involved. • GRM at PMCI level: • 1907 "Suwasawana" hotline is used to log grievances. Officers at Provincial, District and Institutional level are trained on responding to grievances. o Guidelines were revised for GRM mid-2023 for GRM and FFC. o National Level hotline is linked to PMCI. **Information on Vulnerable Groups in PSSP-1:** • Disaggregated data on vulnerable groups is unavailable. Data on total numbers served, such as 60% of patients with high risk levels were directed to clinics are available. • Outreach services for vulnerable groups (disabled, geriatric and palliative care) needs more strengthening in terms of transport facilities, human resources (cadre creation and cadre recruitment). **Coordination between Mithuru Piyasa and PMCIs:** • Base hospitals, PMCUs, MoH each have a focal point for any complaints regarding SEA/SH and GBV. • It is initially handled at the MoH level and it is then escalated according to the requirement.

• Limited waiting areas, segregated sanitation facilities • At present the country is experiencing a growth in the ageing population and there is a need to establish dedicated wards for elderly requiring palliative care/ rehabilitation at DHs.		