Guidelines for Community Engagement and Grievance Redress Mechanism

Ministry of Health

2023

PART 1

1. Introduction

1.1 Background

The need for public participation in health and development is now widely recognized. In the health sector, the importance of community participation in all aspects related to promotion, prevention, treatment, and rehabilitation, is accepted as an essential component in achieving a status of good health.

It has also been recognized that there is a felt need for a formal accountability mechanism within the health system in Sri Lanka. The key policy changes that were proposed by the Ministry of Health, Nutrition and Indigenous Medicine (Ministry of Health at present) in 2018 to reorganize the primary health care system in Sri Lanka to address the emerging health needs in the country, recommended the establishment of a mechanism for addressing public/patient concerns, suggestions and Grievances.

This Guideline is the outcome of a wide consultative process that was intended to reorganize and strengthen the primary healthcare system in Sri Lanka.

1.2 Purpose of the Guidelines

The main purpose of this document is to provide guidance to public health and medical administrators, health staff, other government officials, and community leaders, on planning and implementing Citizens' Engagement (CE) programs and the Grievance Redress Mechanism (GRM) in primary health care.

1.3 Intended audience

- Senior officials of the MoH at the National, Provincial, and District Levels.
- Medical Officers of Health (MOHs), Medical Officers in Charge (MO-ICs), and District Medical Officers (DMOs) of PMCIs.
- Other staff categories at hospitals & health staff at MOH Office
- Provincial, district, and divisional administrators (Chief Secretaries, District Secretaries, Divisional Secretaries, planning officers)

- Key Religious leaders
- Leaders and officials of non-governmental Organizations (NGOs), Civil Society Organizations (CSO), and Community-Based Organizations (CBOs)

1.4 Process of development of the guideline

These guidelines were originally developed by an independent consultant after extensive consultations with a representative sample of senior officials of the MoH and other relevant government Ministries and Departments, district and divisional level health staff, medical officers including MO-ICs and DMOs, patients, civil society leaders, religious leaders, and the general public. The consultant also reviewed the past and current experience and mechanisms related to community participation and citizen engagement related to health services at the level primary health care. He also reviewed the relevant experience and best practices from other countries.

Thereafter the guidelines were utilized for the establishment of FFCs at the PMCI level for 4 years. With that experience through a thorough review, these guidelines were developed

1.4 How to use the Guidelines

It is proposed that these Guidelines be used by all key officials and the community leaders who will be involved in the Community Engagement and GRM processes at each PMCI. These guidelines are subject to review from time to time as and when necessary.

The Guidelines are presented in 2 parts:

Part 1 – Covers the proposed mechanism for Community Engagement (CE)

Part 2 – Presents the Grievance Redress Mechanism (GRM)

2. What Is Citizen Engagement?

Citizen engagement is premised on the principle that people should have and want to have a say in the decisions that affect their lives and to be able to ensure their well-being through their own actions.

Citizen engagement is also a process of inviting feedback and input from citizens on programs, policies, and services that impact their lives.

Community engagement, however, is a very broad concept – from informing citizens to active engagement in decision-making. Community engagement is hence recognized today as a continuum with shared leadership and community empowerment as the ultimate desired goal.

* International Association for Public Participation

The notion of community participation in health received greater attention in the 1970s when it became clear that the basic health needs of the majority of people living in the developing world could only be met with the greater involvement of the local communities. The Alma Ata Declaration of the World Health Organization in 1978 gave a central place to community participation and as a result, it was recognized as an essential component in the planning and delivery of primary health care services.

Today, pubic involvement is firmly accepted and advocated as a means to enhance the responsiveness of healthcare systems and it has been sought in various fields of health policy, including health service planning and delivery, health research, and priority setting.

There has been a long-felt need to establish a more formal and structured mechanism for citizen engagement in health in Sri Lanka and in particular in the provision of primary health care services. In 2018, a policy decision was taken by the Government of Sri Lanka to introduce a formal Citizen Engagement (CEM) Mechanism and a Grievance Redress Mechanism (GRM) under the Ministry of Health, Nutrition, and Indigenous Medicine (MoH).

3. Why Citizen Engagement?

Sri Lanka has a rich tradition of community participation in various aspects related to fulfilling the basic needs of people. Being a predominant country with an agricultural economy for centuries, people's direct participation in managing and maintaining community resources including irrigation systems, preparing land for cultivation, harvesting, etc. could be seen as a routine practice since pre-colonial times.

Historically, mobilizing public participation in health could be seen in the control of infectious diseases. One of the key examples has been the famous *Suriya Mal Movement* during the Malaria epidemic of 1934-1935. Over a million people were affected with over 125,000 deaths. The *Suriya Mal Movement* mobilized a large number of volunteers to combat the Epidemic amongst the poor. [1]

There are many such examples that Sri Lanka has proven its strength of citizen engagement in addressing recovering and rehabilitation process during and after post-catastrophic events in the recent Past. Sri Lanka has been experiencing dengue outbreaks in various magnitudes since 1960 with massive outbreaks in 2017. The government of Sri Lanka has used integrated vector control strategies including community engagement for environmental management and personal protection (citizen's role) in order to reduce the dengue burden.

On December 26, 2004, the world witnessed one of the most destructive natural disasters in modern history, a tsunami and Sri Lankan coastal lines were affected a lot by this tragedy with thousands of deaths and leaving thousands of people homeless. In response to this disaster, Sri Lanka has proven its strength of community participation and empowerment in post-tsunami rehabilitation in the country.

The end of the long civil disturbance in Sri Lanka in 2009 generated widespread expectations of a peace dividend that would enable the country to embark on a development era.

With a high level of community engagement and responsiveness, Sri Lanka has shown immediate resettlement and continuous economic, social, agricultural, educational, health, and infrastructural development during the post-civil conflict era.
Various voluntary development organizations too facilitated community participation in addressing health and nutritional issues in rural villages linking remote and inaccessible rural communities with government health services.

Community participation in the health sector in Sri Lanka has taken a variety of forms and structures. Public participation had in most instances been very passive and mainly intended for specific purposes to assist public health staff in the delivery of services in a resource-constrained environment. Large numbers of village volunteers were trained and mobilized to assist the public health staff in various health-related activities such as maternal and child health, sanitation, and family planning.

With the recognition given to community participation by the Alma Ata Declaration, during the 3 decades that followed, we have seen public engagement being made more structured by way of having greater participation of citizen groups in both policy and planning levels through consultation and representation in committees, etc.

However, the extensive consultative and review process carried out by the Ministry of Health in the reorganization of PHC in Sri Lanka, the Sub-committee on Beneficiary Engagement, Gender, and Citizens Voice, concluded that the Prevailing status of citizen engagement was not sufficient.

The unanimous opinion of the Committee was that *"the health system must increase Citizen empowerment and engagement in their health"* and offered a series of recommendations which included establishing a formal mechanism for Citizens Engagement and a Grievance Redressal Mechanism (GRM).

This Guideline is intended to provide the necessary guidance and direction to set up these mechanisms representing areas served by Medical Care Institutions (PMCIs) delivering citizen-centered primary health care services including OPDs of secondary and tertiary care hospitals.

3.1 Opportunities and Challenges for Citizen Engagement

For any new initiative to succeed, one of the key determinants is the political commitment demonstrated to State policies. It is encouraging to note that there have been commitments made by the Government which provide legitimacy as well as policy windows to promote citizen engagement in PHC. These policies are listed and summarized below.

3.1.1 National Health Policy

Even though Sri Lanka had a state policy of providing free health care for the population even before gaining independence from the British in 1948, a formal Health Policy had not been formulated until 1992. However, this policy document wasn't considered to be comprehensive and hence the new Government which came into power in 1994, appointed a committee to revise the said health policy. Accordingly, a new National Health Policy was drafted and approved in 1996 which has been in existence since then (for 20 years). This Health Policy of Sri Lanka explicitly recognized the importance of public engagement and identified it as a key strategy "Promote the involvement of the community in health care" (Strategy No.10).

Then in 2016, the Government decided that the Health Sector was in need of a New Health Policy that would reflect the current health issues and identify strategies to address the same. Accordingly, a new draft Health Policy was formulated by MoH and public views were called for the same. However, for all practical purposes, this draft Policy is considered to be the health Policy currently being adopted by the Government of Sri Lanka. In this draft policy, although there is no explicit reference to public engagement, the Guiding Principles state *"This is a patient and people-centered health policy, considering the concept of Universal Health Coverage (Equitable access to all services by all patients, Equitable distribution of services to all patients, Quality service to all patients and Financial protection to all patients), assuring patients' rights and social justice."*

Hence it could be clearly deduced that public engagement is a commitment in the draft of the New Policy.

3.1.2 Reorganizing Primary Health Care in Sri Lanka – Preserving our progress, preparing our future, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka. December 2017.

The year 2018 has been a landmark year for Sri Lanka. The country celebrated 70 years since gaining independence from colonial rule. It has also been 40 years since the adoption of the Alma Ata Declaration on Primary Health Care and 40 years since Sri Lanka adopted an Open Market Economy which marked the formal entry of the private sector to the State dominated health sector.

Despite the significant achievements of Sri Lanka's primary healthcare system especially in maternal and child health and response to communicable diseases during the last few decades, formidable challenges caused by the demographic transition; increasing burden of NCDs, and emerging and reemerging communicable diseases still remain. In response to these emerging burdens of diseases, to achieve the United Nations health-related sustainable development goals (SDGs) and universal health coverage the government of Sri Lanka has decided to reorganize the primary healthcare delivery mechanism of Sri Lanka. Accordingly, The Ministry of Health has embarked on the Primary Health Care System Strengthening Project. A wide-ranging consultation process was initiated and the project design is essentially a home-grown model that comes under the banner- 'Reorganizing Primary Health care in Sri Lanka- Preserving our progress, Preparing our future'. This marks a significant turning point in the evaluation of Primary medical care services in Sri Lanka.

One of the key strategies identified in the PSSP is "Beneficiary engagement, gender, and citizen's voice.

3.1.3 Policy on Healthcare Delivery for Universal Health Coverage

Under 4 Policy Priority Areas 4.4 Citizen engagement and empowering the community for rational health-seeking behavior, under 5 Key Strategic Areas for Policy Implementation (Strategic Directions) -5.10 Changes in the demand through citizen engagement and improving health empowerment and health-seeking behavior. Under 7 Implementation Measures, 7.9 Citizen engagement and community participatory mechanisms will be fostered to ensure developments are client and community-centered.

3.1.4 National Health Performance Framework (NHPF) 2018

There has been a long-felt need to evaluate the health system performance at a national level and to facilitate the achievement of National Health Policy objectives. The National Health Performance Framework (NHPF) has been formulated to meet this need. NHPF is intended to act as a tool to facilitate the achievement of strategic objectives of the health sector by stimulating and guiding improvements in health service delivery.

The indicators of the NHPF that is relevant to citizens' engagement are; 1.2 Patient Experience: 32 – Institutions' responsiveness, 3.2 Governance: 64 - Hospitals with adverse event reporting mechanism, 65 - Customer Satisfaction Surveys.

NHPF is in line with the proposed Citizens' Engagement mechanism described below.

3.1.5 Charter of Patient's Rights and Responsibilities

The Charter of Patient's Rights and Responsibilities had been an initiative by a renowned Sri Lankan academic and public health activist late Prof. K.Balasubramanium. In 2008, following the universal principle of "Citizen's Charters"[2], Prof. Balasubramaniam and a group of health rights advocates presented to the then Minister of Health, the need to have legislation to implement a comprehensive and effective Charter of Patients' Rights and Responsibilities. The Sri Lanka Medical Association (SLMA), the People's Movement for the Rights of the Patients, and the Law and Society Trust contributed to the initiative by submitting content to the proposed Charter. The content of the proposed Charter included - the Right to Access to Healthcare Services and to Humane Treatment; the Right to Information, Consent, Privacy, and Confidentiality; the Right to Complain and Compensation, and the Right to Preventive Measures.

However, due to a multitude of reasons, the proposed Charter didn't see the light of the day, to the great disappointment of all parties who worked hard to introduce the charter.

10 years on, in 2018, there was a renewed interest in revisiting the original concept of a Patients' Charter. The Technical Sub-committee for Beneficiary Engagement and Citizen's Voice fully endorsed introduction of the Charter but as a Charter for Health with the content modified to address the present-day challenges and context. The Sectoral Subcommittee of the Parliament of Sri Lanka has taken over the responsibility to get views from all stakeholders and then legislate the Charter through the Parliament. Therefore, the proposed Charter will be a central tool for community engagement.

3.1.6 Open Government Partnership (OGP)

Open Government Partnership (OGP) brings together government reformers and civil society leaders to create action plans that make governments more inclusive, responsive, and accountable. Since 2015 Government of Sri Lanka has developed 2 National Action Plans (NAPs). In the current NAP, there are 2 health sector commitments namely; 1) Creating an integrated public interface for health information, 2) Improving Public Engagement in Primary Healthcare reforms.
This could be considered as an opportunity to build up the synergies in citizens' engagement process in health care services.

3.1.7 Right to Information (RTI) Act

Sri Lanka adopted the Right to Information (RTI) Act on the 4th of February 2017. The Act provides the right to access information held by public authorities and allows the complete or partial release of information held by the state. Public officials are allowed to disclose information requested by any citizen under the RTI unless it falls under one of the exemptions which protect interests such as personal privacy, national security, law enforcement, etc. Accordingly, accessible information includes printed documents, computer files, letters, emails, photographs, contracts, samples, models, and sound or video recordings.

The Right to information was established for transparency, government accountability, and general public protection against mismanagement and corruption together with the

intention of improving public participation in policymaking. In contrast, it is equally important that citizens should ensure the responsible and ethical use of information not only for the betterment of beneficiaries but also for the service providers

Sri Lanka Essential Health Service Package (2019)

This latest policy document which the MoH has released – the Sri Lanka Essential Service Package (ESP), is defined as "detailed lists of interventions or services on personal care, structured care, and endorsed by the government at the national level". ESP commits that "these services should be available to all, and provided free of charge to the users. ESP, therefore, is the set of preventives, promotive, and curative health services, including relevant medical goods, drugs, and technologies, which every person should have access to, regardless of their ability to pay for them."

ESP is an important strategy that could be leveraged by those responsible for CE and GRM.

3.2 Challenges for promoting community engagement

Compared to any time in the past, while there is overwhelming support for promoting community participation and citizen engagement in health services, there are also formidable challenges that are important to be recognized.

i) Poor relationship between the health care providers and the public/patients. (beneficiaries)
ii) Societal attitude towards health care providers as professionals who knows the best, such as medical paternalism.

4. Operationalizing Citizen Engagement

4.1 Current Mechanisms of community participation and citizens engagement in the health sector

Currently, community participation and citizen engagement programs are Properly institutionalized in approximately 550 PMCIs in Sri Lanka. Further, well-functioning Hospital Development Committees are found in secondary and tertiary care hospitals as well as a few Primary Care Medical Institutions (PMCIs).

4.2 Proposed Framework for Citizens Engagement.

i) "Friend of Facility**" Committee (FFC)**

It is proposed that, following the new model that is being introduced, each Primary Medical Care Institute (PMCI) (which consists of Primary Medical Care Units (PMCUs), Divisional Hospitals (DHs), and OPDs of Base, District General, and Teaching hospitals except for specialized hospitals, should have a "Friends of Facility" Committee. (PSSP Project Appraisal Document). The name of the Committee should be stated as "සුවසේවා මිතුරෝ" in Sinhala and "***சுகாதார சேவை நண்பர்கள்***" In Tamil.

ii) Objectives of the "Friends of Facility Committee"

Help the PMCI to strengthen responsive services, meeting the needs of the community that they serve, ensuring that the essential service package is delivered including those with special needs;

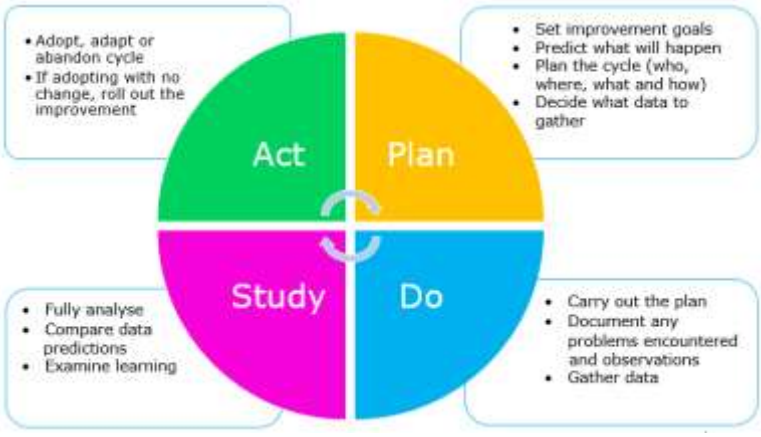
a. Help PMCI to mobilize and inform the community, raising awareness and demand for better community health services.
b. Help resolve grievances at the local level.

iii) role of the committee will be to:

a) Raise awareness and mobilize the community on health issues and help organize the community to effectively, optimally, and rationally use the services provided by the PMCI.
b) Engaged in Health Promotional activities in the community.
c) Serve as the main platform for community/community leaders to be a forum for active collaboration between the public and the Institution in improving health care services

d) Actively contribute to the optimal functioning of the PMCI.
e) Assist in planning and improving service facilities (clinic times, infrastructure, etc.) including PDSA cycle

PDSA cycle



f) Help mobilize resources to fulfill the needs of the hospital (through local philanthropists, the business community, NGOs, CSOs, CBOs, etc.)
g) Contribute to the effective functioning of the hospital – early identification of deficiencies and engaging constructively with the Head of the Institution to address the same.
h) Assess the health needs of the community on a continuing basis and be a link/bridge between the PMCI and the MOH to make the system respond to such needs and particularly those marginalized groups.
i) Implement projects to address identified health issues/needs that could be addressed through community engagement.
j) Members of the committee to act as change agents who will empower the community with correct knowledge and skills.
k) Assist in local emergency situations (outbreaks, disasters, etc.) (Ref. Disaster Preparedness Plan)
l) Help communities to access the GRM services at PMCIs and resolve grievances at the local level.
m) Identify the Health needs of the differently abled and elderly in the empaneled area and assist the PMCI to deliver services.

iv) Composition

The membership of the Committee shall consist of;

a) Head of the Institution
b) The Medical Officer of Health (MOH) for the area.
c) Public officers at the village level (GN, DO, EDO, PHI & PHM, etc.), and representatives from each of the Grama Niladhari (GN) Divisions served by the PMCI (empaneled area). These representatives should be strong community leaders with a demonstrable track record. There should be a substantial representation of women and youth.
d) Key religious leaders from the area reflecting the religious composition of the empaneled area.
e) representatives from professionals and the business community.
f) representatives from active CSO/NGOs.
g) Representatives from key disadvantaged groups

v) COMMITTEE MEMBER SELECTION PROCESS

There may be a Selection Committee if required and it is proposed that the selection committee should be chaired by RDHS of the area.

- DMO/MO-IC
- MOH
- Divisional Secretary
- A respected religious leader from the area
- A respected retired government servant

However, it is not compulsory to have such a selection committee if the members are easily found to establish the committee.

vi) PROCEDURE FOR CONDUCTING MEETINGS

1. Meetings of the Committee should be held regularly.
2. The Chairman of the Committee should be the head of the institution and Secretary should be elected by the members at its first meeting.
3. There will be a vice chairman elected by the committee from public representatives.
4. A member of the public should be the Honorary Secretary. A staff member shall be elected as the co-secretary for the purpose of maintaining documents, coordination, and convening.
5. Membership of the Committee will be two years at a time which can be renewed.
6. A member who has failed to attend three consecutive meetings without a valid reason would be deemed to have ceased to be a member of the committee.
   (Committee should work out a more detailed list of such procedures)
7. Other posts in the committee as required can be decided by the committee

vii) The FFC committee members shall have no right to:

(1) Involve/interfere directly in the administration and management of the PMCI. (i.e. give instructions to the hospital employees on any matter whatsoever).
(2) Expect priority or privileges in obtaining services from the PMCI.
(3) Collect or accept money for or on behalf of the PMCI without the prior approval of the Committee. If the committee so decides to raise funds for the activities of the Committee all transactions should be accounted for through accepted bank procedures and subject to auditing
(4) issue any public or press statements including social media on matters pertaining to the work of the FFC unless otherwise authorized by the committee.
(5) Permit any non-committee member of the public, press, etc. at committee meetings without the expressed permission of the chairman.

(6) If there is a violation, the member shall cease to be a member of the Committee through a common agreement.

Viii. Code of conduct

In order to ensure ethical practice when serving in the Friends of Facility committees' members shall require to follow a code of conduct which will be Agreed upon by the committee until an official code of conduct is published by the Ministry of Health in due course.

5. Reporting, Monitoring, and Evaluation

Process monitoring and Management

It is proposed that the Medical Services division of the Ministry of Health is designated as the apex body to coordinate the CE program from the PMCIs to district, provincial, and national levels. the additional sec MS in consultation with provincial and district health authorities will issue a result framework with measurable indicators for this purpose *(Annexure 01).* this tool will be reviewed and improved from time to time. It is recommended that a grievance coordinating unit (GCU) is operated at the Ministry to coordinate and manage the CE mechanism and grievances under additional secretory medical services. The following activities are proposed to be coordinated.

- Training and capacity building (including designing curricula for training and orientation program health staff and also the members of the FFC)
- Collecting information on best practices and disseminating them to inspire successful interventions happening at the PMCI level.
- Implementing a suitable appraisal program and organizing an Annual Awards ceremony to recognize the best FFCs (This could be first held at the district and provincial levels and then at the National level).
- District FFC at RDHS level and a national FFC movement will be established in due course. These organizations should be considered as official health consumer organizations in appropriate instances.

PART 2

6. Grievance Redress Mechanism (GRM)

6.1 Introduction

It has been universally accepted that information from patient complaints – a widely accepted measure of the patient-provider relationship, can lead to significant improvements in the quality and performance of health services.[3]

While the Community Engagement process is institutionalized through the "Friends of Facility Committees" mechanism, the Ministry of Health has also taken a policy decision to establish a mechanism to receive public complaints and grievances in relation to public and private sector health services. Currently, MoH has established a GRM with a digital platform, short code telephone connection (1907) SMS, and WhatsApp facilities.

Goal: Improve the responsiveness, accountability, and trust between the community and the primary care service provider.

Objectives of the GRM

1. To improve the quality and performance of PMCIs.
2. To build trust and a sense of partnership between the communities served by the PMCIs and health staff.
3. To serve as a public relations mechanism.
4. To safeguard the rights and responsibilities of patients/citizens receiving care from PMCIs.

6.2 Proposed Operational Structure of GRM

There shall be a set of guidelines on administering the GRM by the Ministry of Health through a grievance Coordinating unit. {GCU}

6.2.1 The key functions of this GCU will be to;

1. *Monitor the GRM from PMCI to the national level*
   This would involve

i) Compiling regular reports (through the IT platform) by each PMCI, RDHS, PD, and national level. The "Dashboard" will be accessible by the designated officers of the MoH to check the status online.

ii) Monthly reports will be sent to the assigned officer in the Ministry for information and further action if necessary.

2. *Staff needing GRM Training*

As there will be designated staff (Medical Officers/ Nursing Officers/ Development Officers/ Management Assistants) working at different levels, the GRU will provide regular guidance and support mainly on technical matters and ensure smooth functioning of the system.

3. *Training and capacity of all staff involved in the GRM*
   As a formal GRM is a new introduction to the health care system in the country, the GRU will provide training and/or orientation to all administrative and management staff including MO-ICs/DMOs and district and provincial staff. The content will include the basic structure of the system, total management of the GRM from the point of receipt of suggestion/complaint to the final resolution, and the technical aspects related to the GRM IT platform
4. *Managing public awareness campaigns on the GRM*
   As GRM is a new introduction in the health care delivery system in Sri Lanka, the public and the patients should be fully informed and aware of the objectives and the way GRM works.
5. *Managing the IT platform/ technical standards including a tracking system/"Dash Board"*
   A robust IT platform has been developed to receive and manage suggestions/complaints. As the suggestions/complaints receiving modes of the GRM will include multiple channels (described below), the system needs to be comprehensive, robust, and also importantly – user-friendly.
6. Maintaining a "Hotline" – the "Hotline" (1907) is maintained centrally to receive public inquiries, suggestions, and complaints, as all members of the public do not have online access to use social media. The hotline is available during normal working hours.

6.3 Communications strategy for informing the public

Each PMCI should display posters prominently along with a mechanism for receiving Suggestions/Complaints etc. The communication strategy of the PSSP already consists of campaigning this GRM. In addition, this has been identified as one of the key functions of "Friends of Facility" committees described in part I of this guideline.

6.4 Standard Operational Definitions

Complaint: "A Statement that something is unsatisfactory or unacceptable"

Grievance: "A feeling of resentment over something believed to be wrong or unfair"

Suggestion: "An idea or a plan put forward for consideration"

Redress: "Remedy or set right an undesirable condition or unfair situation"

6.5 Modes of filing a suggestion/complaint:

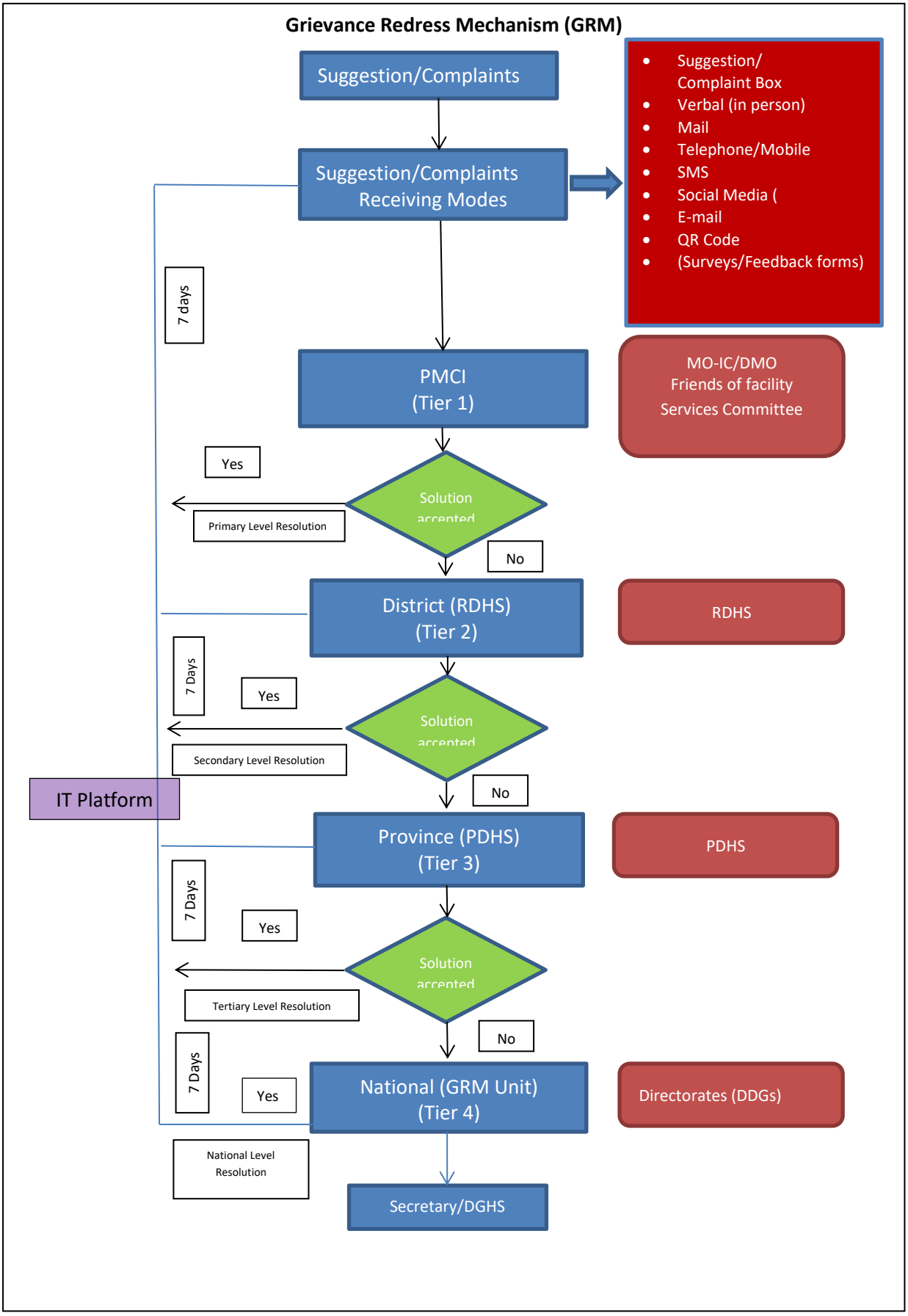
The Ministry of Health has established an electronic grievance handing flatform with specified hierarchical layers of mediation. A suggestion/complaint can be made through multiple channels.

Figure 1: communication modes

- Suggestion/Complaint Box
- Verbal (in person)
- Mail
- Telephone/Mobile
- SMS
- Social Media
- E-mail
- QR code
- (Surveys/Feedback forms)

There is a 4-tiered structure to manage complaints and suggestions. (Figure 1.0 – Grievance Redress Mechanism)

Figure 1: Proposed operational structure for GRM



6.6 The institutional responsibilities for operating, supervising, and reporting of GRM

Tier 1 - At the PMCI Level

This is the first point of contact for the public with health care delivery services. The aim is to resolve this at the facility itself and as quickly and amicably as well. It is proposed that a staff focal point/ representative is assigned in each PMCI to receive and investigate complaints. As soon as a complaint gets lodged, the assigned officer shall attempt to resolve it as quickly as possible. An immediate investigation is instituted that involves an oral and first-line response. If the complaint cannot be resolved on the spot, it will be referred to the head of the PMCI concerned. It is proposed that the MO-IC or the DMO or his/her appointee must be the Complaints Manager of the facility who will investigate and initiate redress.

At the institutional level, all positive activities should be initiated to resolve the complaint within 7 days. If the response is accepted by the complainant the matter is closed. If not, the suggestion/complaint will be directed to the next level – Tier 2 (District Level).

A patient or a member of the public can also lodge the suggestion/complaint directly at the Tier 2 level if he/she believes that the suggestion/complaint may not receive appropriate action at the PMCI level given the particular nature of the suggestion/complaint.

Tier 2 – **At District Level**

At this Tier, The Regional Director of Health Services (RDHS) through a designated unit will heed complaints. The RDHS is expected to respond within 7 days and if the response is accepted by the complainant the matter is closed. In the event of no response or dissatisfaction with how the complaint was managed; the complainant is entitled to take the matter to the Tier-3 Provincial Level.

Tier 3 – Provincial Level

The Provincial Director of Health Services (PDHS) or the designated officer will review and investigate the complaints he/she received. He /She is expected to resolve the issue within 7 days. If the response is accepted by the complainant the matter is closed. If not, the matter will be transferred to the central-level GCU.

Any complaint that relates to the PMCIs/District/Provincial rendering of services received directly by the GCU at the central level will first be channeled to the relevant level and the same procedure will be followed.

Tier 4 – National Level

At the National Level, MOH has established a designated unit – Grievance Coordinating Unit (GCU) with full-time staff to manage the total GRM under the office of Additional Secretary – Medical Services

6.7 Confidentiality, Supervision, and Reporting

1. Confidentiality of all suggestions and complaints shall be maintained as and when required, by assigning a designated authority for access at each level.
2. All manual documents shall be kept under lock and key by MO-IC/DMO at the PMCI level.
3. The IT platform will have security controls built into the system following the access authority levels protocol.
4. It is recommended that Quarterly Reports in the form of a summary of suggestions/complaints and follow-up actions, be submitted by the PMCIs at Review Meetings at RDHS and at PDHS levels.
5. At the National Level, the GCU will prepare regular reports (monthly/quarterly etc.) and submit to relevant officers and agencies as and when necessary, through additional secretory medical services.

Annexure 01

Result framework for community engagement (FFCs)

01. To consider an active FFC, Each FFC should be conducted a minimum of 4 meetings per annum and their minutes should be available in a standard format. (Any language can be used). The minutes need to be signed by the honorary president and secretary. And also, must be signed by the head of the institution.
02. The following suggested activities can be carried out by the committee.
    - infrastructure development
    - renovation and upgrading
    - community engagement and prevention of diseases
    - exercise and physical activity promotions
    - contribution to the NCD screening
    - contribution to the mobile clinic
    - donation of medical and non-medical equipment
    - donation of drugs and printing support
    - innovative ideas and implementation
    - cleaning, shramadhana campaign, and gardening

if any raised activities by the committee they are allowed to conduct with the permission of relevant authorities.