Public Disclosure Authorized

Islamic Republic of Pakistan

National Health Support Program (P172615)

Public Disclosure Authorized

Environmental and Social Systems Assessment

Table of Contents

EXECUTIVE SUMMARY 5

I. INTRODUCTION 6

A. Environmental and Social Systems Assessment: Purpose and Objectives 6

B. ESSA Methodology 7

II. PROGRAM DESCRIPTION AND POTENTIAL ENVIRONMENTAL AND SOCIAL EFFECTS 8

A. Country Context 8

B. Sectoral and Institutional Context 9

C. Relationship to CPS/CPF 10

D. Rationale for Bank Arrangement and Choice of Financing Instrument 10

E. Bank Financed PforR Program Scope, Objectives and Key Result Areas 11

Environmental and Social Effects of the Proposed Program 15

III. ASSESSMENT OF ENVIRONMENTAL AND SOCIAL SYSTEMS AND IMPLEMENTATION CAPACITY 19

A. Introduction 19

B. Core Principle 1 – Environmental and Social Management 20

C. Core Principle 2 – National Habitats and Physical Cultural Resources 29

D. Core Principle 3 – Public and Worker Safety 29

E. Core Principle 4 – Land Acquisition 34

F. Core Principle 5 – Indigenous Peoples and Vulnerable Groups 34

G. Core Principle 6 – Social Conflict 35

IV. DISCLOSURE AND CONSULTATION 36

A. Disclosure 36

B. Stakeholder Consultations 36

C. Summary of the Stakeholder Consultation 36

V. INPUTS TO THE PROGRAM ACTION PLAN 37

A. Introduction 37

B. Recommendations to be Included in the Program Action Plan 38

Annex-1: References 41

Annex-2: Pollutants from Medical Waste Incinerators **42**

Annex-3: Proceedings of the Stakeholder Consultation Workshop held in February 2022 ...... **43**

Annex-4: Profiles of Stakeholder Institutions **48**

Annex- 5 Description of Environmental and Social Management System and Capacity and Performance Assessment **62**

Annex- 6 Grievance Redress and Citizen Engagement **76**

Annex- 7 Questionnaires for Capacity Assessment of Stakeholder Institutions **81**

Annex- 8 List of Participants for Stakeholder Consultation held in February 2021 ...... **89**

ABBREVIATIONS

CERP	Center for Economic Research Pakistan
DLI	Disbursement Linked Indicator
DLR	Disbursement Linked Result
DPT	Diphtheria-Pertussis- Tetanus
ESMP	Environmental and Social Management Plan
ESSA	Environmental and Social Systems Assessment
EPA	Environmental Protection Agency
FBFP	Facility based focal point
FLH	First Level Hospital
GRM	Grievance Redressal Mechanism
HANDS	Health and Nutrition Development Society
IPF	Investment Project Financing
LHW	Lady Health Worker
LHWP	Lady Health Worker Programme
NISP	National Immunization Support Program
MoNHSRC	Ministry of National Healthcare Services, Regulation and Coordination
MOU	Memorandum of Understanding
MNCH	Maternal Newborn and Child Health
NHSP	National Health Support Project
OP	Operational Policy
PforR	Program-for-Results
PFM	Public Financial Management
PHC	Primary Health Care
RSPN	Rural Support Programme Network
SOP	Standard Operating Procedure
SPRC	Social Protection Resource Centre
UHC	Universal Health Coverage
WASH	Water, Sanitation and Hygiene

EXECUTIVE SUMMARY

Pakistan's healthcare system is fragmented and has many overlapping public and private sector stakeholders. The National Health Support Program (NHSP) will tackle a number of systemic issues including an insufficient, underutilized, and underperforming health workforce, and the shortage of essential medicines, family planning commodities, and supplies at the Primary Health Care (PHC) provider level.

The proposed National Health Support Program (NHSP) utilizes a Program for Results (PforR) instrument, the first in the health sector in Pakistan. The PforR is the most suitable lending instrument given the Government's Universal Health Care (UHC) program and associated reforms, the recurrent nature of the expected health expenditures, and improvements in the government's capacity, as witnessed through the National Immunization Support Project (NISP). NISP, which has been under implementation since 2016, is an Investment Project Financing (IPF) with Disbursement Linked Indicator (DLIs). NISP's success, in particular its focus on results, has provided the health authorities at both national and provincial levels with experience in, and knowledge of, results-based operations. Furthermore, Pakistan has demonstrated an effective use of the PforR instrument in other sectors, such as Education and Public Financial Management (PFM).

The program activities will be grouped around three results areas. Result area 1 would tackle some of the key binding constraints to equitable coverage and quality of essential services, such as the ad hoc referral system between primary health care (PHC) and first-level hospitals (FLHs), and low supply side readiness, particularly in remote and lagging areas, such as shortages of skilled staff and health workers, stock-outs of commodities, medicines, and supplies, and poor infrastructure with limited infection prevention and control. Result area 2 would strengthen governance and accountability at the PHC level, in particular in the context of a decentralized health system with a mixed public-private service delivery model. Result area 3 focuses on strengthening health financing and PFM. In addition to low spending on health, it would take on PFM challenges in budget planning and allocation, disbursement, and financial reporting at lower levels of care.

The ESSA concludes that health sector Environmental and Social systems in terms of policies and procedures are adequate for Program implementation, but are lacking in human and financial resources, especially for monitoring of activities in rural and remote regions and engaging with private sector providers.

Recommendations for input into the Program Action Plan include: 1) MOUs with healthcare providers on environmental and social management issues; 2) Development of multimodal communication campaigns to increase the demand for PHC services; 3) Strengthening of Grievance Redressal Mechanisms (GRM); 4) Enforcement of the Hazardous Substances Rules and Hospital Waste Management Rules at Primary Healthcare Facilities by the Health Departments; 5) Healthcare waste to be handed over to licensed healthcare providers and 6) Implementation of Standard Operating Procedures for PHCs

I. INTRODUCTION

A. Environmental and Social Systems Assessment: Purpose and Objectives

1. **This Environmental and Social Systems Assessment (ESSA) has been prepared by the World Bank ESSA Team for the proposed National Health Support Project (NHS**P), which will be supported by the World Bank's Program for Results (PforR) financing instrument. In accordance with the requirements of the World Bank Policy Program-for-Results Financing (PforR Policy), PforR relies on country-level systems for the management of environmental and social effects[1]. The PforR Policy requires that the Bank should conduct a comprehensive ESSA to assess the degree to which the relevant PforR program's systems promote environmental and social sustainability and to ensure that effective measures are in place to identify, avoid, minimize, or mitigate adverse environmental, health, safety, and social impacts. ESSA based on comprehensive assessment makes recommendations to enhance environmental and social management within the program as part of the overall management action plan.

2. **The main purpose of this ESSA is to**: (i) identify the program's environmental and social effects, (ii) assess the legal and policy framework for environmental and social management, including a review of relevant legislation, rules, procedures, and institutional responsibilities that are being used by the program; (iii) assess the implementing institutional capacity and performance to date to manage potential adverse environmental and social issues; and (iv) recommend specific actions to address gaps in the program's environmental and social management system, including with regard to the policy and legal framework and implementation capacity.

3. **The ESSA Team assessed the arrangements, within a program, for managing environmental and social effects** in a manner consistent with Operational Policy/Bank Procedure (OP/BP) 9.00, *Program for Results Financing*. This policy sets out core principles and key planning elements intended to ensure that PforR operations are designed and implemented in a manner that maximizes potential environmental and social benefits, while avoiding, minimizing, or otherwise mitigating environmental or social harm. The Core Principles are listed below. These are further defined in detail through corresponding Key Planning Elements that are included under each Core Principle in Section V.

(a) **Core Principle 1: *Environmental and Social Management***: Environmental and social management procedures and processes are designed to (a) promote environmental and social sustainability in program design, (b) avoid, minimize, or mitigate against adverse impacts; and (c) promote informed decision making relating to a program's environmental and social effects.

(b) **Core Principle 2: *Natural Habitats and Physical Cultural Resources:*** Environmental and social management procedures and processes are designed to avoid, minimize, and mitigate any adverse effects (on natural habitats and physical cultural resources) resulting from the program.

(c) **Core Principle 3: *Public and Worker Safety*:** Program procedures ensure adequate measures to protect public and worker safety against the potential risks associated with (a) construction and/or operations of facilities or other operational practices developed or promoted under the program and (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials

[1]"Effects" is used throughout this report to refer collectively to benefits, impacts, and risks. The subsumed terms are used where necessary to focus on specific topics or issues. The term "benefits" include positive impacts, and the term "impacts" refer to adverse or negative consequences.

(d) **Core Principle 4: *Land Acquisition***: Land acquisition and loss of access to natural resources are managed in a way that avoids or minimizes displacement, and affected people are assisted in improving, or at least restoring, their livelihoods and living standards.

(e) **Core Principle 5: *Indigenous Peoples and Vulnerable Groups***: Due consideration is given to cultural appropriateness of, and equitable access to, program benefits, giving special attention to the rights and interests of indigenous peoples and to the needs or concerns of vulnerable groups.

(f) **Core Principle 6: *Social Conflict:*** Avoid exacerbating social conflict, especially in fragile states, post conflict areas, or areas subject to territorial disputes.

4. An additional purpose of this ESSA is to enable informed decision making by the relevant authorities in the borrower country and to aid the Bank's internal review and decision process associated with the NHSP. The findings, conclusions and opinions expressed in this document are those of the World Bank. The recommended actions that flow from this analysis have been discussed and agreed with the Economic Affair Division counterpart and will become legally binding agreements under the conditions of the new loan.

B. ESSA Methodology

5. **The World Bank undertook the following actions as part of the assessment from November 2021- January 2022**: (a) a comprehensive review of government policies, legal frameworks and program documents, and other assessments of the provincial health departments' environmental and social management systems (b) consultations were done with relevant experts and officials from the Ministry of National Health Services, Regulations and Coordination (MoNHSRC), Department of Health, Sindh (DH-S), Primary and Secondary Health Care Department, Punjab (PSHD), Department of Health, Balochistan (DH-B), and Department of Health, Khyber Pakhtunkhwa (DH-B).

6. **This report is prepared by the World Bank staff and consultants** through a combination of reviews of existing program materials and available technical literature, interviews with government staff, and consultations with key stakeholders and experts. Findings of the assessment will be used in the formulation of an overall Program Action Plan (PAP) with key measures to improve environmental and social management outcomes of the program. The findings, conclusions, and opinions expressed in the ESSA document are those of the World Bank. Recommendations contained in the analysis were presented and discussed during the meetings with the program implementing departments before finalization and disclosure of the ESSA.

7. **The ESSA review process seeks to describe and assess the systems for managing environmental and social effects of a proposed program**. The World Bank drew on a wide range of data, sources, and inputs during the ESSA review process, including the following actions:

a) **Assessment of the environmental and social effects of the program**: The ESSA Team assessed the potential for the program to cause adverse environmental and social effects, either due to its design and program components or due to gaps in program systems.

b) **Comprehensive desk review of policies, legal framework, program documents, and other assessments** of environmental and social management systems: The review examined the set of national/provincial policy and legal requirements related to environment and social management

associated with the activities described under the program components. The review also examined technical and supervision documents from previous and ongoing World Bank projects and programs whereby ESSA's were produced.

c) **Institutional analysis**: An institutional analysis was carried out to identify the roles, responsibilities, and structure of the relevant institutions responsible for implementing the NHSP funded activities, including coordination between different entities at the national, provincial, and local levels. The assessment of the capacity of key institutions to implement required environmental and social management actions was assessed. The stakeholder institutional profiles and organograms are provided in **Annex 4** and a detailed environmental and social capacity analysis is attached at Annex 5 along with the questionnaires employed at **Annex 7**. An important input for this assessment was an evaluation of these institutions' previous track record in management of such risks in the context of previous projects and programs.

d) **Consultations and interviews**: Consultations were done with relevant experts and officials from the Ministry of National Health Services, Regulations and Coordination, Department of Health, Sindh, Primary and Secondary Health Care Department, Punjab, Department of Health, Balochistan, and Department of Health, Khyber Pakhtunkhwa, through a joint consultation session held in October 2021. The primary purpose of the consultative session was to orient the Government departments on the Environmental and Social Standards applicable to the project. In particular the process for the preparation of the ESSA was also discussed and the Ministry and provincial health departments were informed about capacity assessment questionnaires prepared by the team. These questionnaires are attached at **Annex 7**. A stakeholder consultation workshop was held in February 2022 attended by representatives of NGOs and CSOs working in the health sector. The proceedings of the workshop are attached at **Annex 3** and the list of participants is provided at **Annex 8**.

II. PROGRAM DESCRIPTION AND POTENTIAL ENVIRONMENTAL AND SOCIAL EFFECTS

A. Country Context

8. **Pakistan has made significant progress over the last two decades towards reducing poverty.** The expansion of off-farm economic opportunities, and the increase in migration and associated remittances allowed over 47 million Pakistanis to escape poverty between 2001 and 2018. Nonetheless, challenges for inclusive growth remain, systematically related to spatial disparities and deficits in human capital endowment, and access to services and opportunities. Human capital outcomes are poor and stagnant, with high levels of stunting at 38 percent and learning poverty at 75 percent. Growth of per capita gross domestic product (GDP) has also been low, averaging only around 1.8 percent annually.[2] Economic growth in Pakistan has historically been fueled by private and government consumption, with productivity-enhancing investment and exports contributing relatively little. Furthermore, consumption-led growth has been associated with frequent macroeconomic imbalances. Achieving sustained higher economic growth is important for Pakistan to reduce inequality and increase shared prosperity.

9. **Over the next decade, Pakistan is projected to face a greater frequency and intensity of extreme climate events, such as heatwaves, river and coastal flooding, landslides, and drought, placing a greater disaster risk and health burden on the population, particularly on poor and other vulnerable groups.** These changes are expected to reduce production of key food and cash crops and lead to higher temperatures, thereby increasing the risk of heat-related

[2] World Bank. 2022. Pakistan Development Update: Financing the Real Economy. April. Islamabad: World Bank.

sickness and death. Changing temperature and precipitation patterns will also affect vector- and water-borne diseases such as malaria, dengue, and diarrhea. Pakistan Climate and Health Vulnerability Assessment (CHVA) elaborates on the climate exposures and consequent health impacts.

B. Sectoral and Institutional Context

10. **Pakistan has witnessed a substantial improvement in health outcomes over the past decade, but at current trends, it is unlikely to meet most of the 2030 health-related Sustainable Development Goals (SDGs).** Life expectancy increased from 60 years in 1990 to 65 years in 2020; it remains, however, among the lowest in the South Asia Region. Progress on reproductive, maternal, and child health has also been inadequate, as evidenced by a low contraceptive (modern methods) prevalence rate among married women (25 percent in 2017/18),[3] high levels of stunting (38 percent in 2018) and elevated neonatal mortality (41 deaths per 1000 live births in 2019). Only 76 percent of children between 12 and 23 months have received a third dose of diphtheria, pertussis, and tetanus (DPT) vaccination, compared to 90 percent for the South Asia Region. Furthermore, Pakistan is also one of the two countries where polio remains endemic.

11. **Human capital continues to lag.** According to the Human Capital Index (HCI), a child born in Pakistan is expected to be only 41 percent of his or her potential given the risks of poor health and education prevalent today (HCI 2020). This is lower than the average for the South Asia Region (48 percent) and the Lower-middle income countries (LMICs) (47 percent). Moreover, the national level HCI hides the vast provincial differences; Punjab with 42 percent, Khyber Pakhtunkhwa (KP) 39 percent, Sindh 36 percent, and Balochistan 32 percent.

12. **Exacerbating the already low human capital accumulation, the COVID-19 pandemic has further weakened and strained the public health system.** Pakistan has witnessed repeated waves of COVID-19 infections. The infections and the containment measures impeded the delivery of essential health services due to supply chain disruptions and redeployment of health care workers; concurrently, restrictions on movement, lost income and fear of infection deterred people from seeking care they needed. Based on global simulations for education and child mortality, the pandemic could well erase eight years of progress on human capital (2 HCI points), with likely greater implications for the poor and/or vulnerable.

13. **Disparities—across socioeconomic groups and geography—remain stark**. The poor are being left behind; for example, the fourth wealth quintile sees 34 neonatal deaths per 1,000 live births, while the lowest quintile sees 51 deaths per 1,000 live births. Provincial differences in health outcomes and access to health services is vast (Table 1).

14. **Per the 18th Constitutional Amendment, health became a devolved subject in 2010, whereby the provinces finance and deliver health services for their populations.** The provinces, under the leadership of the Health Departments, are responsible for the stewardship of their own health sector, assuming the responsibility for priority setting, strategy development, regulation, and management of vertical programs and federally funded facilities and initiatives. At the federal level, the Ministry of National Health Services, Regulations and Coordination (MoNHSR&C) is responsible for the country's adherence to international commitments and for the overall coordination with and across the provinces, drug licensing, registration, and pricing, export/import of goods, and overseeing the professional councils, such as the Pakistan Medical Commission and the Pakistan Nursing Council.

15. **Pakistan's public health system is extensive.** The public sector comprises of five administrative levels (Community, Union Council, Tehsils, Districts, and Federal/Provinces) and five levels of

[3] Demographic and Health Survey, 2017–18.

health care (Population, Community, primary health care (PHC), First Level Hospitals, Tertiary Hospitals) that provide preventive, promotional, curative, and rehabilitative healthcare services. Preventive and promotive services are primarily delivered through the public health system at the population, community, and PHC facility level (i.e., Rural Health Centers, RHCs, and Basic Health Units, BHUs), whereas curative and rehabilitative services are predominantly provided at secondary and tertiary hospitals and in the private sector. There are more than 90,000 Lady Health Workers (LHWs) in Pakistan, which are a linchpin of all community-based healthcare services, especially in rural areas. They are supported by vaccinators and community midwives for outreach services.

16. **The private sector plays a large role in health care delivery.** The private health sector consists of diverse healthcare facilities ranging from more than 700 small and medium sized hospitals, 73,650 private healthcare institutions, tertiary care hospitals with more than 65,000 hospital beds, and thousands of pharmacies, laboratories, and diagnostic centers. Private health service providers include doctors, nurses, paramedical staff, laboratory personnel, pharmacists, and drug sellers in the formal sector, traditional healers, homeopathic doctors, as well as unqualified practitioners in the informal sector. Most private hospitals, clinics, and health-related facilities are situated in urban areas with high population clusters and are well equipped with modern diagnostic facilities while their numbers are considerably lower in rural areas. The care provided by the private sector largely goes unregulated. Sindh has the highest concentration and utilization of private providers in Pakistan. Furthermore, the Governments of Sindh and Balochistan have contracted-out the management of PHC facilities to non-profit organizations, while KP is in the process of outsourcing PHC facilities through the KP Health Foundation.

C. Relationship to CPS/CPF

17. **The proposed operation is well-aligned with Pakistan's World Bank Group Country Partnership Strategy FY15–19, namely the results area on service delivery, covering sub-results areas of 4.1. improved public resources management and 4.2. improved access to MCH health services.** The strategy was discussed at the Board on May 1, 2014 (Report No. 84645-PK) and was extended through FY21. It has been further extended during the COVID-19 crisis and remains in effect at the present time. A new Country Partnership Framework is currently under preparation, backed by findings of numerous analytical works, including the Systematic Country Diagnostic and Pakistan@100 report, which focuses on necessary reforms required for Pakistan to become an upper-middle-income country by 2047. These analytics highlight that Pakistan has still to achieve basic developmental goals in health and education, with stark implications for productivity growth and socioeconomic inclusion.

D. Rationale for Bank Arrangement and Choice of Financing Instrument

18. **The proposed National Health Support Program (NHSP) utilizes a Program-for-Results (PforR) instrument, the first in the health sector in Pakistan.** The PforR is the most suitable lending instrument given the Government of Pakistan's (GoP) UHC program and associated reforms, the recurrent nature of the expected health expenditures, and improvements in the GoP's capacity, as witnessed through the IDA and grant-financed National Immunization Support Project (NISP) (P132308), which include federal ministry and the four provincial governments. NISP, under implementation since 2016, is an Investment Project Financing (IPF) instrument with Disbursement Linked Indicator (DLIs). NISP's success, in particular its focus on results, has provided health authorities at both National and Provincial Levels with experience in, and

knowledge of, results-based operations. Furthermore, Pakistan has demonstrated an effective use of the PforR instrument in other sectors, such as Education and PFM.

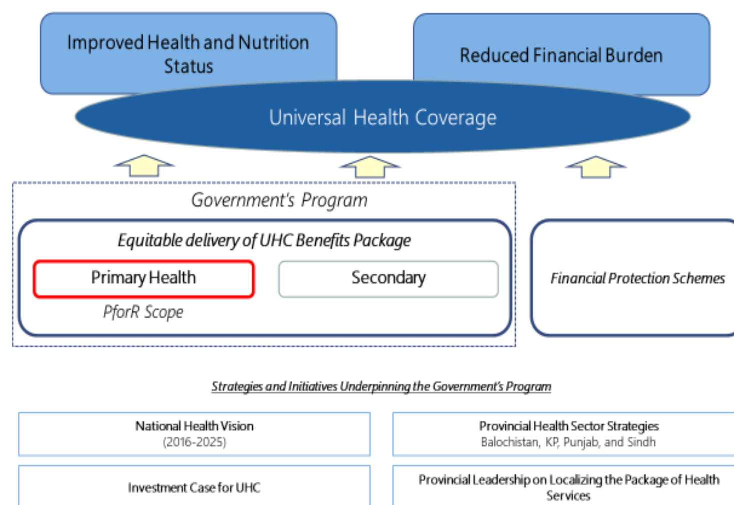
19. **The results-based financing would be complemented by an IPF component, estimated at about 15 percent of the total financing under this operation.** This component would also be managed by the Health Departments in the provinces and the MoNHSR&C to mobilize technical assistance (TA) in a timely manner, support coordination, build institutional capacity, and manage the program's environmental and social (E&S) risks.

E. Bank Financed PforR Program Scope, Objectives and Key Result Areas

20. **The proposed NHSP would be national in scope, intended to benefit the MoNHSR&C and the provinces of KP, Punjab, and Sindh.** It aims to support the GoP's UHC program, which focuses on the implementation of the UHC BP at the primary and secondary care levels. As the provision of health care is decentralized, the proposed NHSP would support the provincial governments to strengthen the equitable delivery and quality of essential PHC services.

21. **The provinces of KP, Punjab, and Sindh have been appraised as ready to participate in the Program, whereas Balochistan would be provided with an opportunity to join at a later time when the clearances have been processed and the financing agreed upon.** At that time, an additional financing would be submitted to the consideration of the WB Board of Executive Directors, and grant financing for the consideration of donors.

Figure 1. Government's Program and NHSP Program Scope



22. **The proposed Program Development Objective (PDO) is to strengthen equitable delivery and quality of essential health services at the primary health care level, in support of UHC**. The proposed PDO level results indicators are as follows:

- UHC SCI (adjusted to reflect essential health services at PHC level) (Percentage)
- Use of modern contraceptives prevalence among women of reproductive age (Percentage)
- Effective coverage of antenatal care (ANC) (Percentage) Non-salary budget for PHC (Percentage)
- Non-salary PHC budget

C. The Results Framework consists of three Results Areas, under which DLIs are grouped. DLIs are presented in a table below, outlining the indicator, theory of change, and the equity and gender considerations.

Results Area 1: Improving coverage and quality of essential health services
RA1.1. ***PHC facilities meeting essential health services delivery norms, including in lagging areas, and addressing climate risks (DLI 1)***
The norms and standards, such as MSDS, exist but they have not been reviewed and updated to be in line with the prioritized UHC package or EPHS. This DLI focuses on ensuring that key inputs (e.g., staffing, including female providers, medicines, commodities, vaccines, WASH, supplies for HCW management, etc.) are in place at the PHC facilities and community level to deliver this package. Furthermore, it institutionalizes the implementation of the service delivery norms, the routine assessment of readiness of the facilities and communities, and the use of this data for planning and investment decisions. This would also complement the Health Care Commissions in undertaking an important task of licensing public and private health care facilities. **Equity and Gender Consideration:** Supply side readiness and gender equity are greater challenges in remote and disadvantaged areas. Therefore, the DLRs would explicitly include a share of the progress of PHC facilities taking place in lagging areas. In addition, the norms include availability of essential female staff, as well as medicines and commodities (including for FP), which are essential for RMNCAH and nutrition services. **Climate Action:** See Table 7.
RA1.2. ***PHC providers delivering quality essential health services, including in lagging areas (DLI 2)***
Scope of work, competencies, and skills of PHC providers have not been updated or aligned with the delivery of UHC benefits package or EPHS. PHC providers include those at the community level (e.g., vaccinators, LHWs) as well as those attached to the BHUs and RHCs. Select essential health services are based on prioritized set of services that include immunization, FP, maternal and newborn care, mental health, and nutrition counseling. This DLI would focus on clarifying the scope of work and aligning with it the improved competencies and skills of front-line providers to deliver these services, which include skills related to gender-sensitive communications and counseling (e.g., use of destigmatizing and non-discriminatory language). It also goes beyond ad hoc training, by institutionalizing competency-based training and focusing on improvements of providers in adhering to protocols and guidelines. This DLI complements DLI 1.1 to ensure that providers at the community and facility levels are not only available but also are competent. The competencies and skills framework would also apply to contracted private providers, and modules and tools to be shared with other private sector stakeholders. **Equity and Gender Consideration:** DLRs would explicitly include a share of the progress among providers in lagging areas, defined by zero-dose or UHC SCI. Gender competency, such as in communications and counseling about reproductive and sexual health issues, will be incorporated into the competency-based training curriculum and modules related to prioritized set of services. **Climate Action:** See Table 7.
RA1.3. ***Timely and appropriate referral between PHC level and higher levels of care, including in lagging areas (DLI 3)***
A referral system between primary, including community level, and secondary/tertiary care, complemented by emergency transportation, would support the delivery of UHC benefits package. It is critical for timely appropriate care; for example, pregnant women, who need emergency obstetric and neonatal care, or a severely malnourished child. A functioning referral system also

produces timely data for follow up, would also improve efficiencies, and increase trust in the health system. The referral system would expand in a phased manner to include private providers.

Equity and Gender Consideration: Remote and lagging areas would benefit greatly from a functioning referral system. Referral protocols would incorporate gender issues related to mobility and security.

RA1.4. ***TB case notification rate (DLI 4)***

The number of TB cases diagnosed and reported within the provincial surveillance system, and then notified onwards to the World Health Organization (WHO), demonstrates the impact of system-wide improvements in case detection and notification, and signals the importance of addressing infectious diseases, and TB in particular, to the province. The number of TB cases detected can be tracked using data routinely collected and reported. This DLI provides a robust incentive—the ambitious targets can only be achieved by increasing the contribution of public and private sector providers, and community case detection, to the total provincial TB case notification. This DLI will incentivize community case reporting through LHWs.

Equity and Gender Consideration: Geographic equity will not be assessed in the results, as Provincial TB Strategic Plans do not include district-level targets; however, district and gender disaggregated data will be collected. Ambitious overall case notification targets are to be achieved through new programs of community case reporting through LHWs. LHWs have the potential to address inequities in TB detection and treatment.

RA1.5. ***Average provincial coverage of Penta-1 and coverage of fully immunized children (FIC) in lagging areas (DLI 5)***

The NHSP would continue to sustain progress made under the NISP and address remaining gaps. Although national Penta-1 coverage is high, Pakistan has many zero-dose children (fourth highest in the world) who continue to be left out of immunization services; without clear incentives to reach the un-reached, these communities and children will continue to be missed. Pakistan has a high rate of drop-out, nationally, and sub-nationally—this must be addressed to fully protect all children, including those newly brought into the system as part of the zero-dose agenda. Therefore, a two-component indicator of Penta-1 and FIC is being proposed to allow incentivizing both elements. Tracking this indicator through routine dashboard review and geo-localized case tracking will help improve immunization outcomes on both parts of the indicator.

Equity and Gender Consideration: Lagging areas would be explicitly included in the achievement. Gender disaggregated data to be collected. **Climate Action:** See Table 7.

Results Area 2: Enhancing governance and accountability

RA2.1. ***Health information systems strengthened through greater integration and use of dashboard, including in lagging areas (DLI 6)***

One of the PHC systems bottlenecks is fragmentation of information systems. Strategic plan and vision for moving towards an integrated information system that produces standardized quality data is essential. Such improvements in data quality, timeliness and completeness instill trust in users of data (Directorate General Health Services (DGHS), provincial, district, facility managers and providers), which will have recursive effects in improving further quality improvement and use of data. Integrated dashboards facilitate ease of use through data visualization. Governance and accountability through use of dashboards (integrated data) by key provincial and district authorities ensure problems are identified early, remedial action plans formulated and follow up tracked at subsequent reviews. Birth registration reporting to be included in the dashboard.

Equity and Gender Consideration: Lagging areas would be explicitly included in the achievement. Gender and equity responsive indicators to be integrated in dashboards. **Climate Action:** See Table 7.
RA2.2 ***PHC facilities reporting reductions in stock outs of select FP and nutrition commodities and essential drugs/medicines, including in lagging areas (DLI 7)***
Aligned with the UHC BP or EPHS, continuous and predictable availability of commodities and essential drugs form one of the pre-requisites for a high-quality health service, without which a complete service cannot be provided to the consumer. Reduction in stock outs will increase provider motivation to offer a quality service and improve consumer trust in the health facility. For example, a key cause of low contraceptive use is lack of availability of FP commodities at the PHC facilities. **Equity and Gender Consideration:** Lagging areas would be explicitly included in the achievement. Male and female methods of contraceptive commodities would be made available. **Climate Action:** See Table 7.
RA2.3. ***Punjab DGHS strengthened to monitor and manage performance of PHC providers and facilities for an integrated service delivery (DLI 10)***
Weak and ineffective management of PHC can affect poor motivation of staff, wastage of resources, lack of trust in the health system by the consumers, and, in turn, poor utilization of the system, resulting in poor health outcome. The reasons for weak management are the fragmented nature of the financing and programs, lack of management capacity, and low accountability for performance. Investments to strengthen the management cadre of the DGHS at provincial and district levels will improve the accountability up the chain of command for each and every manager to improve performance as a contribution to the system and to the communities it serves. A strengthened performance management system will also be able to provide oversight of fragmented programs, flag and provide support for lagging performance, as well as acknowledge and reward exceptional performance to better motivate and build confidence in managers to do their jobs better. **Equity and Gender Consideration:** In Punjab, there are over 300 health managers, of whom less than 1 percent are female. Improvements in gender equity in managerial positions would further strengthen the responsiveness and inclusion of the health systems. The DLI would support progressively increasing the proportions of female managers expected to be recruited at district and provincial levels. **Climate Action:** See Table 7.
RA2.4. ***Increased community engagement in LHW-uncovered areas in Punjab, including in lagging areas (DLI 11)***
Community and private sector engagement is critical to public health and PHC services in poor areas, in particular where essential community workers, such as LHWs, do not exist. There is a need to define an inclusive and innovative strategy to increase community-based services in these areas and then to implement the strategy in a phased manner. **Equity and Gender Consideration:** Both geographical and gender equity are central to this DLI, as LHW-uncovered areas are most often where vulnerable communities reside.
Results Area 3: Improving health financing/public financial management
RA3.1*. Improved budgeting and budget flow practices (DLI 8)*
Lack of transparency and accountability of PHC expenditure often results in inadequate budget allocation and delayed release for operating costs, which are impediments for delivery of PHC. This DLI aims to institutionalize fund availability at PHC facilities by supporting financial management capacity and incentivizing the recording and reporting of financial data using the IFMIS.
RA3.2. ***Domestic resource mobilization for PHC (DLI 9)***

Historically low under-resourcing of PHC has resulted in high OOP payments, low coverage, and quality of services as well as deeply entrenched inefficiencies. Pakistan spends considerably more proportionally on tertiary care than on PHC which contributes to inefficiency. A deliberate reform of identifying sources of fiscal space for domestic resource mobilization for PHC specifically will ensure that PHC spending, as a percentage of public total health expenditure, is maintained or increased.

Environmental and Social Effects of the Proposed Program

D. Consistent with the requirements of the Bank PforR Policy, the proposed PforR operation does not support activities that pose high environmental or social risks. The activities to be supported by the program are likely to provide environmental and social benefits, and pose low adverse environmental and moderate social impacts and risks

Environmental Effects

E. **Most of the above-mentioned project activities will not pose environmental risks**. However, operation of primary healthcare facilities including rural health centers and basic health units to provide PHC services will generate healthcare waste. This healthcare waste will include a large component of general waste and a smaller proportion of hazardous waste. The exposure to hazardous health care waste can result in disease or injury. The hazardous nature of healthcare waste may be due to one or more of the following characteristics:

- it contains infectious agents;
- it is genotoxic;
- it contains toxic or hazardous chemicals or pharmaceuticals;
- it is radioactive;
- it contains sharps.

Risks

F. All individuals exposed to hazardous health care waste will be potentially at risk, including those within healthcare units that will generate hazardous waste, and those outside these sources who will either handle such waste or are exposed to it because of careless management.

Hazards from infectious Waste and Sharps

G. Infectious waste may contain any of a great variety of pathogenic microorganisms. Pathogens in infectious waste may enter the human body by several routes:

- through a puncture, abrasion, or cut in the skin;
- through the mucous membranes;
- by inhalation;
- by ingestion.

H. There is particular concern about infection with human immunodeficiency virus (HIV) and hepatitis viruses B and C, for which there is strong evidence of transmission via healthcare waste. These viruses are generally transmitted through injuries from syringe needles contaminated by human blood.

I. The existence of bacteria resistant to antibiotics and chemical disinfectants in healthcare establishments may also contribute to the hazards created by poorly managed healthcare waste. It has been demonstrated, for example, that plasmids from laboratory strains contained in healthcare waste were transferred to indigenous bacteria via the waste disposal system.

J. Concentrated cultures of pathogens and contaminated sharps (particularly hypodermic needles) are probably the waste items that represent the most acute potential hazards to health. Sharps may not only cause cuts and punctures but also infect these wounds if they are contaminated with pathogens. Because of this double risk of injury and disease transmission, sharps are considered as a highly hazardous waste class. The principal concerns are infections that may be transmitted by subcutaneous introduction of the causative agent, e.g., viral blood infections. Hypodermic needles constitute an important part of the sharps waste category and are particularly hazardous because they are often contaminated with patients' blood.

Hazards from Chemical and Pharmaceutical Waste

K. Many of the chemicals and pharmaceuticals used in healthcare units and centers are hazardous (e.g., toxic, genotoxic, corrosive, flammable, reactive, explosive, shock-sensitive). These substances are commonly present in small quantities in healthcare waste; larger quantities may be found when unwanted or outdated chemicals and pharmaceuticals are disposed of. They may cause intoxication, either by acute or by chronic exposure, and injuries, including burns. Intoxication can result from absorption of a chemical or pharmaceutical through the skin or the mucous membranes, or from inhalation or ingestion. Injuries to the skin, the eyes, or the mucous membranes of the airways can be caused by contact with flammable, corrosive, or reactive chemicals (e.g., formaldehyde and other volatile substances). The most common injuries are burns.

Hazards from Genotoxic Waste

L. The severity of the hazards for healthcare workers responsible for the handling or disposal of genotoxic waste is governed by a combination of the substance toxicity itself and the extent and duration of exposure.

Hazards from Radioactive Waste

M. The type of disease caused by radioactive waste is determined by the type and extent of exposure. It can range from headache, dizziness, and vomiting to much more serious problems. Because radioactive waste, like certain pharmaceutical waste, is genotoxic, it may also affect genetic material.

Recycling of Healthcare Waste

N. Recycling business of healthcare waste further aggravates the health hazards of the waste by extending and expanding the number of people exposed to this waste and the associated health hazards. According to a study, about 78 Percent of hospital employees surveyed reported that medical waste was being sold for profit earning. Plastic ware industry is the biggest buyer of used syringes, infusion and blood bags, plastic tubing, and other similar items. Scavengers, junk dealers, persons who are involved in the processing/recycling of healthcare waste and even the people using the recycled products could become victim of this heinous practice4.

[4] TRF, Punjab Health Sector Reforms Supports Project, Environmental and Medical Waste Management Plan, 2013

Incineration of Healthcare Waste[5]

O. Uncontrolled burning of healthcare waste in open and poorly designed incinerators can produce emissions such as dioxins and furans, which are potentially hazardous and carcinogenic, and which have regional and global impacts. According to the US Environment Protection Agency, medical waste incinerators are one of the largest sources of mercury pollution in the environment and the amount of mercury emitted by such incinerators represents more than 60 times the emission level from pathological waste incinerators.

Emissions from Incinerators[6]

P. Medical waste incinerators can emit significant quantities of pollutants into the atmosphere. These pollutants include: (1) particulate matter (PM), (2) metals, (3) acid gases, (4) oxides of nitrogen (NOx), (5) carbon monoxide (CO), (6) organics, and (7) various other materials present in medical wastes, such as pathogens, cytotoxins, and radioactive diagnostic materials. Details of these pollutants are provided in annex 1.

Social Effects

Q. **The social risks of this program are assessed as Moderate**. The primary risks are related to the complexity of institutional arrangements and intra-provincial coordination, the risks of social exclusion if proper community outreach and social mobilization activities (especially targeted to women) are not implemented; risk to occupation and health safety issues from repair and renovation activities – though small in nature but at dispersed locations and the risk that technology upgrades envisaged are not effective because of a lack of commensurate investment in the human capabilities needed to implement technological change. There are also concerns related to data privacy and security with upgrading of the data management system.

R. **The project does not anticipate any land acquisition and/or involuntary resettlement as the infrastructure improvement activities are limited to repair, renovations, and minor expansion within the existing footprint of the health facilities**. To mitigate these risks, screening will be conducted for each of the subprojects to avoid and adverse social impacts including potential impacts on informal/ illegal settlers residing within the health facility premises/ land (if any). The nature of the proposed activities in NHSP does not suggest that specific marginalized communities/indigenous peoples could be harmed by the Program. However, the exclusion of these groups is harmful therefore the design of the Program aims to foster the protection and integration of marginalized communities/indigenous peoples into the Program design, including consultation during project selection and monitoring, development of the appropriate social accountability systems, and effective Grievance Redress Mechanisms.

S. **The over-arching social risks in the project emerge from risks of exclusion and access to services by vulnerable populations**. Existing research on the health sector in Pakistan highlights several critical gender gaps, especially those pertaining to MCH and nutrition. Overall, access to health facilities remains a challenge for women, exacerbated by social norms and mobility issues. The availability of facilities also reflects a rural-urban divide, with difficulty in accessing services among rural women. The national health policy 2016-2025 envisions "improved health of all Pakistan, especially women and children by providing universal access to affordable, quality and essential health. services which are delivered through a resilient and responsive health system…." Improved conditions for girls and women enable improved lives for all members of the family. Poverty too

[5] Estimating Exposure to Dioxin-Like Compounds, USEPA, 1994
[6] https://www.epa.gov/sites/production/files/2020-10/documents/c02s03.pdf

will be reduced only when girls and women are able to access universal reproductive health care including family planning, adequate nutrition and when their rights are ensured.

T. **Access to health services for people with disabilities**, with pre-existing medical conditions, and those living in remote areas, or the peripheries is further truncated and difficult to address under exceptional circumstances, for instance in the midst of a pandemic such as Covid-19. In general, there is an unavailability of ramps for wheelchair access in health facilities and lack of psychosocial support to the disabled people. In fact, more often than not there is also a lack of awareness and training of health professionals on handling differently abled people

U. **Amongst indigenous or remotely located populations**, many would not be able to access basic health and relief distribution points due to distances to health facilities, lack of infrastructure, and cultural/ racial and gender-based discrimination. Often women in remote areas do not have identification cards or there may be issues with domicile in some instances among the general population and therefore these citizens cannot avail health facilities even if they are in proximity.

V. **The ongoing pandemic has highlighted the deep interlinkages between the health sector and emergency response, as well as the need to improve the resilience of health systems**. The training of healthcare staff through the project will build capacity in hospitals to provide healthcare service beyond the scope of COVID-19, and enable better response to public health emergencies, as well as climate-induced shocks.

W. **Gender inequalities and norms are critical considerations for the design of interventions in emergency situations and pandemics such as the ongoing Covid-19 pandemic which is now in its fifth wave in Pakistan**. They play an important role in who gets access and how fast, to critical health services. Gender norms also influence risk of exposure to disease, as well as of spreading it. At the same time, biological sex can influence how susceptible a person is to disease and how well they respond to treatment and/or vaccines. In a pandemic, this has multiple implications. On the one hand, the response to the pandemic has to be cognizant of the gender-based differences in access to and use of services due to limited mobility and financial capacity; and on the other hand, support needs to be provided to at-risk groups such as family caregivers (the majority of whom are women) to reduce their risk of getting ill and/or passing it on to others. There is also a risk that vaccine deployment plans could leave women behind, considering the larger male mortality of COVID-19 and the tendency in many countries to overlook the importance of gender inequalities in social and economic activity. Evidence from Pakistan (DHS 2017–18) shows that only 55 percent of women have access to adequate healthcare facilities and only 34 percent reported consulting a medical professional for health concerns. 67 percent of women reported at least one problem (e.g., mobility, getting permission, not wanting to go alone etc.) in accessing healthcare for themselves. Another issue in this context relates to women having ID cards in order to be able to access the system. In some instances, for instance in remote areas women do not have their own ID cards without which they cannot avail any medical facilities.

X. **A key determinant for access, in a context like Pakistan, where segregation of sexes is largely practiced, is availability of female staff at healthcare facilities**.[7] Women feel uncomfortable interacting with male healthcare staff, seeking assistance from female staff, even if it means traveling long distances.[8] This need for female personnel to provide healthcare assistance to

[7] Polio Global Eradication Initiative, Accessed: https://polioeradication.org/news-post/celebrating-the-female-vaccinator/

[8] Ayesha Khan, 1999, Reproductive Health Matters, Mobility of women and access to health and family planning services in Pakistan.

women has been widely recognized in research.[9] Without their presence, women in Pakistan are less likely to seek and receive medical care, including for Covid-19 related treatment, prevention, and vaccines. Secondly, women also have less access to information, particularly due to limited mobile phone ownership and use. Pakistan has the widest gender gap in mobile ownership, where women are 38 percent less likely than men to own a mobile and 49 percent less likely to use mobile internet.[10] Therefore, women in Pakistan may have lack of information and greater misconceptions about Covid-19 and particularly, COVID-19 vaccines. Thirdly, the majority of nurses and paramedic staff in Pakistan are women. Being at the forefront of treating Covid-19 patients, these women face a greater risk of exposure to the disease. However, at present, MoNHSR&C does not have updated, gender disaggregated data on the frontline health workers, in order to ensure equitable access to vaccination.

Y. **Global evidence also suggests that the incidence of gender-based violence (GBV)** increases in crisis situations and it may expose women to higher risk of domestic violence due to heightened tensions in households, particularly when families are quarantined. This has also been highlighted in the ongoing COVID-19 emergency in China. Targeted training for health care professionals will be undertaken to sensitize them to a host of GBV (i.e., sexual harassment, sexual exploitation and abuse, domestic violence) and trauma issues, to enable them to connect survivors with existing referral mechanisms in the country and provide life-saving health care, psycho-social support. The health sector has a vital role in providing comprehensive health care to women subjected to violence, and as an entry point for referring women to other support services they may need.

Z. **Further, women frontline workers such as LHWs themselves may experience sexual harassment** or violence while carrying out their work. The project GRM for Healthcare providers along with a mechanism for GBV complaints will seek to address and mitigate these concerns. The health sector has a vital role in providing comprehensive health care to women subjected to violence, and as an entry point for referring women to other support services they may need. Targeted training for health care professionals will be undertaken to sensitize them to a host of GBV (i.e., sexual harassment, sexual exploitation and abuse, domestic violence) and trauma issues, to enable them to connect themselves and other survivors with existing referral mechanisms in the country.

III. ASSESSMENT OF ENVIRONMENTAL AND SOCIAL SYSTEMS AND IMPLEMENTATION CAPACITY

A. Introduction

AA. **Program for Results policy requires the proposed program to operate within an adequate environmental and social management system** that can manage environmental and social effects (particularly adverse impacts and risks) identified during the ESSA process. This includes (a) an adequate legal and regulatory framework and institutional setting to guide environmental and social impact assessment and the management of environmental and social effects, and (b) adequate institutional capacity to effectively implement the requirements of the system.

BB. **Sections V and VI assess whether the program's environmental and social management systems are consistent with the core principles** and key planning elements contained in the PforR and whether the involved institutions have the requisite capacity to implement these systems'

[9] Zubia Mumtaz et al, 2003,Gender-based barriers to primary healthcare provision in Pakistan: the experience of female providers
[10] Mobile Gender Gap Report, GSMA, 2020.

requirements. Both elements (e.g., program systems and capacity) are necessary to ensure that the environmental and social effects identified in Section III are effectively managed. Through both analyses, the ESSA team has identified gaps in both areas, which are addressed in Section VIII: Recommendations and Proposed Actions.

CC. **A program system is constituted by the rules and "arrangements within a program for managing environmental and social effects,"** including "institutional, organizational, and procedural considerations that are relevant to environmental and social management" and that provide "authority" to those institutions involved in the program "to achieve environmental and social objectives against the range of environmental and social impacts that may be associated with the program." This includes existing laws, policies, rules, regulations, procedures, implementing guidelines, etc. that are applicable to the program or the management of its environmental and social effects. It also includes inter-agency coordination arrangements if there are shared implementation responsibilities in practice.

DD. **This ESSA examines and discusses only those aspects of the proposed program's environmental and social management systems that the ESSA Team found to be relevant**, considering its identified environmental and social effects. This section provides a summary assessment of the program's systems as these relate to each of the core principles and key planning elements. The text and tables below clarify the instances in which one or more of the Core Principles or Key Planning Elements are not relevant to the program and are thus inapplicable.

B. Core Principle 1 – Environmental and Social Management

EE. The assessment of program systems under this principle determines that there might be the environmental risks associated with healthcare waste services and disposal

FF. **The operation of primary healthcare facilities including rural health centers and basic health units to provide PHC services will generate healthcare waste**. This healthcare waste will include a large component of general waste and a smaller proportion of hazardous waste. The exposure to hazardous health care waste can result in disease or injury. All individuals exposed to hazardous health care waste will be potentially at risk, including those within healthcare units that will generate hazardous waste, and those outside these sources who will either handle such waste or are exposed to it because of careless management.

GG. **The healthcare waste is regulated through Hospital Waste Management Rules formed under Federal and Provincial Environmental Protection Acts in Pakistan**. Considering the hazardous nature of healthcare waste, Hazardous Substance Rules, formed under Federal and Provincial Acts are applicable to regulate healthcare waste. Khyber Pakhtunkhwa Environmental Agency has not prepared any of such rules to regulate healthcare waste and hazardous substances in the province.

HH. **Generally, healthcare waste is not considered to be a hazardous substance, therefore, environmental protection agencies do not consider regulating it under hazardous substances rules**. Federal and provincial EPAs have issued licenses to multiple public and private sectors incinerators.[11] Whereas environmental monitoring of these incinerators by EPAs is not at the desired level. Capacity of EPAs for environmental monitoring of healthcare facilities and incinerators is assessed as low.

[11] For example, in Punjab EPA has issued no-objection certificates and licenses to 26 incinerators operated by Health Department through Primary & Secondary Healthcare Department program "Hepatitis & Infection Control Program". Similarly, multiple incinerators licensed by federal and provincial EPAs are operating in the tertiary and secondary healthcare facilities and private sector throughout the country.

II. **The disposal of hazardous healthcare waste in the secured landfill and/or incineration. In Pakistan, there is no secured landfill site where hazardous waste could be disposed of**. As mentioned above there are number of licensed incineration facilities operating in the country in the public and private sectors where hazardous waste or healthcare waste could be incinerated. There are few secondary and tertiary healthcare hospitals where incineration facilities are available. Paid incineration facilities in the private sector exist where healthcare waste along with other hazardous waste are incinerated on a payment basis. Mostly the monitoring data for environmental compliance of incineration facilities is not available.

JJ. **The primary healthcare facilities, providing PHC services, are not able to enforce Hospital Waste Management Rules in their facilities**. Compliance of Hospital Waste Management Rules in tertiary and secondary healthcare facilities, other than in Punjab, urban Sindh, Peshawar, and Quetta, is also limited. There are very few such facilities which can manage their healthcare waste and comply with the rules whereas most of such facilities are partially complying with the rules. Mostly healthcare waste is not segregated. The risk waste which is just 15% of the total healthcare waste is not separated from the non- risk waste and dumped at the municipal solid waste dumping sites. The sharp waste is not segregated and sealed separately. Waste is not labelled, stored, and disposed of as per the prescribed rules.

KK. **The primary social risks are related to the complexity of institutional arrangements and intra-provincial coordination,** the risks of social exclusion if proper community outreach and social mobilization activities (especially targeted to women) are not implemented; risk to occupation and health safety issues from repair and renovation activities – though small in nature but at dispersed locations and the risk that technology upgrades envisaged are not effective because of a lack of commensurate investment in the human capabilities needed to implement technological change.

LL. **There are also concerns related to data privacy and security with upgrading of the data management system**. The project does not anticipate any land acquisition and/or involuntary resettlement as the infrastructure improvement activities are limited to repair, renovations, and minor expansion within the existing footprint of the health facilities. To mitigate these risks, screening will be conducted for each of the subprojects to avoid and adverse social impacts including potential impacts on informal/ illegal settlers residing within the health facility premises/ land (if any).

MM. **There is also an urgent need to tackle social determinants affecting RMNCH in Pakistan which relate to fundamental issues of the status of women, adolescents' girls' education and. empowerment**. Given the critical role of maternal education in improving child survival and maternal health, investments. in integration of health and development messages, in linking RMNCH to other sectors such as education, prevention of early/forced/ child marriage and gender empowerment is a key task for the federal ministry in tandem with the provinces

NN. **Existing research on the health sector in Pakistan highlights several critical gender gaps, especially those pertaining to MCH and nutrition**. Overall, access to health facilities remains a challenge for women, exacerbated by social norms and mobility issues. Closing the gap between FP knowledge and practice through comprehensive service that encompasses family planning awareness, options, commodity security with focus on modern methods, as well as innovations, keeping in mind the cultural and religious sensitivities.

OO. **The health care delivery system in Pakistan consists of both public and private sectors**. Under the Constitution, health is primarily the responsibility of the provincial government, except in the

federally administrated areas. Five kinds of health services namely promotive, preventive, curative, rehabilitative and palliative constitute essential healthcare. The common understanding about health services is limited to curative care provided in hospitals. Preventive and promotive health services are actually more cost-effective than curative services and, in fact, in many cases determine curative services. Examples of preventive services are vaccination, screening for various common diseases, disease control measures for both communicable and non-communicable infirmities and protection against injuries. Meanwhile, promotive services include, for example, information and education for adopting healthy behaviors and making healthy choices to guard against risks to health (smoking cessation; wearing masks; salt control in diet; exercising; planning the number of children and appropriate spacing between them).

PP. **The importance of primary healthcare is immense in UHC as this is the level where 60 to 70 per cent of essential health services can be provided**. Health services should also be of 'sufficient quality' in order to have the intended effect on users. Lack of ensuring quality of services can have two negative effects: services can be ineffective at best and outrightly unsafe at worst. Patient safety is a very major concern in healthcare.

QQ. **'Financial hardship' is a key component of Universal Healthcare and relates to poor sections of society who often lack financial resources to access the health system**. number of different stakeholders involved in healthcare service delivery---sometimes with overlapping jurisdictions and functions-creates coordination challenges that negatively impact outcomes for citizens. The Naya Pakistan Qaumi Sehat Programme recently launched in parts of Punjab also provides a platform for public private sector linkages to benefit the poorest sections of society and should be replicated in other parts of Pakistan.

RR. **Social, community and political pressures for visible health infrastructure projects**, specialty schemes, and other benefits at the local level have the potential to derail healthcare sector strategies and plans. Therefore, distrust in the state and low administrative capacity significantly augments administrative burdens on citizens. Citizen engagement activities should be undertaken to promote participation, strengthen local capacity to engage in monitoring, and establish robust mechanisms to collect, analyze, and respond to citizen feedback.

SS. **Health Management Committees, BISP beneficiaries' committees, Citizen Facilitation Centers and District Committees on Status of Women would also be instrumental in engaging citizens in the provinces**. The objective will be to mitigate risks that have previously deteriorated trust among citizens and in government institutions. Social mobilization partners would be integral to enhancing the capacities and strengthening Village councils particularly in management, finance, and accounting. Participatory mechanisms may be customized for women and men to ensure that different needs are reflected in project activities. Beneficiary feedback surveys may also be used to obtain continuous feedback and fine-tune project activities. The role of local institutions, district administrators, and buy-in from local influencers (community notables, religious leaders, or tribal elders) would be critical to ensure effective mobilization of beneficiaries.

TT. **A robust and effective GRM would also foster citizen engagement** as it seeks to resolve complaints and grievances in a timely, effective, and efficient manner that satisfies all parties involved. Specifically, it provides a transparent and credible process for fair, effective, and lasting outcomes. It also builds trust and cooperation as an integral component of broader community consultation that facilitates corrective actions. The existing GRM. System in use by the MOHNSRC and Provincial Health Departments is outlined in **Annex 6.** However, citizen engagement and stakeholder feedback on program design, performance and impacts is a relatively new concept in Government

departments and needs further strengthening. In this regard, registering grievances and getting resolution has high social value. Failing to do so is a cause of concern for the public at large.

Table 1: Core Principle 1- Environmental and Social Management

Core Principle 1: Environmental and social management procedures and processes are designed to (a) promote environmental and social sustainability in program design; (b) avoid, minimize, or mitigate adverse impacts; and (c) promote informed decision-making relating to a program's environmental and social effects.			
Key Planning Elements	**System Assessment**	**Capacity Assessment**	**Recommendations**
Program procedures operate within an adequate legal and regulatory framework to guide environmental and social impact assessment at the program level	▪ Federal and provincial environmental protection Acts regulate hazardous waste (Balochistan Environmental Protection Act specifically mentions hospital waste along with other waste to be regulated whereas laws of other provinces don't mention hospital waste in any of the clauses). ▪ Federal and Provincial Environmental Protection Agencies have formed Hospital Waste Management Rules and Hazardous Substances Rules to regulate healthcare waste and hazardous substances in the country. ▪ Khyber Pakhtunkhwa Environmental Agency has not formed any of such rules in the province. ▪ Generally healthcare waste is not considered as hazardous substances, reason being, hazardous substances rules are not applied on healthcare waste by the EPAs. ▪ IPC 2020 Guidelines comprehensively cover environmental cleaning required at PHCs (Section 6), management	▪ Capacity of MOHNSRC and Provincial Health Departments is low for managing healthcare waste as per the requirements recommended in IPC 2020 Guidelines at the PHC level. ▪ EPAs have issued multiple licenses for healthcare incinerators in the country. EPAs capacity to conduct environmental monitoring of these incinerators and capacity to enforce hospital waste and hazardous substances rules at the healthcare facilities is limited. ▪ Incinerators' operations are not up to the required standards. These facilities are not equipped with air pollution control devices. Ash disposal is an issue. ▪ ▪ ▪ Overall, the enforcement of healthcare waste management is very weak in the country. ▪ EPAs are not able to regulate healthcare waste recyclers.	▪ Develop SOPs for PHCs environmental and social management of PHCs based on Sections 6, 7, and 8, and Annex 2 of IPC 2020 Guidelines. ▪ Enforcement of hazardous substances rules and hospital waste management rules at primary healthcare facilities by the provincial Health Departments. ▪ Health Departments and the primary healthcare facilities should ensure that hazardous healthcare waste is handed over to the licensed incineration facilities.

	of healthcare waste (Section 7), protection of healthcare workers (Section 8), minimum requirements for infection prevention. IPC 2020 recommends that PHCs should adopt Standard Operating Procedures (SOPs) and train healthcare staff. ▪ There are no secured landfill sites in the country to dispose of healthcare waste ▪ There are number of licensed incineration facilities operating in the country in the public and private sectors where hazardous waste or healthcare waste could be incinerated whereas primary healthcare facilities don't have such incinerators at their facilities. ▪ There are some paid incineration facilities in the country where healthcare waste is incinerated. ▪ As per Federal and Provincial Review of IEE and EIA Regulations, EIA study is required for the installation of incinerators for healthcare waste disposal.		
Program procedures incorporate recognized elements of environmental and social assessment good practices, including (a) early screening of potential effects	▪ IPC 2020 Guidelines in Section 7 describe in detail the primary healthcare waste screening and best management and disposal practices. ▪ Under Hazardous Substances Rules, the entity handling hazardous waste (healthcare facilities, incinerators) requires getting a license from the environmental protection agency.	▪ Capacity of MOHNSRC and Provincial Health Departments is low for managing healthcare waste as per the requirements recommended in IPC 2020 Guidelines at the PHC level. ▪ EPAs have adequate capacity for review and approval of no-objection certificates, licenses, EIA, and other plans.	As above

	The conditions to acquire a license includes submission of EIA report, safety plan, waste management plan, hazardous substance report and emergency plan. These reports/ plans assess the potential hazards and incorporate social and environmental good practices. ▪ Hospital Waste Management Rules instruct the healthcare facilities to formulate waste management plan and comply with the rules. The waste management plan assesses the potential hazards and incorporates social and environmental good practices. ▪ As per Federal and Provincial Review of IEE and EIA Regulations, EIA study is required for the installation of incinerators for healthcare waste disposal.	▪ There are no rules at KPK province and no compliance for the environment and social assessment and adoption of good practices in this province. ▪ Generally, the healthcare facilities are not considered to be the generator of hazardous substances, therefore hazardous substance rules are not applied on them. ▪ EPAs have limited monitoring capacity to enforce hospital waste and hazardous substances rules at the healthcare facilities. ▪ EPAs have limited capacity to regulate incinerators in the country. ▪ Healthcare facilities and solid waste, either municipal or healthcare waste, are not the priorities of the EPAs.	
(b) consideration of strategic, technical, and site alternatives (including the 'no action' alternatives)	▪ Site alternatives are considered during environmental impact assessment (EIA) under Hazardous Substances Rules for Federal, Sindh and Balochistan. ▪ Punjab Hazardous Substances Rules don't require EIA report ▪ There are no Hazardous Substances Rules for the KPK province, therefore no requirement of EIA in the KPK. ▪ As per Federal and Provincial Review of IEE and EIA Regulations, EIA study is required for the	As above	As above

	installation of incinerators for healthcare waste disposal.		
c) explicit assessment of potential induced, cumulative, and trans-boundary impacts	▪ Environmental impact assessment is carried out in the EIA studies under Hazardous Substances Rules for Federal, Sindh and Balochistan. ▪ Punjab Hazardous Substances Rules don't require EIA report ▪ There are no Hazardous Substances Rules in the KPK province, therefore no requirement of EIA in the KPK. ▪ License is issued by EPA after ensuring that the impacts arising from the facility (healthcare facility, incinerator) are not severe and will be managed accordingly. ▪ As per Federal and Provincial Review of IEE and EIA Regulations, EIA study is required for the installation of incinerators for healthcare waste disposal.	As above	As above
d) identification of measures to mitigate adverse environmental or social impacts that cannot be otherwise avoided or minimized	▪ The EIA study reports, waste management plan, hazardous substance report, safety reports, and emergency plans, submitted to the EPAs under Hazardous Substances Rules and Hospital Waste Management Rules, identify measures to mitigate E&S impacts. The applicant has the obligation to implement these measures to acquire a license or comply with the rules.	As above	As above

	▪ As per Federal and Provincial Review of IEE and EIA Regulations, EIA study is required for the installation of incinerators for healthcare waste disposal.		
e) clear articulation of institutional responsibilities and resources to support implementation of plans	▪ Federal and Provincial Environmental Protection Agencies are the regulatory and monitoring institutions responsible for environmental management in the country. ▪ The management of the healthcare facilities under provincial Health Departments and the incinerators are responsible for implementing mitigation measures and complying with environmental laws and the relevant rules.	Overall, the regulators are lacking in infrastructure, capacity, and resources to enforce environmental regulations and rules in the country.	The Health Departments need to take the responsibility to enforce all the legislative requirements associated with healthcare waste (hazardous substances, hazardous waste) at primary healthcare facilities.
f) responsiveness and accountability through stakeholder consultations, timely dissemination of program information, and through responsive and inclusive grievance redress measures	▪ Stakeholder consultation is part of every IEE and EIA process. Public hearings are also a compulsory part of the EIA process. ▪ All the implementing departments disseminate project information to the public through electronic and paper media. All investment projects are duly approved by the national and provincial assemblies as a part of the annual budget which are disclosed on web sites of respective departments.	Adequate processes exist for information dissemination and disclosure.	None

C. Core Principle 2 – National Habitats and Physical Cultural Resources

Core Principle 2: Environmental and social management procedures and processes are designed to avoid, minimize, and mitigate against adverse impacts on natural habitats and physical cultural resources resulting from the program.

UU. Given the scope of the proposed program's activities, the ESSA team concludes that the program is unlikely to have any adverse impacts or pose any risk for natural habitats and physical cultural resources.

D. Core Principle 3 – Public and Worker Safety

VV. **The ESSA team assessed that the mishandling of healthcare waste can pose health risks to the public and workers involved in handling the waste**. All individuals exposed to hazardous healthcare waste will be potentially at risk, including those within healthcare units that will generate hazardous waste, and those outside these sources who will either handle such waste or are exposed to it because of careless management. Pathogens in infectious waste may enter the human body by several routes. There is particular concern about infection with human immunodeficiency virus (HIV) and hepatitis viruses B and C, for which there is strong evidence of transmission via healthcare waste. These viruses are generally transmitted through injuries from syringe needles contaminated by human blood.

WW. **When hazardous healthcare waste, mixed with the non-hazardous waste**, is dumped at municipal waste dumping sites and these are picked up by the scavengers, there is severe health risks for these scavengers. These scavengers are interested in picking plastic healthcare waste such as urine bags, blood bags, syringes, sample bottles etc. which are demanded by the plastic waste recyclers. These scavengers are directly exposed to these infectious wastes. These scavengers are hardly equipped with any of the PPE and without any information about the infectious nature of the waste which they are picking, collecting, and selling.

XX. **Workers involved at the illegal healthcare waste recycling facilitie**s for handling waste, without taking safety precautions and wearing PPE, are also at risk.

YY. **When hazardous healthcare waste is incinerated at improperly functioning incinerators**, the nearby communities are at risk due to the contamination of the surrounding air from various un-arrested air pollutants releasing from incinerators. Recent studies indicate that as much as 33 percent of Hepatitis B virus (HBV) and 42 percent of Hepatitis C virus (HCV) infections arise from direct or indirect exposure to infectious waste[12].

ZZ. **Healthcare waste is regulated under Hazardous Substances Rules and Hospital Management Rules**, formulated under Federal and Provincial Environmental Acts (except KPK). Healthcare waste is not considered under Hazardous Substances; therefore, Hazardous Substances Rules are not being applied upon healthcare facilities. EPAs have limited resources and capacity to monitor and enforce Hospital Waste Management Rules at the healthcare facilities.

---

[12] WHO Website, Unsafe injection practices -a plague of many health care system http://www.who.int/injection_safety/about/resources/BackInfoUnsafe/en/

AAA. **In Pakistan, there is no secured landfill site where hazardous waste could be disposed of**. The incineration facilities are installed at secondary and tertiary healthcare facilities or commercially operational on a payment basis in Punjab and Sindh. In KPK and Baluchistan there a few incineration facilities in the tertiary and secondary healthcare facilities. Environmental compliance data for incineration facilities is scanty and limited. In case if these facilities don't operate under controlled environment, then these are the contributors of the pollution rather than controlling it. The EPAs do not have resources or capability to regulate these incinerators.

Table 2: Core Principle 3- Public and Worker Safety

Core Principle 3: Environmental and social management procedures and processes are designed to protect public and worker safety against the potential risks associated with (a) construction and/or operations of facilities or other operational practices developed or promoted under the program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.			
Key Planning Elements	**System Assessment**	**Capacity Assessment**	**Recommendations**
Promotes community, individual, and worker safety through the safe design, construction, operation, and maintenance of physical infrastructure, or in carrying out activities that may be dependent on such infrastructure with safety measures, inspections, or remedial works incorporated as needed.	▪ Operation of primary healthcare facilities generate healthcare waste which is hazardous. The Federal and Provincial Environmental Agencies have formulated Hazardous Substances Rules and Hospital Waste Management Rules (Except KPK) to regulate healthcare waste. ▪ IPC 2020 Guidelines (Section 8) recommend measures (SOPs, training) to protect healthcare workers and communities from exposure to risks attached to healthcare waste. ▪ There are no secured landfill sites for the disposal of healthcare waste in the country. ▪ There are number of licensed incineration facilities operating in the country in the public and private sectors where hazardous waste or healthcare waste could be incinerated ▪ Mostly the incineration facilities don't operate at standard conditions and are not equipped with proper air pollution control devices. Air pollution is a concern for the	▪ Capacity of MOHNSRC and Provincial Health Departments is low for managing healthcare waste as per the requirements recommended in IPC 2020 Guidelines at the PHC level. ▪ ▪ EPAs have issued multiple licenses for healthcare incinerators in the country. EPAs capacity to conduct environmental monitoring of these incinerators and capacity to enforce hospital waste and hazardous substances rules at the healthcare facilities is limited. ▪ ▪ Monitoring of primary healthcare facilities is not under the priority of the EPAs for environmental regulation. ▪ ▪ EPAs don't have resources or capacity to regulate incinerators and healthcare waste recycling facilities. ▪ Primary healthcare facilities don't have resources and capacity and under no	▪ Develop SOPs for PHCs environmental and social management of PHCs based on Sections 6, 7, and 8, and Annex 2 of IPC 2020 Guidelines. ▪ Enforcement of hazardous substances rules and hospital waste management rules at primary healthcare facilities by the provincial health departments. ▪ Health Departments and primary healthcare facilities should ensure that hazardous healthcare waste is handed over to the licensed incineration facilities

	communities living around the incineration facilities ▪ Healthcare waste is not considered as hazardous substance so hazardous substances rules are not applied on healthcare facilities by the EPAs. ▪ Due to mismanagement of healthcare waste, workers involved in handling waste at healthcare facilities, scavengers picking waste from municipal dumping sites or collection points and workers at waste recycling facilities are at risk.	pressure from regulators are not able to enforce hospital waste management rules.	
Promotes the use of recognized good practices in the production, management, storage, transport, and disposal of hazardous materials generated through program construction or operations; and promotes the use of integrated pest management practices to manage or reduce pests or disease vectors; and provides training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous chemicals in accordance with international guidelines and conventions.	▪ IPC 2020 Guidelines (Section 7) recommend measures to manage hazardous waste under a comprehensive waste management system ▪ Hazardous Substances Rules and Hospital Waste Management Rules, formulated by Federal and Provincial Environmental Protection Agencies, promote the good practices in the production and disposal of healthcare waste at primary healthcare facilities and incinerators respectively, and require that the workers involved in waste handling are trained on best practices.	As above	As above
Includes measures to avoid, minimize, or mitigate community, individual,	Project activities don't involve major construction activities so	Not applicable	Not Applicable

and worker risks when program activities are located within areas prone to natural hazards such as floods, hurricanes, earthquakes, or other severe weather or climate events.	there is no need to include any such measures in the activities.		
Promote and advocate for vaccination uptake particularly in the context of Covid-19 and seeks to remove myths and misconceptions of vaccination	Although vaccination is being promoted by the Government there are still misconceptions regarding side effects among the public	Vaccination at public health facilities may be further encouraged and facilitated	Incorporate key messages. On importance pf vaccination and management of side effects in the project communication campaigns

E. Core Principle 4 – Land Acquisition

Core Principle 4: Land acquisition and loss of access to natural resources are managed in a way that avoids or minimizes displacement, and affected people are assisted in improving, or at least restoring, their livelihoods and living standards.

BBB. Given the scope of the proposed program's activities, the ESSA Team concludes that the program is not likely to have any adverse impacts or pose any risks caused by the acquisition of land or the restriction of use or access to land or natural resources, including the loss of income caused by such actions. Program activities are not involved in major construction or land clearing activities which could result in land acquisition and/or displacement of people and affecting their livelihood and living standards.

F. Core Principle 5 – Indigenous Peoples and Vulnerable Groups

Core Principle 5: Due consideration is given to cultural appropriateness of, and equitable access to, program benefits giving special attention to rights and interests of Indigenous Peoples and to the needs or concerns of vulnerable groups.

CCC. **In Pakistan, the Kalash people, living in Chitral Valley (Province Khyber Pakhtunkhwa) are recognized as Indigenous Peoples under WB ESF Environmental and Social Standard 7**. This program is for all the provinces of Pakistan so there will be program activities at KPK province as well. Program intervention will also take place at Chitral Valley and the primary healthcare facilities at Kalash valley will also be the focus of the equitable access and quality of health services for the Kalash people.

DDD. At present there is no system at the Health Department, Khyber Pakhtunkhwa, to undertake free, prior, and informed consultations with the Kalash people to determine broad community support for the provision of quality healthcare services to the Kalash valley. The Kalash people of Chitral Valley will be consulted by the Education Department of KPK. The Kalash people living in Bamburet, Rumbur and Birir valleys will be engaged through focus group discussions and meetings with the key informants (eminent and influential members of the society) and the women. There are many NGOs and INGOs working in these valleys such as Kalash Foundation, Pakistan Poverty Alleviation Fund (PPAF), Kalash People Welfare Society etc. These organizations will also be engaged in consulting Kalash people and getting their feedback to appropriately design the program activities as per their needs and requirements. Consultations with the Kalash people will be important to give special attention to their rights and interests. It is required that the Kalash people are given due consideration to cultural appropriateness of, and equitable access to program benefits.

EEE. **The nature of the proposed activities in NHSP does not suggest that specific marginalized communities/indigenous peoples could be harmed by the Program**. However, the exclusion of these groups is harmful therefore the design of the Program aims to foster the protection and integration of marginalized communities/indigenous peoples into the Program design, including consultation during project selection and monitoring, development of the appropriate social accountability systems, and effective Grievance Redress Mechanisms.

G. Core Principle 6 – Social Conflict

Core Principle 6: Avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

FFF. **Women and girls across Pakistan do not have equitable access to health facilities** due to limited resources, distances, availability of dedicated facilities and quality of services available, since male and mix facilities take priority, the risk of which may continue through the Program and be a potential source of discord.

GGG. **One of the major challenges for health sector in the country is related to Human resou**rces i.e., severe shortage of health workforce especially nurses, midwives, and lady health workers (LHWs), imbalanced geographical distribution of health workforce including between urban and rural areas, imbalanced skill mix, inadequate skills acquired by the health workforce, poor job satisfaction and work environment. Human resources especially female medical officers, lady health visitors at rural health facilities, need to be staffed with competent cadres capable of delivering quality maternal and newborn care at first contact with formal health services and regular on job training.

HHH. **Lady Health Workers (LHWs) provide an effective interface** between the communities and health services and seek to address the equity and gender challenges in the health sector while ensuring availability of primary, preventive, promotive and some curative care services at the doorstep of the community. In areas where the Lady Health Worker Programme (LHWP) is operating, it does generally address the needs of marginalized and vulnerable women and children. However, the extent to which it does is compromised across all regions by: (i) the lack of an explicit focus on geographical areas and socio-economic groups with the greatest need; (ii) an increasing focus on immunization relative to other health, health education, and nutrition needs; and (iii) management and resourcing problems[13]. There are a number of significant and systemic challenges faced by the LHWP that limit its ability to meet its health outcome targets and program objectives. These include: a freeze on recruitment following the regularization of LHWs; increased LHW responsibilities beyond core functions (in particular, polio programming); significant funding deficits, which have created shortages of supplies and equipment; and a significant reduction in the regularity of training received by LHWs. Inadequate operational expenses for social mobilization and community outreach (e.g., fuel, vehicles, and travel allowances etc.) also create hurdles in accessing and advocacy efforts with local communities. The lack of non-salary resources has contributed to a weakening in effective supervision.

III. **At the district level, the absence of effective linkages of health centers and management with communities are key barriers to quality improvement and utilization of health facilities**, Effective coverage has now become a serious issue given that there are managerial inefficiencies and between 30-50% of the population in several rural districts, especially the poorest and most remote areas, are without LHW cover.[14] The quality of services offered by the LHWs and CMWs needs a review and constant monitoring to ensure the trust of clients in these cadres.

13

Lady Health Worker Programme, Pakistan Performance Evaluation Report September 2019, Oxford Policy Management; conducted for UNICEF and the Ministry of National Health Services, Regulations and Coordination

14 National Vision 2016-2025 for Coordinated Priority Actions to Address Challenges of Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition, MNHSRC, Government of Pakistan

JJJ. **The integration of vertical programs in the health sector** is therefore inadequate at the management, accountability, and service delivery levels and this fragmentation and lack of synergy between the health programs can also be an impediment in the efficient delivery of services.

KKK. **The attitude of health providers towards women beneficiaries, the lack of responsiveness to women's special health needs**, shortage of female staff, inadequate community outreach and counselling are reflected in the underutilization of both public and private health services and poor health indicators. The vast majority of young women depend on their male family members for major decisions related to their lives, including healthcare. The degree of dependency varies across and rural/urban locations and rigidity of social and cultural norms (e.g., ex- FATA and Balochistan); but remains an ongoing outreach challenge. Furthermore, the COVID-19 pandemic has deepened gender inequalities in Pakistan: over a quarter of Pakistani women have been laid off or suspended from their jobs in different sectors. Quarantine, isolation wards and other health facilities are not equipped well enough to consider the needs of women and of other marginalized groups.

LLL. **There is a risk that remote and historically underserved districts** in the provinces which have traditionally received lesser shares in PFC awards due to scattered and low populations, may receive similar lesser benefits from the Program (for both male and females). Health facilities in remote areas with zero or low network connectivity may also be excluded from Program benefits. By reinforcing existing inequities or grievances particularly in fragile districts the Project may risk exacerbating social conflict and greater mistrust for the government.

IV. DISCLOSURE AND CONSULTATION

A. Disclosure

MMM. This draft ESSA will be disclosed in-country and on the World Bank's external website, prior to formal appraisal of the relevant PforR, to serve as the basis for discussion and receipt of formal comments. Following the incorporation of feedback received from different stakeholders, the revised ESSA will be disclosed in-country and on the World Bank's external website.

B. Stakeholder Consultations

NNN. A stakeholder workshop was held on February 3, 2022, to collect feedback on the environmental and social aspects of the NHSP. Stakeholders from the government and private sector were invited. Following a presentation by the NHSP team, stakeholder comments and concerns were recorded. It was an interactive session which was held virtually using WebEx given the Covid-19 protocols and restrictions in place.

C. Summary of the Stakeholder Consultation

The consultation was attended by civil society members, rural development practitioners, public health experts and representatives from think-tanks. Feedback was provided around the following overarching themes:

- Sharing of experiences with community outreach and mobilization around public health issues
- Given that Pakistan has a very high percentage of youth and young population, they are the most important cohort from a reproductive health perspective.
- The effectiveness of Provincial Healthcare Commissions
- Improvement of service structure of facilities should focus on physical upgradation, placement of more qualified staff, strong monitoring, and supportive supervision for a continuum of care
- In addition to access to services, the quality of services offered is also important and skills such as communication and counseling are important in this regard.
- Engaging with private providers may be facilitated by the District Health Departments in terms of registering with the Healthcare Commissions
- District level management teams should be regularized and held accountable for making those systems work. For instance, District Committees can take an active role in ensuring citizen voices,
- An effective mechanism and a best practice for improving coordination may be the establishing of a country engagement working group. This engagement may improve the coordination between the Federal and provincial levels, increase the level of trust and partnership in Family Planning and provide a learning forum as well.

V. INPUTS TO THE PROGRAM ACTION PLAN

A. Introduction

OOO. This section summarizes the measures that the ESSA team recommends being included in the Program Action Plan and should be executed during program implementation to address important gaps identified above between the program system and the PforR core principles and key elements as well as to address any capacity shortcomings.

PPP. As noted in Section III, the ESSA identified the following issues as needing additional action:

a) **Low level of Enforcement of Hazardous Substances Rules & Hospital Waste Management Rules at Primary Healthcare Facilities:** In Punjab and urban Sindh, the provincial government have made arrangements for the implementation of Hospital Waste Management Rule at tertiary, secondary and primary levels. In KPK, Baluchistan, and many rural areas of the country the primary healthcare facilities are not able to implement hazardous substances and hospital waste management rules at their facilities. The reasons behind such noncompliance include lack of resources and capacity to implement waste management at the facilities and there is no pressure from regulators, health departments and the communities. Due to such negligence, the risk and non-risk healthcare waste is mixed and dumped at the municipal dump sites or the collection points from where these wastes are picked up by the scavengers and sold to the illegal waste recyclers. The mismanagement of healthcare waste poses risks to the healthcare workers, scavengers and the workers involved at recycling facilities. Open and uncontrolled burning of such waste is also a severe health concern.

b) **Improper Functioning of Healthcare Waste Incinerators:** In case if healthcare waste is handed over to the incineration facilities for disposal, the environmental compliance and performance data is scanty and limited. The disposal of the ash produced from these facilities is another issue. Most of these facilities may be the contributors to pollution rather than controlling it.

The recommendations and proposed actions are described in detail below:

B. Recommendations to be Included in the Program Action Plan

QQQ. **Recommendation 1: Develop SOPs for PHCs environmental and social management of PHCs based on Sections 6, 7, and 8, and Annex 2 of IPC 2020 Guidelines.**

IPC 2020 Guidelines are comprehensive with respect to effective environmental and social management of PHCs. SOPs specific to PHCs environmental and social management should be derived and summarized from Section 6-Environmental Cleaning, Section 7-Management of Healthcare Waste, Section 8- Protection of Healthcare Workers, and Annex 2- Minimum requirements for infection prevention at the primary health care. Environmental and social management measures proposed in the IPC 2020 Guidelines are sufficient for the effective environmental and social management as per the requirements of federal and provincial environmental protection Acts, Hazardous Substances Rules, and Hospital Waste Management Rules.

RRR. Recommendation 2: Enforce the Hazardous Substances Rules and Hospital Waste Management Rules at Primary Healthcare Facilities by the Health Departments

It is recommended that the provincial health departments should enforce the hazardous substance rules and hospital waste management rules at all the primary healthcare facilities for the management of healthcare waste under NHSP as an environmental mitigation measure. There are no such rules in KPK province. The Health Department, KPK can adopt rules from other provinces and enforce them in the province. For the compliance of these rules, the healthcare facilities will have to acquire license from the concerned EPA by submitting EIA report and relevant plans (waste management plan, safety plan, and emergency plan). The Health Department of the respective province will be responsible for enforcing these rules at all the primary healthcare facilities under its jurisdiction through adopting strict monitoring and evaluation mechanism.

SSS. Recommendation 3: Handing Over the Healthcare Waste to the Licensed Incineration Facilities

Provincial Health Departments will also be responsible to ensure that the primary healthcare facilities hand over the segregated, properly sealed and labelled hazardous healthcare waste to the EPA licensed incineration facilities (Note: As per hazardous substances rules, the incinerators will have to get license from the concerned EPA). It will also be the responsibility of the Health Departments that designated representatives should also visit the incinerator facilities to ensure that these facilities are being operated as per the required standard, fully equipped with air pollution control gadgets and there is proper arrangement of ash disposal.

TTT. Recommendation 4: **Trainings on Hazardous Substances Rules, Hospital Waste Management Rules, and Life and Fire Safety Guidelines**

Provincial Health Departments in collaboration of Ministry of Health should strengthen existing training programs by including trainings for compliance with Hazardous Substances Rules, Hospital Waste Management Rules, and Life and Fire Safety Guidelines. In provinces where training programs are not conducted these provinces should replicate the training programs under implementation in Punjab and Sindh. These training programs should also include the requirements of Environmental Protection Acts and generation of environmental performance data of incinerators.

UUU. Recommendation 5: Improve Inter and intra provincial coordination among the implementing organizations

Memorandums of Understanding (MoUs) should be developed with the provincial health and education departments as well as service providers to clearly stipulate roles and responsibilities, not only at the provincial level, but to the district level. MOUs should also involve guidelines on the management of personal healthcare data collected as part of the program

VVV. Recommendation 6: Develop Communication Campaigns

Develop multi-modal communication campaigns in local languages; particularly focused on principles of Universal Health Care (UHC) and incorporating digital and technology literacy aspects. medical and public health education, training, practice, and research needs to be aligned with UHC. On the demand side, linkages with community-based service providers and NGOs should be created to build community support for family planning, maternal health and vaccination and immunization services. Use of technology may be extended to healthcare professionals such as training them to provide health information, follow up reminders, and any health-related referrals and assistance via text messages to the communities in remote and far-flung areas. This would also entail stakeholder consultations to enhance inclusion and effective participation of project beneficiaries, which include the vulnerable and indigenous peoples across the country.

WWW. Recommendation 7 Evaluation of Complaint Management System

Conduct periodic evaluation of the CMS to ensure that the GRM remains transparent, effective, and inclusive, and also involves project workers.

Table 3: Recommended Inputs for Program Action Plan

#	Action	Responsible Department	Timeline	Estimated Cost (US$)	Progress Indicator
1	Develop SOPs for PHCs environmental and social management of PHCs	MNHSRC and Provincial Health Departments	First six months	15,000	SOPs document
2	Training on Hazardous Substances Rules & Hospital Waste Management Rules, and Life & Fire Safety Guidelines	MNHSRC, PSHD, HD-S, HD-K, HD-B	First six months of program implementation	15,000	Training Documents, Post Training Report
3	Training on standard operations of the healthcare waste incinerators and assessment of their infrastructure	PSHD, HD-S, HD-K, HD-B, Provincial EPAs	First six months of program implementation	15,000	Training Documents, Post Training Report

4	Improved coordination amongst service providers	MNHSRC, provincial departments and PHC providers	Second year of program implementation	5,000	Signed MOUs
5.	Communications campaign	MNHSRC	Throughout the program	30,000	Communications tools developed
6.	GRM Monitoring	MNHSRC	Throughout the program	30,000	Quarterly reports

Annex-1: References

Project Appraisal Document for a National Health Support Program (P172615), December 2021

Ayesha Khan, 1999, Reproductive Health Matters, Mobility of women and access to health and family planning services in Pakistan.

The GRM Template available at http://pubdocs.worldbank.org/en/909361530209278896/ESF-Template-ESS10-SEP-June-2018.pdf.

The GRM Checklist available at (http://pubdocs.worldbank.org/en/354161530209334228/ESF-Checklist-ESS10-GRM-June-2018.pdf)

Lady Health Worker Programme, Pakistan Performance Evaluation Report September 2019, Oxford Policy Management; conducted for UNICEF and the Ministry of National Health Services, Regulations and Coordination

Mobile Gender Gap Report, GSMA, 2020

Polio Global Eradication Initiative, Accessed: https://polioeradication.org/news-post/celebrating-the-female-vaccinator/

Zubia Mumtaz et al, 2003, Gender-based barriers to primary healthcare provision in Pakistan: the experience of female providers

Annex-2: Pollutants from Medical Waste Incinerators

Particulate Matter: PM is emitted as a result of incomplete combustion of organics (i.e., soot) and by the entrainment of noncombustible ash due to the turbulent movement of combustion gases. Particulate matter may emit as a solid or an aerosol, and may contain heavy metals, acids, and/or trace organics. Uncontrolled particulate emission rates vary widely, depending on the type of incinerator, composition of the waste, and the operating practices employed.

Metals: The type and amount of trace metals in the flue gas are directly related to the metals contained in the waste. Metal emissions are affected by the level of PM control and the flue gas temperature.

Acid Gas: Acid gas concentrations of hydrogen chloride (HCl) and sulfur dioxide (SO_2) in the flue gases are directly related to the chlorine and sulfur content of the waste. Most of the chlorine, which is chemically bound within the waste in the form of polyvinyl chloride (PVC) and other chlorinated compounds, will be converted to HCl. Sulfur is also chemically bound within the materials making up medical waste and is oxidized during combustion to form SO_2.

Oxides of Nitrogen: Oxides of nitrogen (NOx) represent a mixture of mainly nitric oxide (NO) and nitrogen dioxide (NO_2). These are formed during combustion by: (1) oxidation of nitrogen chemically bound in the waste, and (2) reaction between molecular nitrogen and oxygen in the combustion air. The formation of NOx is dependent on the quantity of fuel bound nitrogen compounds, flame temperature, and air/fuel ratio.

Carbon Monoxide: Carbon monoxide is a product of incomplete combustion. Its presence can be related to insufficient oxygen, combustion (residence) time, temperature, and turbulence (fuel/air mixing) in the combustion zone.

Organics: Failure to achieve complete combustion of organic materials evolved from waste can result in emissions of a variety of organic compounds. The products of incomplete combustion (PICs) range from low molecular weight hydrocarbon (e. g., methane or ethane) to high molecular weight compounds (e. g., polychlorinated dibenzo-p-dioxins and dibenzofurans [CDD/CDF]). In general, combustion conditions required for control of CO (i. e., adequate oxygen, temperature, residence time, and turbulence) will also minimize emissions of most organics. Emissions of CDDs/CDFs from incinerator may occur as either a vapor or as a fine particulate.

Annex-3: Proceedings of the Stakeholder Consultation Workshop held in February 2022

Shandana Khan, **RSPN:**

- Largest civil society network. Mobilize communities in rural areas to improve public service delivery and link them to government. It Is happening in an ad hoc way. 54 million indirectly mobilized into community groups across the country. Important to note the issues at micro level. Working to improve service delivery and community health in non LHW covered areas. Our experience is that if you do a mobilization process, even with sensitive subjects like family planning it is not difficult to do. One has to look at that level and see what works on the ground. RSPN offer is to support public-sector in-service delivery.

Dr. Yasmin Qazi, **RIZ Consulting:**

Women's voices and accountability at the community level. Need feedback from community level. Three observations:

- In Result 1, family planning is mentioned but not the way it should be. If talking of improving immunization. How would you assess that FP has improved? through the improved CPR or introduction of unmet need? Should not lose sight of FP AS Nothing can be improved unless work on FP at the primary level.

- The primary player to implement project would be health department and in Pakistan without the vertical arrangement of both population dept and DOH. So how would we ensure that PHC is fully functional but also there are provider biases and there is a lack of understanding at the facility level? Why should health dep be putting their time and resources into it.

- Private sector is important. In social risks mention lack of confidence and public opinion How do u create positive demand about using a public sector facility. It will not happen overnight. There is a large private sector not just NGOs but also for profit. It might be unregulated but communities are going. Unless there is a mechanism to bring in the private sector, only referrals are going to be done from RHCs and BHUs to the higher health system to DHQs and THQs. How do we bring them in if we really want UHC? The universality of the health system in Pakistan will not be complete without the private sector. Except for Sindh which has PPP mode we don't see strong mechanisms or structures about private public partnership.

- Also regarding behavior change communication, if we want to increase demand for any preventive health care services whether its immunization, FP etc. BCC is a science now with use of digital technology and this is proven in COVID times. To increase positive demand, we need to factor in that Pakistan has a very high percentage of youth and young population and from reproductive point of view they are most important cohort we need to reach. but even in preventive care, creating positive demand for preventive care FP, immunization, maternal care, breastfeeding.

Muhammad Sarwat Mirza**, HANDS:**

- Looking at PHC from lens of Government is focused on health facilities and although HANDs have a very good outreach program there are still 30% communities with no access to health facilities and no LHW program. HANDs working there for 20 years and have access to at least 30 million community members through a community-based health program. There is a need to link primary health care program with the outreach program- FP and nutrition should be mentioned as they are two significant programs which are usually missed out. There must be indicators but FP and nutrition not flagged which are significant considering the MNCH indicators.

- For oversight of private sector providers currently Health Care commissions at provincial level is existed but coordination mechanism is currently missing piece. Do NHSP will include to focus this aspect.

- One of the proven improving health financing models even in Pakistan is Public Private partnership. Do you suggest this mode in NHSP?

- HANDS has undertaken many pilots in collaborations with health departments in all four provinces and established best practicing models. It is the time to negotiate or include in national level strategies to scale those models on community services for MNCH, FP, and nutrition, and institutionalize these models such as HANDS Marvi workers for non-LHW areas currently serving 30.0 million population.

World Bank:

- Regarding community and community engagement, how can this program support institutionalizing community engagement and feedback. Using technology in some counties and continuous mechanisms that allow for communities to provide to the provider. Especially PHC being the face of the health services, the community, trust, feedback and responsiveness of the provider to those concerns is really critical. What has worked from your experience? how can this exchange be institutionalized?

- Regarding the private sector, Pakistan has a mixed model where we know the private sector has played an extremely important role especially in curative care. In the provinces we do see quite a bit of effort already being undertaken to contract private providers. There are different models of engaging the private sector. Here NHSP is interested in the public commissions. How NHSP can help is, for instance on supply side readiness and information systems, we need to look beyond getting information from the public sector. However it is not easy as we need to ensure trust between public and private and that there are mechanisms and dialogue platforms at the provincial and lower level for public and private to engage. We see that TA and capacity building component under NHSP can play an important role in that. Some provinces may be ready to be looking at PPPs but in some areas, it could be about starting a constructive dialogue and sharing information and data. Look forward to input on what do you think would be valuable actions and intervention that the public sector (districts and provinces) can take to meaningfully engage the private sector?

- Regarding demand generation and Social and Behavior change communication, using technology is a very powerful way to reach a wide group of consumers and community but digital technology is still restricted for some groups for instance woman in remote areas. Under TA and capacity building have an innovation where provincial authorities can work with NGOs and different providers that are already using technology to reach women, to build trust etc. If successful pilots already and there is consideration on how to scale that up, that could be supported under input base of the program.

- On gender, for example some of the DLIs such as competencies of facility and community-based providers we see the competency and skill not as just as hard skills but also soft skills of communication, gender sensitivity which need to be integrated in the training and into assessing performance. Hope NHSP can support improving the providers on supply side to become more responsive and sensitive especially on FP?

- What mechanisms and interventions need to be integrated from Government to address some of the issues that you raise?

Shandana Khan, **RSPN:**

- The key question being asked is how you institutionalize people's participation and we know various projects create various committees which end with the project. Citing the example of the Sindh government

there is a program called the Peoples Poverty Reduction Program and the govt is putting public funds in and EU funding it. Largest rural women's' program in Pakistan. Contracted RSPs in Sindh and because the Sindh Rural Support Organization was set up by the Govt they are doing the mobilization at the grass roots level. This is a huge scale of mobilization. Women are organized into groups and they are sitting with district government with their own multi sector plans which include health. On an ad hoc basis government does respond.

- Now at this point that the policies have to change at the provincial level. In other words the rules of business of the Govt have to change to say that education, health, livestock functionaries will work through these community groups. Biggest scale outreach and it is by the Government. So one hand of the government needs to coordinate better with the other hand. Huge potential to formalize this and health dept can take the lead.

Dr. Razia, **Social Protection Resource Centre :**

Recently published a report on social protection model and mechanisms existing in Pakistan. Now launching second report on old age well beings and impact of environment and climate change on health of old people. Two comments:

- For environmental risks is vaccine waste included or not? campaign going on for covid vaccine lot of complaints with EPA for vaccine management.

  Environmental risks for PHC facilities- 4 components vulnerable human resources, infrastructure, procurements, availability of medicine and vaccine, transportation, energy supply, WASH should also be considered. The infrastructure is v imp but that is not included in this project.

- Social risk Workplace harassment and hierarchical harassment of the health workforce also important to include

- On government and accountability pharmacological waste is mentioned but for waste management still at the basic level for disposal. Did a study recently on waste management- At primary level capacity not up to the mark. Appropriate management lacking. Also how much IT waste produced at primary health care level.

- Although you state Minimal risk in environment in result 3, infection prevention is high. The same study showed that one of the bottlenecks is an issue of funds at PHC level hindering the buying of materials used for infection prevention and control so that is also a risk.

- Climate hazard is a big risk and needs to be included in the social risks.

Dr. Yasmeen Qazi, **RIZ Consulting:**

- Coordination between provincial govts can be problematic especially due to political arrangement and Govt which we have seen in recent year. Cite an example under FP2020 arrangements working with the Secretariat. Everywhere there is a national road map. In Pakistan due to devolved system each province had own trajectory so Federal Government created a country engagement group- what is called FP2030 Country Engagement Working Group -CEWG- act like a facilitator and every quarter the meeting is organized by a province on a rotational basis. It is kind of an accountability forum where you look at the indicators. Federal ministries have a custodian role and provinces play an active role and report. Lead FP NGOs and Donors are also part of it. Initially it was tough as had to negotiate and then build it up. Now cited as a global practice in the meetings of FP2020 and now it is FP 2030. How Pakistan has improved the coordination between the Federal and provincial levels and increased the level of trust and partnership in Family Planning. This is a great way of having your own significance as a province and also a learning forum

as learning from each other and there have been sharing of commodities also when one province has a shortfall. This can be modified and improved.

- Digital technology is a great tool for accountability. Also district level management teams should be regularized and held accountable for making those systems. For instance village health committees which LHWs use to collect people's voices and other processes. District committees can take an active role in ensuring citizen voices, women's' voices that they are satisfied with the services.

World Bank:

- NHSP being a national platform, the provinces lead the service delivery. Hope NHSP creates this platform around results of essential services- critical to that are maternal child health services, RH and FP being one. There is a power to bringing stakeholders, not just provincial but also private NGOs to actually come around results which creates a discussion around accountability and transparency because of the sharing. When there are different provinces aspiring for UHC and taking slightly different approaches but coming together on shared results, this is a powerful platform.

- Under NHSP there will be strong provincial oversight such as steering committees, multi stakeholder platforms but also have joint reviews and missions which brings together the achievements, progress and learning that comes with it. So would like to use NHSP as a dialogue platform where we can learn more. Interested in learning about the FP2020 experience and what makes it work. Also appreciate learning about the struggles as lessons learnt and make new mistakes.

- PFM Reforms- one is to ensure flow of funds to PHC and that they can be used for important goods and inputs in a timely way. These are critical in involving the financial departments to own it and be supportive of it. PFM can be a huge stumbling block for delivering services and managing waste and implementing infection prevention control. This reform will have positive benefits across many actions and services that the primary health care has to deliver.

World Bank:

- Issues around grievance. How can we communicate more effectively to people that these are options available to them?

Dr Sarwat, **HANDS:**

It is mandatory for all private providers to be registered with the Healthcare Commission. However for instance in Sindh in rural areas, the private providers are still not registered with the Healthcare Commission. It is a difficulty for organizations like HANDs working in these areas who have to sign an MOU with them and need them for FP services and nutrition counselling, so they have to convince the providers to be a part of the Healthcare Commission. It is difficult to engage private providers and the Government should facilitate this mechanism for registering the private providers with the Healthcare Commissions and the District Health Department may be a facilitator in that regard.

Dr Razia, **Social Protection Resource Centre :**

- Healthcare Commissions can be quite effective but the problem is that they are at different stages in the provinces. In KP and Punjab they are working quite well. In Sindh they have started but what about in Baluchistan. IHRA (Islamabad Health Regulatory Authority) has started working. The ministry is there for the coordination and monitoring. We need to work on this mechanism.
  Regarding coordination between federal and provinces, in all four provinces there are social security systems but there is no joint body at the federal level to provide equal provisions. There should be a central body in addition to the ministry which can coordinate activities of the Program.

- Accountability at the community level can also be utilized especially for grievance redressal mechanisms. Legislation is there but how to make it operational.

World Bank:

- How to increase citizen trust in public service delivery? Not just an issue of healthcare but with any public service. There are mechanisms in the Program what can be done to make people more comfortable with what the state promises and what it delivers?

Dr Yasmin Qazi, **RIZ Consulting**

- Easy to see what makes people comfortable and happy with a provider that they want to return to and access the services. Quality speaks for itself. It's not about hard skills but also soft skills such as communication, counselling as you said especially in areas like FP. It would make anyone return to that facility.

- The second example is social marketing programs. How do they market their programs? For instance, Greenstar Social Marketing. An example of Sindh, the PPHI is managing BHUs and the way they have turned around the service structure and show results is impressive- physical upgradation, placement of more qualified staff, strong monitoring and supportive supervision that you need to have for a continuum of care. So it is not just one time but as an institution how they are managing and monitoring and of course stockouts and supply chain are managed. This is a kind of example that can be looked at to increase citizen trust. Also social marketing which applies like Thanak Clinics for instance paint the midwife house etc. and garner interest. These are a few principles and there are examples in the private sector which the Government can follow and transform the way the Government functionaries work. They should draw on out of the box thinking and solutions that can work differently from the public sector mode and transform it.

World Bank:

- Citizen engagement with the public financial management and budgeting process is important. Communication should not be just around health care issues but the UHC principle. If the state is committing to the UHC principle and the citizens can advocate for that to keep the government accountable or even the private sector if it is a shared responsibility.

Maham Javed, **Punjab Public Health Authority:**

- Service delivery is important but the availability of quality services for FP is also important

- Women in towns or villages trust each other than a clergy person, religious person, NGO or social organization. If there is one bad experience with a contraceptive that is loud in the community. Good examples should be used to convince people for FP.

Dr. Razia, **Social Protection Resource Centre :**

- Important to work on health care providers satisfaction at the facility level, their trainings and giving ownership to them of their facility. Some incentives given to them when they have increased OPD and indicators improving will also work at the PHC level.

- Management for healthcare workers at PHC is also important and can bring out good results

Annex-4: Profiles of Stakeholder Institutions

Ministry of National Health Services Regulations and Coordination

Functions

The following business is allocated to MoNHSRC:

1. Pakistan Medical and Dental Council.
2. Pakistan Council for Nursing.
3. College of Physicians and Surgeons.
4. National Councils for Tibb and Homeopathy.
5. Pharmacy Council of Pakistan.
6. National associations in medical and allied fields such as Pakistan Red Crescent Society and TB Association.
7. Directorate of Central Health Establishment.
8. Drug Regulatory Authority of Pakistan.
9. International aspects of medical facilities and public health, International Health Regulations, health and medical facilities abroad.
10. National Institute of Health.
11. National Health Emergency Preparedness and Response Network.
12. Pakistan Medical Research Council.
13. Health Services Academy, Islamabad.
14. Coordination of Vertical Health Programmes including interaction with GAVI, EPI and the Global Fund for AIDS, TB, Hepatitis and Malaria.
15. National Planning and Coordination in the field of health.
16. Planning and Development Policies pertaining to Population Programmes in the country.
17. Matters relating to National Trust for Population Welfare and National Institute of Population Studies.
18. Mainstreaming population factor in development planning.
19. Directorate of Central Warehouse and Supplies, Karachi.
20. Human Organ Transplant Authority.
21. Charitable endowments for Federal area.
22. Medical and health services for Federal Government employees.
23. Administrative control of the National Institute of Handicapped, Islamabad.
24. Shaheed Zulfiqar Ali Bhutto Medical University, Islamabad.
25. Federal Medical and Dental College, Islamabad.
26. Federal General Hospital, Islamabad.
27. National Institute of Rehabilitative Medicine.
28. District Population Welfare Office.
29. Dealing and agreements with other countries and international organizations in matters relating to Population Planning Programs.
30. Dealing and agreements with other countries and international organizations, in the field of health, drugs and medical facilities abroad.
31. Scholarships / fellowships, training courses in health from International Agencies such as WHO and UNICEF.

32. Federal Government Tuberculosis Centre, Rawalpindi.

Organizations

The list of organizations under MoNHSRC are:

A: Autonomous Bodies

1: National Institute of Health (NIH)
2: Drugs Regulatory Authority of Pakistan (DRAP)

3: Health Services Academy (HSA)
4: Pakistan Health & Research Council (PHRC)

5: Pakistan Medical & Dental Council (PMDC)
6: College of Physician & Surgeons Pakistan (CPSP)

7: Pakistan Nursing Council (PNC)
8: Pharmacy Council of Pakistan (PCP)
9: National Council for Homeopathy (NCH)

10: National Council for Tibb (NCT)
11: National Trust for Population Welfare (NATPOW)

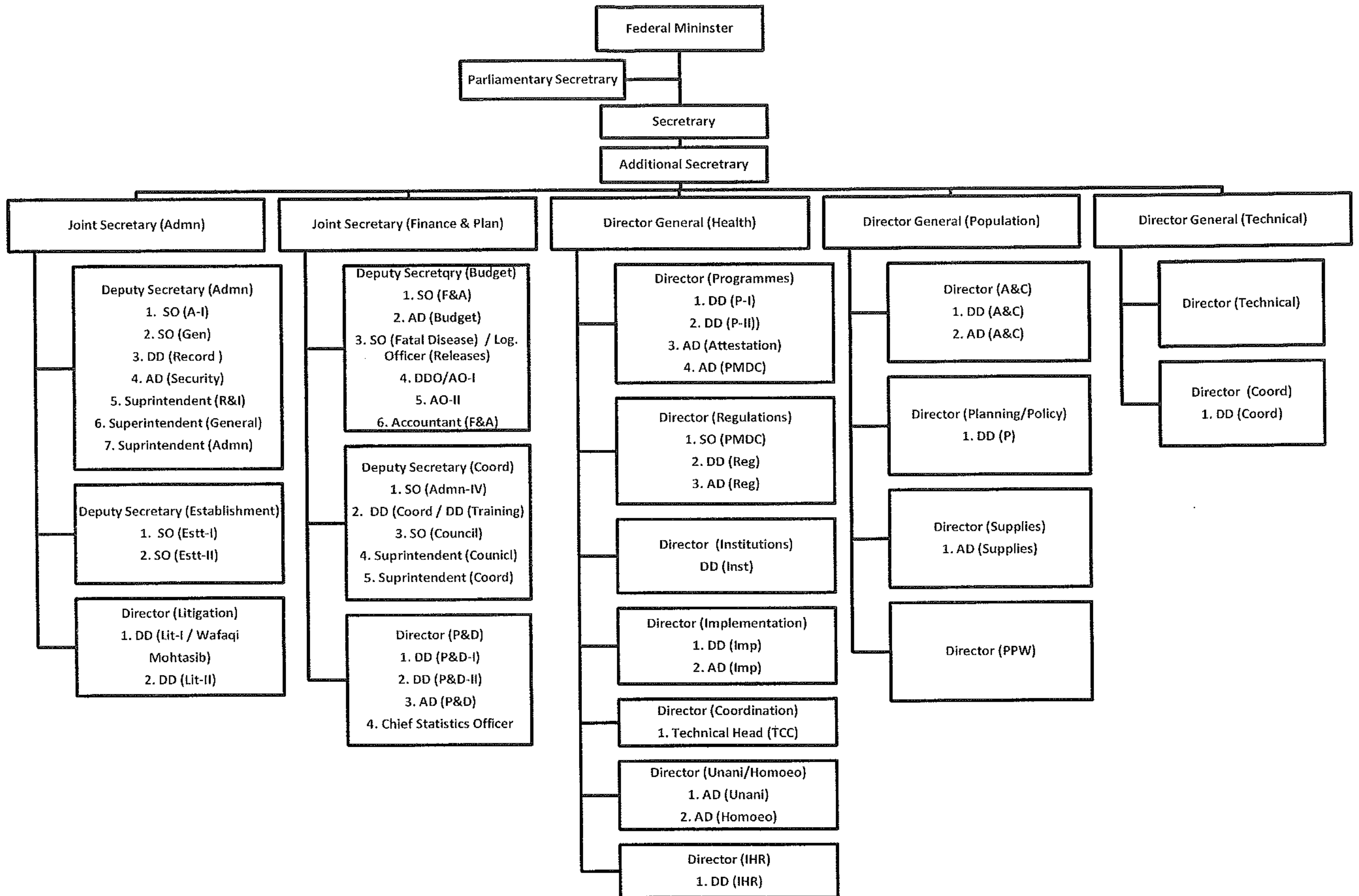
12: Human Organs Transplant Authority (HOTA)
13.Shaheed Zulfiqar Ali Bhutto Medical University (SZABMU)

B: Attached Departments

1: Directorate of Central Health Establishment (CHE)
2: Federal Government Poly Clinic (FGPC)
3. Pakistan Institute of Medical Sciences (PIMS)
4: Directorate of Malaria Control (DMC)

C: Subordinate Offices

1: National Research Institute of Fertility Care (NRIFC)
2: National Health Emergency Preparedness & Response Network (NHEPRN)
3: National Institute of Population Studies (NIPS)
4: National Health Information Resource Centre (NHIRC)
5. Central Warehouse and Supplies (CW&S)
6: Health Planning, System Strengthening & Information Analysis Unit (HPSIU)



Organogram

The organogram of the Ministry is as under:

Primary and Secondary Healthcare Department, Punjab

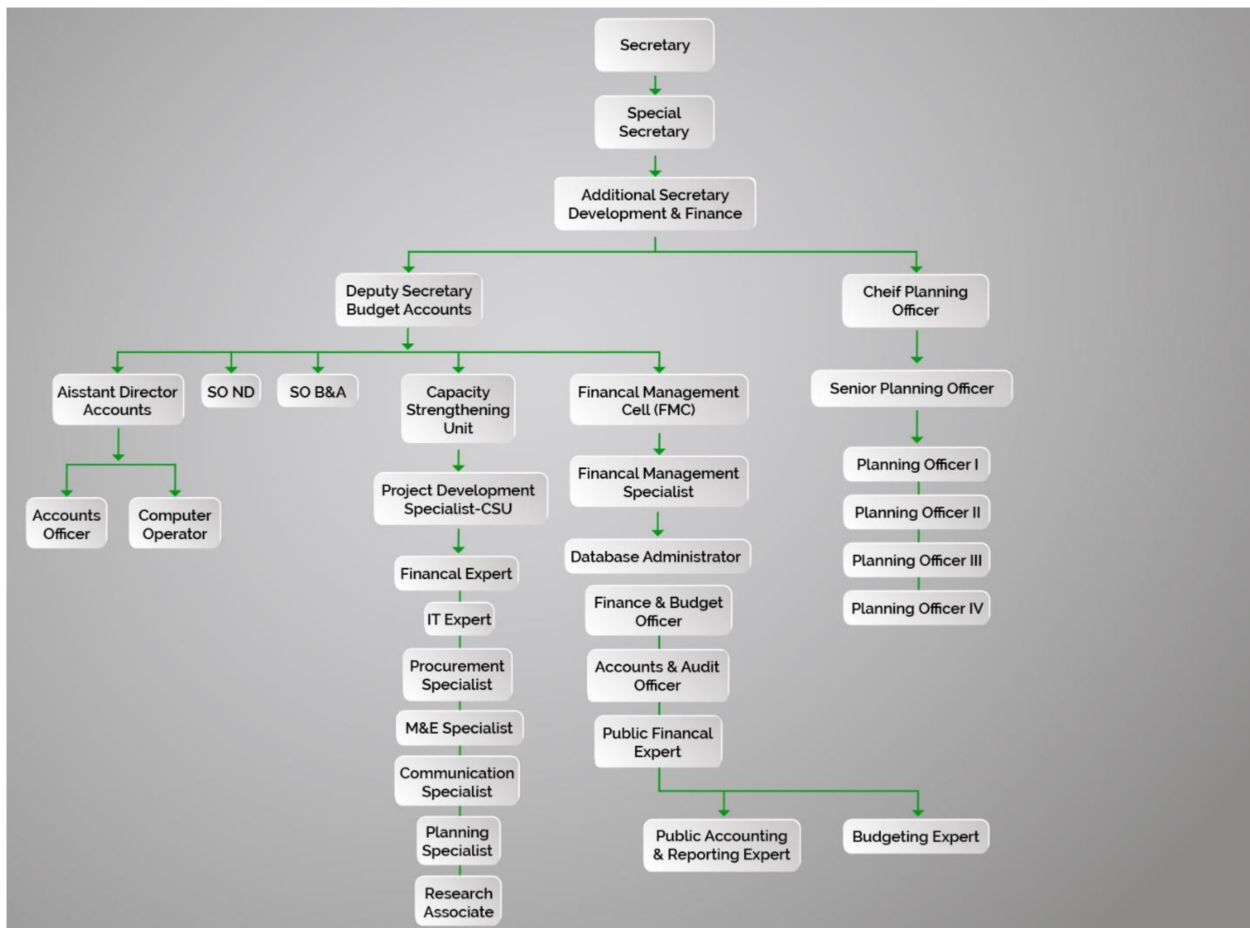
Functions and Services

- Health management planning and policy
- Prevention and control of dengue and other vector borne diseases
- Collection, compilation registration and analysis of vital health

- Health management planning and policy
- Service matters except those entrusted to services and general administration
- Indigenous system of medicine
- Control of medicinal drugs poisons and dangerous drugs
- Administrative control of the entire nursing
- Budget, accounts and audit matters, purchase of stores
- The Public Health Ordinance 1944, Epidemic Disease Act 1958

Organogram (Development Wing)

The organogram of the department is as under:



Health Department, Government of Sindh

Functions

The Department of Health is responsible of public health in Sindh, Pakistan. The Department of Health performs the following major functions:

- Accreditation to the provincial Medical Schools-Medical Course
- Has responsibility for government medical employment in Sindh

- Make decision regarding Sindh Health Force
- Health Legislation to curb quackery
- Regulation of Private Health Sector
- Legislation of medico legal & organ transplant
- Execute different Projects/Schemes with Donor coordination
- Administer Human Resource of Health Department

Organogram

The organogram of the department is as under:

Functions

- The department of health has several functions and manifold responsibilities to improve the health standard throughout the province of Balochistan. Functions of health department include delivery of health care services, health planning, management and development, development of human resources and regulatory functions.
- Delivery of Health care services includes preventive, curative and special services. Preventive program such as EPI, MCP, TB Control Program, HIV/AID controls program, Leprosy Control Program, MCH Program, National Program for FP&PHC, Polio Eradication Initiatives (PEI) etc. are being run by the health department.
- Curative services are provided at the secondary and tertiary level in multiple specialties. Under special services: emergency and disaster services, medico-legal services and referral care are included.
- In health planning, management and development, the health department proposes a provincial health policy which is implemented after approval, a Health Management Information System (HMIS) exists, the function of which is to retrieve and store data from reports and survey. Planning for various interventions is done, both at macro and micro level. Coordination is an important function of the health department, it is performed at various levels with the federal Government, International Agencies as well as there is intra and inters department coordination. Research is done for health care planning, management and human resource development. Another vital function the health department performs is human resource development, in which need identification is done, in-service training for health staff and assessment of quality and regulatory affairs of formal training. Training is provided, both at pre-service level and in-service level. The pre-service level institutions are Bolan Medical College, Multipurpose Training School, Public Health School and Nursing Schools. In-service training institutes are the postgraduate Medical Institute, Institute of Public Health, Midwifery Training Schools, the provincial and district Health Development Center. Training covers a wide range of topics, some examples are training for preventive program, project training, training sponsored by international agencies for doctors and paramedics.
- Slots from the federal Government for foreign Training also exist for the province, and from time-to-time health staff are nominated for long / short courses, seminars, workshops, conferences, to represent the department of health.
- Regulatory functions of the health department include: developing and strengthening regulatory framework to standardize. Health care services like: Balochistan Hospital Regulatory Authority Act. Balochistan Clinical Laboratory Authorities Act, Safe Blood Transfusion Act of Balochistan. Enforcing Regulation of the above-mentioned Acts. Drug Act for sale and quality of medicines. Food and water regulation and standard, environmental occupational health.
- Health Department also arranges special program / project with international agencies like the women health project in collaboration with ADB. The Reproductive Health Project with ADB and UNFPA. HIV /

AIDS Control Program with the World Bank. An Isolation Ward has been established in FJ Chest & General Hospital. Quetta for patients of Congo virus Hemorrhagic Fever (CCHF). During the year 2004 several medical camps have been held in collaboration with Pakistan Army. The Health Department has taken steps to eradicate polio through the polio eradication initiative (PEI), which started in 1994, and total NIDs to date are 49.

- The provincial offices functioning at Quetta are the Provincial Health Directorate. Expanded program on Immunization (EPI). Malaria Control Program (MCP). HRD / PHDC, Govt. Public Analyst. Food Laboratory, Drug Testing Laboratory, Govt. Medical Store Depot (MSD). Leprosy and blindness Control Program. HIV / AIDS, TB Control Program, Women Health Project, National Program for FP & PHC. Reproductive Health Project, Drug and Quality Control Program, Office of Chief Planning officer, planning cell, Managing Director Health Foundation and MNCH Program. Another Important feature is the maintenance of Vital Health, statistics and under special services, there is provision of medical and health services for provincial Government employees.

Organogram

The organogram of the department is as under:

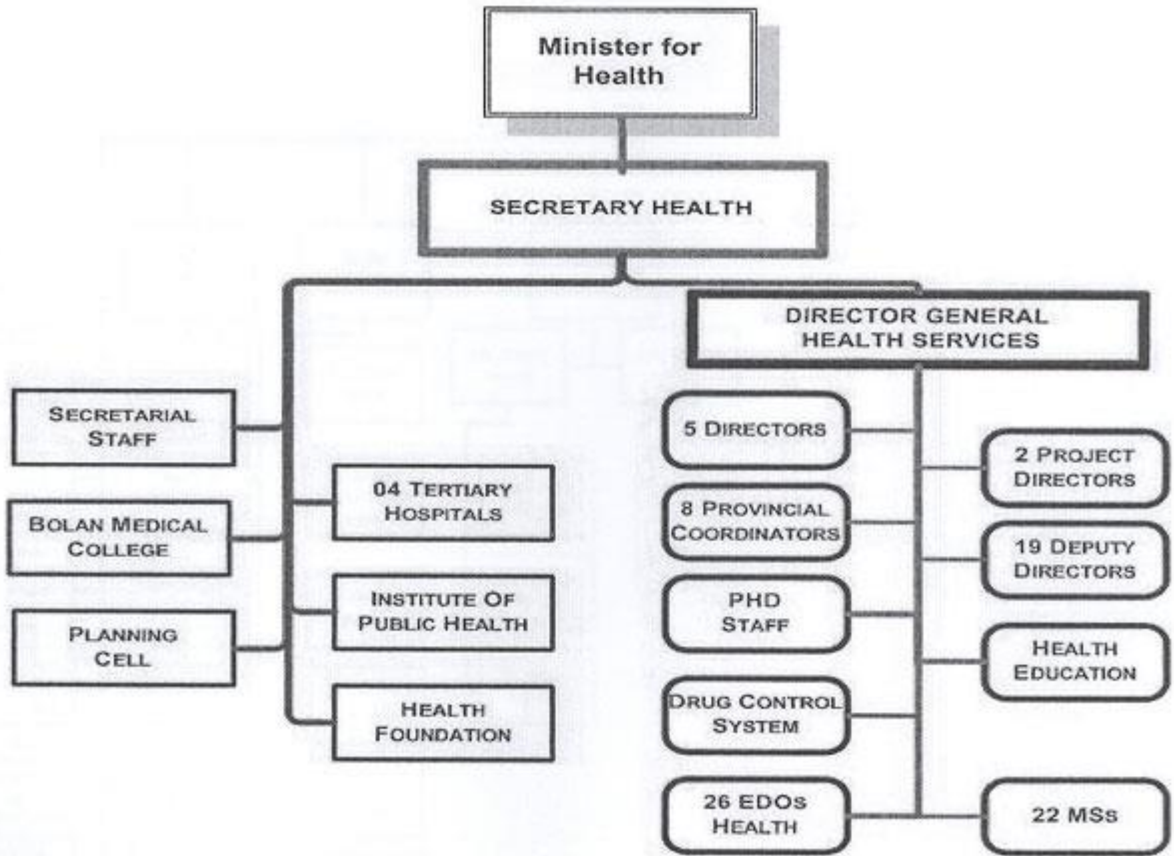
Functions

- The department of health has several functions and manifold responsibilities to improve the health standard throughout the province of Balochistan. Functions of health department include delivery of health care services, health planning, management and development, development of human resources and regulatory functions.
- Delivery of Health care services includes preventive, curative and special services. Preventive program such as EPI, MCP, TB Control Program, HIV/AID controls program, Leprosy Control Program, MCH Program, National Program for FP&PHC, Polio Eradication Initiatives (PEI) etc. are being run by the health department.
- Curative services are provided at the secondary and tertiary level in multiple specialties. Under special services: emergency and disaster services, medico-legal services and referral care are included.
- In health planning, management and development, the health department proposes a provincial health policy which is implemented after approval, a Health Management Information System (HMIS) exists, the function of which is to retrieve and store data from reports and survey. Planning for various interventions is done, both at macro and micro level. Coordination is an important function of the health department, it is performed at various levels with the federal Government, International Agencies as well as there is intra and inters department coordination. Research is done for health care planning, management and human resource development. Another vital function the health department performs is human resource development, in which need identification is done, in-service training for health staff and assessment of quality and regulatory affairs of formal training. Training is provided, both at pre-service level and in-service level. The pre-service level institutions are Bolan Medical College, Multipurpose Training School, Public Health School and Nursing Schools. In-service training institutes are the postgraduate Medical Institute, Institute of Public Health, Midwifery Training Schools, the provincial and district Health Development Center. Training covers a wide range of topics, some examples are training for preventive program, project training, training sponsored by international agencies for doctors and paramedics.
- Slots from the federal Government for foreign Training also exist for the province, and from time-to-time health staff are nominated for long / short courses, seminars, workshops, conferences, to represent the department of health.

- Regulatory functions of the health department include: developing and strengthening regulatory framework to standardize. Health care services like: Balochistan Hospital Regulatory Authority Act. Balochistan Clinical Laboratory Authorities Act, Safe Blood Transfusion Act of Balochistan. Enforcing Regulation of the above-mentioned Acts. Drug Act for sale and quality of medicines. Food and water regulation and standard, environmental occupational health.
- Health Department also arranges special program / project with international agencies like the women health project in collaboration with ADB. The Reproductive Health Project with ADB and UNFPA. HIV / AIDS Control Program with the World Bank. An Isolation Ward has been established in FJ Chest & General Hospital. Quetta for patients of Congo virus Hemorrhagic Fever (CCHF). During the year 2004 several medical camps have been held in collaboration with Pakistan Army. The Health Department has taken steps to eradicate polio through the polio eradication initiative (PEI), which started in 1994, and total NIDs to date are 49.
- The provincial offices functioning at Quetta are the Provincial Health Directorate. Expanded program on Immunization (EPI). Malaria Control Program (MCP). HRD / PHDC, Govt. Public Analyst. Food Laboratory, Drug Testing Laboratory, Govt. Medical Store Depot (MSD). Leprosy and blindness Control Program. HIV / AIDS, TB Control Program, Women Health Project, National Program for FP & PHC. Reproductive Health Project, Drug and Quality Control Program, Office of Chief Planning officer, planning cell, Managing Director Health Foundation and MNCH Program. Another Important feature is the maintenance of Vital Health, statistics and under special services, there is provision of medical and health services for provincial Government employees.

Organogram

The organogram of the department is as under:



Functions

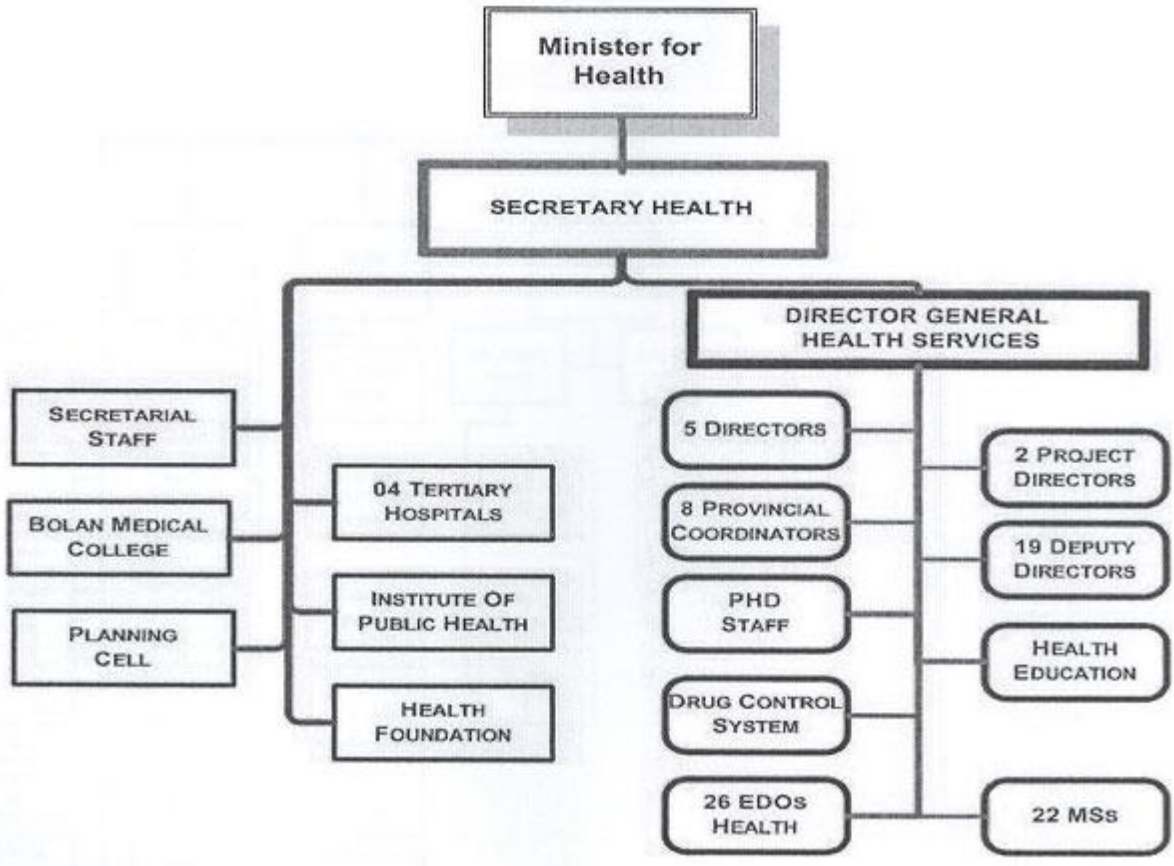
- The department of health has several functions and manifold responsibilities to improve the health standard throughout the province of Balochistan. Functions of health department include delivery of health care services, health planning, management and development, development of human resources and regulatory functions.
- Delivery of Health care services includes preventive, curative and special services. Preventive program such as EPI, MCP, TB Control Program, HIV/AID controls program, Leprosy Control Program, MCH Program, National Program for FP&PHC, Polio Eradication Initiatives (PEI) etc. are being run by the health department.
- Curative services are provided at the secondary and tertiary level in multiple specialties. Under special services: emergency and disaster services, medico-legal services and referral care are included.
- In health planning, management and development, the health department proposes a provincial health policy which is implemented after approval, a Health Management Information System (HMIS) exists, the function of which is to retrieve and store data from reports and survey. Planning for various interventions is done, both at macro and micro level. Coordination is an important function of the health department, it is performed at various levels with the federal Government, International Agencies as well as there is intra and inters department coordination. Research is done for health care planning, management and human resource development. Another vital function the health department performs is human resource development, in which need identification is done, in-service training for health staff and assessment of quality and regulatory affairs of formal training. Training is provided, both at pre-service level and in-service level. The pre-service level institutions are Bolan Medical College, Multipurpose Training School, Public Health School and Nursing Schools. In-service

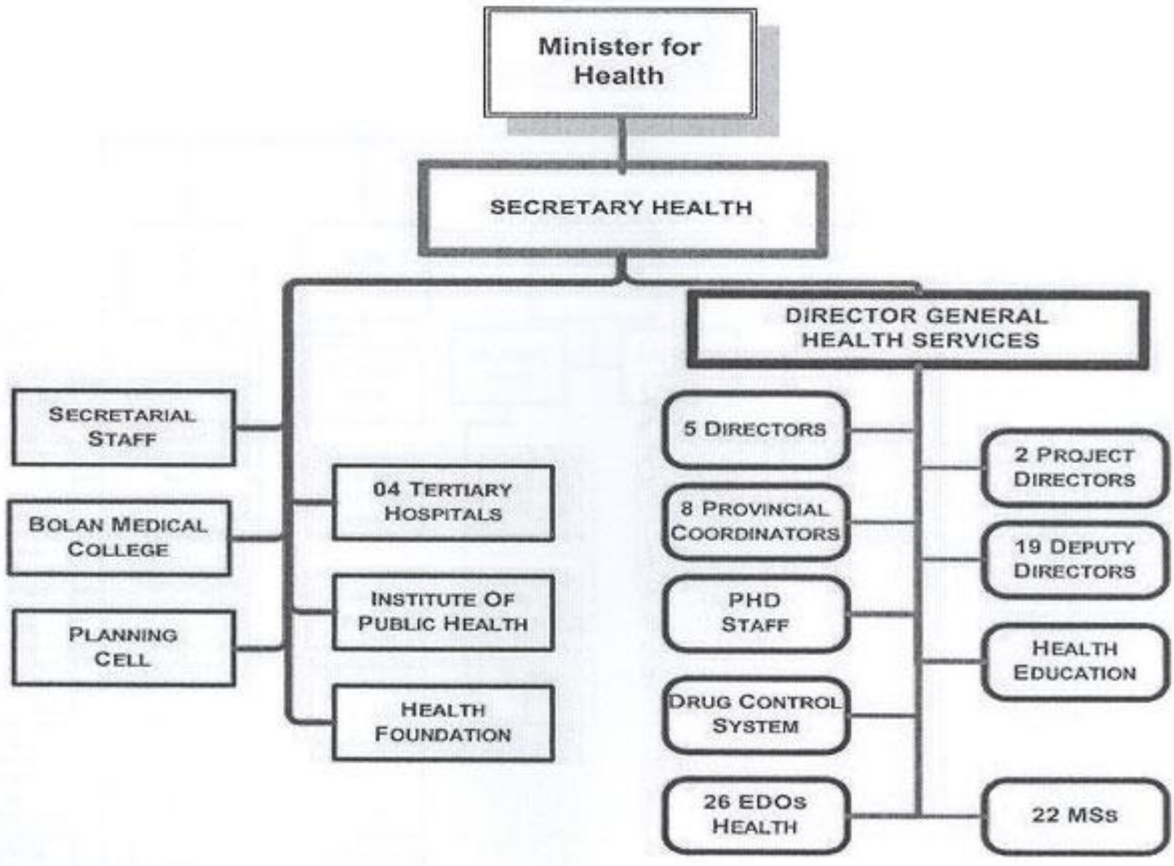
training institutes are the postgraduate Medical Institute, Institute of Public Health, Midwifery Training Schools, the provincial and district Health Development Center. Training covers a wide range of topics, some examples are training for preventive program, project training, training sponsored by international agencies for doctors and paramedics.

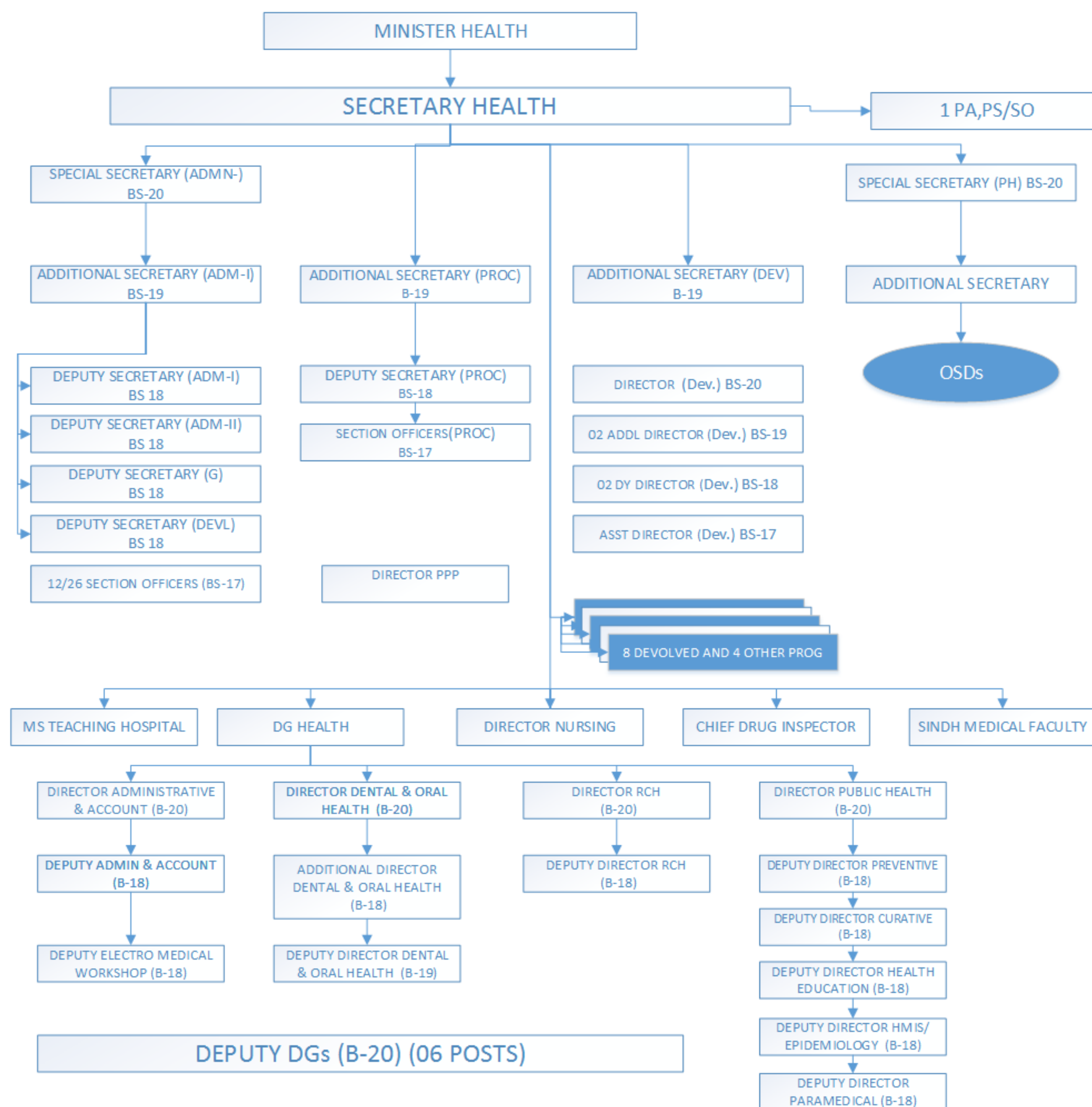
- Slots from the federal Government for foreign Training also exist for the province, and from time-to-time health staff are nominated for long / short courses, seminars, workshops, conferences, to represent the department of health.
- Regulatory functions of the health department include: developing and strengthening regulatory framework to standardize. Health care services like: Balochistan Hospital Regulatory Authority Act. Balochistan Clinical Laboratory Authorities Act, Safe Blood Transfusion Act of Balochistan. Enforcing Regulation of the above-mentioned Acts. Drug Act for sale and quality of medicines. Food and water regulation and standard, environmental occupational health.
- Health Department also arranges special program / project with international agencies like the women health project in collaboration with ADB. The Reproductive Health Project with ADB and UNFPA. HIV / AIDS Control Program with the World Bank. An Isolation Ward has been established in FJ Chest & General Hospital. Quetta for patients of Congo virus Hemorrhagic Fever (CCHF). During the year 2004 several medical camps have been held in collaboration with Pakistan Army. The Health Department has taken steps to eradicate polio through the polio eradication initiative (PEI), which started in 1994, and total NIDs to date are 49.
- The provincial offices functioning at Quetta are the Provincial Health Directorate. Expanded program on Immunization (EPI). Malaria Control Program (MCP). HRD / PHDC, Govt. Public Analyst. Food Laboratory, Drug Testing Laboratory, Govt. Medical Store Depot (MSD). Leprosy and blindness Control Program. HIV / AIDS, TB Control Program, Women Health Project, National Program for FP & PHC. Reproductive Health Project, Drug and Quality Control Program, Office of Chief Planning officer, planning cell, Managing Director Health Foundation and MNCH Program. Another Important feature is the maintenance of Vital Health, statistics and under special services, there is provision of medical and health services for provincial Government employees.

Organogram

The organogram of the department is as under:


Minister for Health
SECRETARY HEALTH
DIRECTOR GENERAL HEALTH SERVICES
SECRETARIAL STAFF
BOLAN MEDICAL COLLEGE
PLANNING CELL
04 TERTIARY HOSPITALS
INSTITUTE OF PUBLIC HEALTH
HEALTH FOUNDATION
5 DIRECTORS
8 PROVINCIAL COORDINATORS
PHD STAFF
DRUG CONTROL SYSTEM
26 EDOs HEALTH
2 PROJECT DIRECTORS
19 DEPUTY DIRECTORS
HEALTH EDUCATION
22 MSs


Minister for Health
SECRETARY HEALTH
DIRECTOR GENERAL HEALTH SERVICES
SECRETARIAL STAFF
BOLAN MEDICAL COLLEGE
PLANNING CELL
04 TERTIARY HOSPITALS
INSTITUTE OF PUBLIC HEALTH
HEALTH FOUNDATION
5 DIRECTORS
8 PROVINCIAL COORDINATORS
PHD STAFF
DRUG CONTROL SYSTEM
26 EDOS HEALTH
2 PROJECT DIRECTORS
19 DEPUTY DIRECTORS
HEALTH EDUCATION
22 MSS



Department of Health, Balochistan

Functions

- The department of health has several functions and manifold responsibilities to improve the health standard throughout the province of Balochistan. Functions of health department include delivery of health care services, health planning, management and development, development of human resources and regulatory functions.
- Delivery of Health care services includes preventive, curative and special services. Preventive program such as EPI, MCP, TB Control Program, HIV/AID controls program, Leprosy Control Program, MCH Program, National Program for FP&PHC, Polio Eradication Initiatives (PEI) etc. are being run by the health department.

- Curative services are provided at the secondary and tertiary level in multiple specialties. Under special services: emergency and disaster services, medico-legal services and referral care are included.
- In health planning, management and development, the health department proposes a provincial health policy which is implemented after approval, a Health Management Information System (HMIS) exists, the function of which is to retrieve and store data from reports and survey. Planning for various interventions is done, both at macro and micro level. Coordination is an important function of the health department, it is performed at various levels with the federal Government, International Agencies as well as there is intra and inters department coordination. Research is done for health care planning, management and human resource development. Another vital function the health department performs is human resource development, in which need identification is done, in-service training for health staff and assessment of quality and regulatory affairs of formal training. Training is provided, both at pre-service level and in-service level. The pre-service level institutions are Bolan Medical College, Multipurpose Training School, Public Health School and Nursing Schools. In-service training institutes are the postgraduate Medical Institute, Institute of Public Health, Midwifery Training Schools, the provincial and district Health Development Center. Training covers a wide range of topics, some examples are training for preventive program, project training, training sponsored by international agencies for doctors and paramedics.
- Slots from the federal Government for foreign Training also exist for the province, and from time-to-time health staff are nominated for long / short courses, seminars, workshops, conferences, to represent the department of health.
- Regulatory functions of the health department include: developing and strengthening regulatory framework to standardize. Health care services like: Balochistan Hospital Regulatory Authority Act. Balochistan Clinical Laboratory Authorities Act, Safe Blood Transfusion Act of Balochistan. Enforcing Regulation of the above-mentioned Acts. Drug Act for sale and quality of medicines. Food and water regulation and standard, environmental occupational health.
- Health Department also arranges special program / project with international agencies like the women health project in collaboration with ADB. The Reproductive Health Project with ADB and UNFPA. HIV / AIDS Control Program with the World Bank. An Isolation Ward has been established in FJ Chest & General Hospital. Quetta for patients of Congo virus Hemorrhagic Fever (CCHF). During the year 2004 several medical camps have been held in collaboration with Pakistan Army. The Health Department has taken steps to eradicate polio through the polio eradication initiative (PEI), which started in 1994, and total NIDs to date are 49.
- The provincial offices functioning at Quetta are the Provincial Health Directorate. Expanded program on Immunization (EPI). Malaria Control Program (MCP). HRD / PHDC, Govt. Public Analyst. Food Laboratory, Drug Testing Laboratory, Govt. Medical Store Depot (MSD). Leprosy and blindness Control Program. HIV / AIDS, TB Control Program, Women Health Project, National Program for FP & PHC. Reproductive Health Project, Drug and Quality Control Program, Office of Chief Planning officer, planning cell, Managing Director Health Foundation and MNCH Program. Another Important feature is the maintenance of Vital Health, statistics and under special services, there is provision of medical and health services for provincial Government employees.

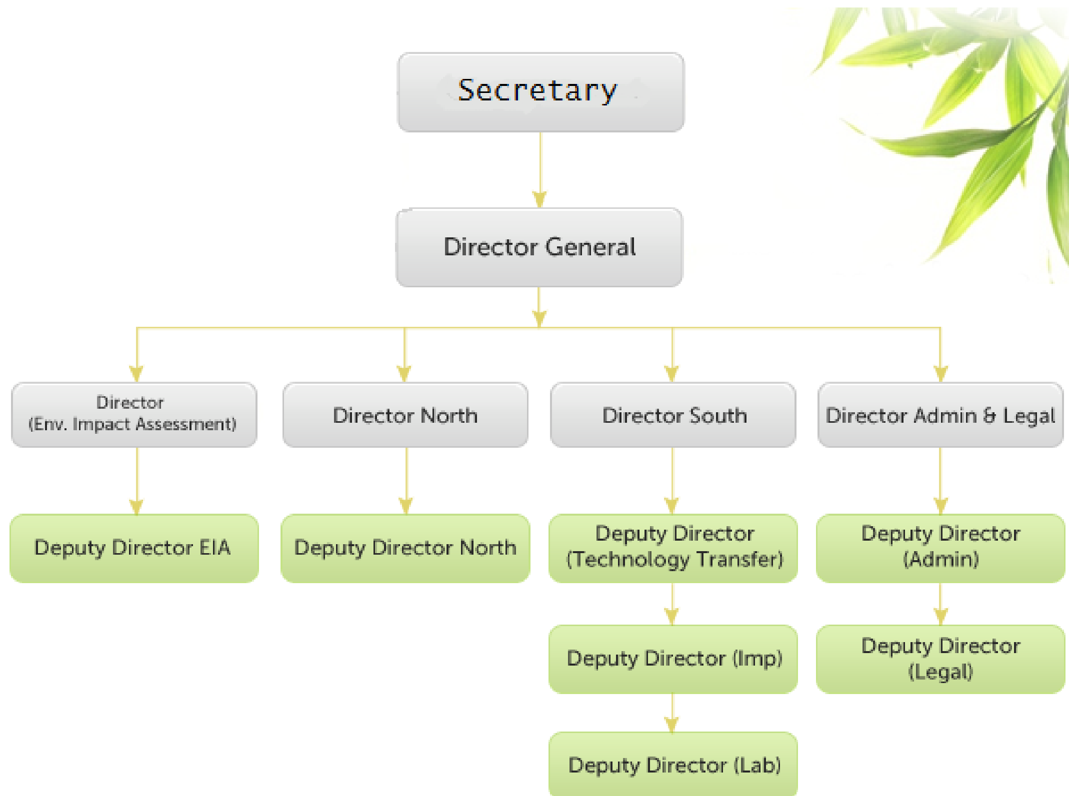
Organogram

The organogram of the department is as under:

Functions: The major functions of the Environment Protection Departments (EPDs) include:

- Administer and implement the provisions of the Environment Protection Act and the rules and regulations made there under
- Prepare and establish the Provincial Environmental Quality Standards with approval of the Council and Enforcement
- Take measures to promote research and development of science and technology which may contribute to the prevention of pollution, protection of the environment and sustainable development
- Identify the needs for, and initiate legislation in various sectors of the environment
- Provide information and guidance to the public on environmental matters
- Specify safeguards for the prevention of accidents and disasters which may cause pollution
- Encourage the formation and working of non-government, community and village organizations to prevent and control pollution and promote sustainable development
- Take all necessary measures for protection, conservation, rehabilitation and improvement of the environment, and for prevention and control of pollution
- Promotion of sustainable development

Organogram: The organogram of EPD, Punjab is presented below:



Annex- 5 Description of Environmental and Social Management System and Capacity and Performance Assessment

Introduction

This section describes the existing environmental and social management system of the institutions applicable in the implementation of the proposed program. It provides an overview of the policy and legal framework and a profile of the roles and responsibilities of the institutions involved in the environmental and social assessment and management.

There are many federal and provincial policies and legislations relevant to the overall management of the environmental and social impacts. Those policies and legislations are described which have relevance with the potential environmental and social impacts of the proposed program.

Policy Framework

In 2010, the 18th Constitutional Amendment was approved by the National Assembly of Pakistan. Under the amendment, environmental functions in the territory of the federal capital were delegated to Pakistan Environmental Protection Agency (Pak-EPA), and Provincial Environmental Protection Agencies were delegated the environmental management functions of provinces. In 2012, the federal government converted the Ministry of Environment to the Ministry of Climate Change (MCC). The MCC is mainly responsible for managing common national-level environment issues and climate change impacts and implementation of international conventions signed by the Government of Pakistan.

Environmental Policies

National Guidelines Infection Prevention & Control 2020 (IPC): National Institute of Health-Pakistan prepared comprehensive IPC guidelines with the support of WHO and national experts. IPC guidelines are applicable at the federal and provincial levels. Section 6 Environmental Cleaning focuses on cleaning methods, cleaning equipment, disinfection by detergent and chemicals, measurements of cleanliness, and management of potentially infectious spills. Section 7 focusses on management of healthcare waste. Section 7 describes in detail the type of education and training required for the waste management, steps to be taken for healthcare waste management, waste minimization measures, waste segregation, waste collection, storage and transport, treatment and disposal of waste, and finally the monitoring of waste. Section 8 focusses on protection of healthcare workers. This section describes responsibilities of healthcare facility and workers, immunization required by the staff, management of sharps injuries & blood and body fluid exposure, first aid, risk assessment, evaluation of source patient, and post-exposure prophylaxis.

Annex 2 of IPC establishes the minimum requirements for infection prevention at the primary, secondary, and tertiary health care. IPC guidelines propose that at primary health care level the following measures should be taken:

- Designate trained healthcare officer
- Facility-adapted standard operating procedures (SOPs) and their monitoring, including multimodal strategies for priority IPC interventions
- IPC training for all front-line clinical staff and cleaners upon hiring

- Availability of materials and equipment such as safe water, sanitation facilities, hand hygiene facilities at toilets, labelled bins for healthcare waste segregation, safe waste disposal facilities, availability of sufficient and appropriate IPC supplies and equipment.

National Environmental Policy 2005: The policy measures specific to the ***waste management*** include to strictly enforce the National Environmental Quality Standards, devise and implement National Sanitation Policy, establish cleaner production centers and promote cleaner production techniques and practices, encourage reduction, recycling and reuse of municipal and industrial solid and liquid wastes, develop and enforce rules and regulations for proper management of municipal, industrial, hazardous and hospital wastes, develop and implement strategies for integrated management of municipal, industrial, hazardous and hospital waste at national, provincial and local levels, and provide financial and other incentives for technology up-gradation, adoption of cleaner technology, implementation of pollution control measures and compliance with environmental standards.

The policy measures specific to the ***environment and health*** to prevent, minimize and mitigate detrimental health impacts associated with the environmental hazards include to incorporate environmental health and healthcare waste management components into medical teaching and training programs, develop and enforce occupational health and safety rules and regulations, and introduce effective waste management system in all healthcare facilities.

National Sanitation Policy 2006: The policy measure under ***hospital waste*** emphasizes that the provincial government should ensure that city government and TMAs follow the Hospital Waste Management Rules, 2005 notified by the Ministry of Environment for the safe disposal of hospital waste.

Environmental Legislations

Pakistan Environmental Protection Act 1997: PEPA 1997 is the basic legislative tool empowering the Government to frame regulations for the protection of the environment. It is a comprehensive legislation and provides the basic legal framework for protection, conservation, rehabilitation, and improvement of the environment. The Act is applicable to a wide range of issues and extends to air, water, soil, marine, and noise pollution, and to the handling of hazardous wastes.

Environmental pollution control associated with hazardous waste is addressed in this Act under Section 13 and 14. Under Section 13 ‘Prohibition of Import of Hazardous Waste’, no person shall import hazardous waste into Pakistan and its territorial waters, Exclusive Economic Zone and historic waters. Under Section 14 ‘Handling Hazardous Substances’, no person shall generate, collect, consign, transport, treat, dispose of, store, handle or import any hazardous waste except under a license issued by the Federal Agency and in such manner as may be prescribed or in accordance with the provision of any other law or of any international treaty, convention, protocol, code, standard, agreement or other instruments to which Pakistan is a party. *As per IEE and EIA Regulations 2000, EIA study is required for the installation of incinerators for hazardous waste disposal*.

Hospital Waste Management Rules 2005: These rules are made under Pakistan Environmental Protection Act 1997. The hospital waste under the rules includes a clinic, laboratory, dispensary, pharmacy, nursing home, health unit, maternity center, blood bank, autopsy center, mortuary, research institute and veterinary institutions, including any other facility involved in health care and biomedical activities. The hospital waste includes both risk waste and non-risk waste. As per these rules the Medical Superintendent shall constitute a waste management team and appoint a Waste Management Officer. This team shall be

responsible for the preparation, monitoring, periodic review or updating, if necessary, and implementation of the Waste Management Plan, and for supervision of all actions taken in compliance with the provisions of these rules. The duties and responsibilities of Medical Superintendent, Heads of Departments, Infection Control Officer, Chief Pharmacist, Radiology Officer, Senior Matron and Head of Administration, Hospital Engineer, and Waste Management Officer for the waste management and control of infections and other risks associated with the hospital waste. Waste Management Officer will prepare the Waste Management Plan based upon internationally recognized environmental management standards. These rules provide guidelines for the segregation of waste into risk waste and non- risk waste and placement accordingly, waste collection as per the schedule provided in the Waste Management Plan, waste transportation, waste storage, and waste disposal at landfill sites or incineration or any other methods approved by the Federal or Provincial Agency. These rules also provide guidelines in case of accidents and spillage of the waste, waste minimization and reuse.

Hazardous Substance Rules 2003: Under these rules, made under PEPA 1997, a license will be required for the import and transportation of hazardous substances from Federal or Provincial agency. The application for the grant of license for the industrial activity involving generation, collection, consignment, transport, treatment, disposal, storage, handling or import of hazardous substances, will also be accompanied with EIA report and safety plan. The validity of the license will be for three years from the date of issue. The licensee will notify any major accident occurring at licensed facility to provincial and federal agencies. There will be packing and labelling requirements, safety precautions for the premises and workers which will have to be followed. The licensed facility may be inspected by the provincial or federal staff.

Provincial Environmental Protection Acts: All the four provinces have enacted the following provincial environmental protection Acts:

- Punjab Environmental Protection Act 2012
- Sindh Environmental Protect Act 2014
- Khyber Pakhtunkhwa Environmental Protection Act 2014
- Balochistan Environmental Protection Act 2012

All these provincial environmental protection Acts address prohibition of discharges and emissions of wastewater and air emissions, noise control, requirements of initial environmental examination and environmental impact assessment for the newly established development projects, and hazardous waste and substances.

Under these Acts, no person is allowed to discharge or emit any effluent or waste or air pollutant or noise in an amount, concentration or level which is in excess of the prescribed provincial Environmental Quality Standards. No one is allowed to import hazardous waste into the province, generate, collect, consign, transport, treat, dispose of, store, handle or import any hazardous substance except he/she gets license from the authority.

Further under these Acts, provincial agency can issue Environmental Protection Order where agency is satisfied that the discharge or emission of any effluent, waste, air pollutant or noise, or the disposal of waste, or handling of hazardous substance, or any other act or omission is likely to occur, or is occurring, or has occurred, in violation of any provision of this act, rules or regulations or of the condition of license, or is likely to cause, or is causing, or has caused an adverse environmental effect. The provincial agency may, after giving the person responsible for such discharge, emission, disposal, handling, act or omission

an opportunity of being heard, by order, direct such person to such measures as the provincial agency may consider necessary with such period as may be specified in the order.

Only the Balochistan Environmental Protection Act addresses hospital waste in its clause 19 (General Prohibition in relation to Solid and Hospital Waste Management and Waste Management License) and regulates it to prevent its adverse environmental impacts. As per this clause, no person shall construct, own or operate a landfill site, incinerator or other facility at which waste is permanently disposed of or is stored indefinitely without acquiring the license from agency.

All the provincial environmental protection agencies have formulated Review of IEE and EIA Regulations, except KPK (KPK uses the regulations under Federal agency). As per these regulations, EIA study is required for the installation of incinerators for the hazardous waste disposal.

Punjab (2014), Sindh (2014), and Baluchistan (2020) Hospital Waste Management Rules: These rules are made under provincial Environmental Protection Acts. The hospital under the rules includes a clinic, laboratory, dispensary, pharmacy, nursing home, health unit, maternity center, blood bank, autopsy center, mortuary, research institute and veterinary institutions, including any other facility involved in health care and biomedical activities. These Rules mostly deal with hospital waste management. Guidelines for the segregation of waste into risk waste and non- risk waste and placement accordingly, waste collection as per the schedule provided in the Waste Management Plan, waste transportation, waste storage, and waste disposal at landfill sites or incineration or any other methods are applicable to PHC facilities. These Rules also provide guidelines in case of accidents and spillage of the waste, waste minimization and reuse.

Punjab (2018), Sindh (2014), Baluchistan (2020) Hazardous Substances Rules: These rules are made under Punjab (2012), Sindh (2014), and Baluchistan (2020) Environmental Protection Acts to manage hazardous substances in the province for their collection, generation, handling, consignment, transport, treat, dispose of, manufacturing and storage. The names of the hazardous substance and their threshold quantities are listed in Schedule 1, 2, 3, and 4 which are regulated under these rules.

The concerned authorities are required to inspect the subject industrial activity once a year and submit the report on the compliance of the rules by the occupiers to the EPA annually. The occupier is required to notify the concerned authority in case of major accident within the premises or outside the premises of the licensee within 48 hours during manufacturing, loading or unloading, supply, storage, marketing, and transportation of hazardous substances. The notified officer will take appropriate actions to prevent accidents from recurring.

The occupier of the subject industrial activity will require to acquire a license from concerned authority i.e., EPA to operate the facility after submitting Hazardous Substance Report. The occupier is also required to submit a safety report to the concerned authority 90 days before commencing industrial activity. This safety report will be updated annually. The occupier is also required to prepare and keep an onsite emergency plan to date. It shall be the duty of Rescue 1122 to prepare and keep up to date an adequate off-site emergency plan with details that how emergencies relating to a possible major accident on that site will be dealt with.

The rules provide guidelines to the occupier regarding packaging and labelling of the hazardous material, conditions to be maintained for the premises where hazardous substance is generated, collected,

consigned, treated, disposed of, stored or handled, general and specific safety precautions to be taken at the facility and for the workers, and requirements of the safety plan and waste management plan.

The Canal and Drainage Act, 1873: Under this act, the Provincial Government, may prohibit the discharge of any effluent, including any solid or liquid matter or combination of them from industrial, municipal or any other source, into any river, canal and drainage work including any natural drainage channel. Any person, organization or entity, interested in discharging such effluent into any river or drainage work, including any natural drainage channel, shall apply to the Divisional Canal Officer or any other person authorized by the Provincial Government in this behalf, for grant of permission for the discharge of such effluent.

Provincial Local Government Acts: As per the provincial local government Acts, the functions of a Metropolitan Corporation, Municipal Corporation and Municipal Committee include management of primary, elementary and secondary education facilities, monitoring and supervision of primary health care facilities, preventive health and hygiene, solid waste collection and disposal, sewage collection and disposal including water management and treatment, building control and land use, public parking facilities, city roads and traffic management, public transport, drinking water supply, community safety, and parks and landscape development.

Gender Equality

The Constitution of Islamic Republic of Pakistan provides the principle of equal rights and equal treatment to all citizens/ persons, without any distinction including on the basis of sex. The following articles of Constitutional of Islamic Republic of Pakistan broadly cover women rights:

Article 3 calls upon the State to eliminate all forms of exploitation.
Article 4 provides for the right of individual to enjoy the protection of law and to be treated in accordance with the law. This applies to the citizens as well as "to every other person for the time being within Pakistan" without distinction. This article also clearly states that certain rights cannot be suspended.
Article 25 ensures equality before the law and equal protection of the law and states that there shall be no discrimination on the basis of sex alone.
Articles 25(3) and 26(2) allow the state to make special provisions for the protection of women and children.
Article 26 & 27 provide for equal access to public places and equality of employment in the public and private sector.
Articles 11 & 37 (g) prohibit trafficking in human beings as well as prostitution.
Article 32 makes special provisions for the representation of women in local Government.
Article 34 directs the state to take appropriate measures to enable women to participate in all spheres of life and social activities.
Article 35 asks the state to protect the marriage, the family, the mother and the child.
Article 37 (e) directs the state to make provisions for securing just and humane conditions of work ensuring that children and women are not employed in vocations unsuited to their age or sex, and for ensuring maternity benefits for women in employment
Articles 51 & 106 provide for the reservation of seats for women in the legislatures.

Guidelines for Public Consultation,1997
These Guidelines will be used at planning and implementation stages of sub-projects under

NHSP. Further, a public consultation framework will be designed and included in the communication and outreach strategy.

Guidelines for Regulation of Disclosure of Environmental Information & Citizen engagement 2020
These guidelines are relevant to NHSP and will be used for public disclosure of environmental information of NHSP sub-projects and relevant instruments and GRM and citizen engagement

Provincial Occupational Safety and Health Acts
Punjab and Sindh provinces have promulgated following two acts on occupational safety and health:
- The Punjab Occupational Safety and Health 2019
- The Sindh Occupational Safety and Health 2019

Under these Acts, the employer would be responsible to ensure the health and safety of the workers at workplaces (construction sites are also considered as workplace under the act). These acts mention health and safety requirements which need to be ensured to be complied by the employer/site in-charge and the workers. The Chief Inspector and the inspectors appointed under the act shall be responsible to enforce health and safety requirements prescribed.

Protection of Women against Violence Act in 2016
The Punjab, Sindh and Balochistan Legislatures passed the **Protection of Women against Violence Act in 2016**, to establish an effective system of protection, relief and rehabilitation of women against violence. The law prohibits all forms of violence against women including sexual, emotional, economic and psychological abuse, cyber-crime, stalking and abetting of offenders. It calls on the setting up of district protection centers, to provide services to victims including first aid, police reporting, FIR lodging, prosecution, medical examination, forensics and post-trauma rehabilitation under one roof. KP remains the only province that is yet to pass a law against domestic violence as it has been referred to the Council of Islamic Ideology, which had rejected the previously tabled domestic violence bill.

The Prevention of Anti-Women Act (2011)
This Act criminalizes forced marriages and inheritance deprivation, whether in the form of exchange marriage (watta satta), compensation marriage (swara, wanni, etc.), marriage to the Quran, or **under any other** compulsion.

CAPACITY ASSESSMENT FOR MANAGING ENVIRONMENTAL AND SOCIAL EFFECTS

This section assesses whether the involved institutions have the requisite capacity to implement the program's environmental and social management systems. *Program capacity* is the "organizational capacity" the institutions authorized to undertake environmental and social management actions to achieve effectively "environmental and social objectives against the range of environmental and social impacts that may be associated with the program." This ESSA has examined the adequacy of such capacity by considering, among other things, the following factors:

(a) Adequacy of human resources (including in terms of training and experience), budget, and other implementation resources allocated to the institutions;
(b) The adequacy of institutional organization and the division of labor among institutions;
(c) Effectiveness of interagency coordination arrangements where multiple agencies or jurisdictions are involved; and
(d) The degree to which the institutions can demonstrate prior experience in effectively managing environmental and social effects in the context of projects or programs of similar type and magnitude.

This ESSA examines and discusses only those aspects of the proposed program's environmental and social management systems and related capacity that the ESSA Team found to be relevant, considering its identified environmental and social effects. This section provides a *summary assessment* of the program's capacity.

The capacity of the stakeholder institutions was assessed through one-to-one meetings, desk research and detailed questionnaires which raised specific environmental and social capacity questions.

This section describes the functions of various departments involved in the implementation of the project and their capacity assessment to manage E&S impacts of the project activities. Brief institutional profiles along with institutional capacity assessment are present below.

Ministry of National Health Services Regulations and Coordination[15]

The Federal Ministry of Health (MoH) was abolished in 2011 as a result of the 18th constitutional amendment, while residual health related functions in the Federal Legislative Lists (Part I & II) were assigned to different federal level ministries. To execute federal health functions effectively, the Cabinet decided in May 2013, to create the Ministry of National Health Services, Regulations and Coordination (MoNHSRC).

Vision

In the post-devolution scenario, the need for a common binding national health vision was articulated and endorsed during a series of meetings in 2013-16 between the federal and provincial health authorities and stakeholders including inter-ministerial health & population strategic forum and chief ministers. National Health Vision is a set of unified and common strategic priorities agreed with the provinces and other stakeholders.

The Vision Statement is:

"To improve the health of all Pakistanis, particularly women and children by providing universal access to affordable, quality, essential health services which are delivered through a resilient and responsive health system, capable of attaining the Sustainable Development Goals and fulfilling its other global health responsibilities"

The overarching national vision sets the common direction that harmonizes provincial and federal efforts, health strategies, and inter-provincial / sectoral efforts to achieve desired health outcomes. This document provides a jointly developed account of strategic directions to achieve the common vision and is a guideline for best practices for the provinces/ areas to develop their respective policies and initiatives within their domains.

Capacity Assessment

The MNHSRC is not mandated regarding the regulation of healthcare waste from the primary healthcare facilities in the country and coordinating with the provincial health departments and the environmental

[15] Government of Pakistan, MoNHSRC, Year Book 2018-19

protection agencies with respect to waste management. MNHSRC has no regulatory and enforcement role for the healthcare waste and the operational incinerations in the country. There is no coordination mechanism among the ministry and the environmental protection agencies to enforce hospital waste management rules at the healthcare facilities.

MNHSRC with the support of United Nations Children's Fund (UNICEF) conducted "Scoping Study to Establish a Baseline for Reporting to SDGs for WASH in Health Care Facilities in Pakistan" July 2021 (Study). The study assessed the status of healthcare facilities and capacities at primary, secondary, and tertiary levels, with a focus on primary healthcare by applying Bottleneck Analysis at the federal and provincial levels. Institutional capacity assessment conducted by the study is relevant to this program. Table 3 presents the assessment of MNHRSC.

Table 3: MNHSRC Capacity Assessment by Enabling Factors

Sr. No.	Enabling Factors	Capacity	Functions
1	Sector policy and strategy	Low	Limited compliance to: - Hospital Waste Management Rules 2005 - National Drinking Water Quality Standards 2008 - National Environmental Quality Standards – NEQS 2000
2	Institutional arrangement	Low	- Lack institutional structure for the operation and management of PHCs - Roles and responsibilities of different government stakeholders in not clear
3	Budgeting and financing	Low	- Inadequate financing for PHCs
4	Planning, monitoring and review	Low	- Absence of environmental and social monitoring system
5	Capacity development	Low	- Dedicated staff for managing environmental and social aspects are not available
6	Broader enabling environment	Low	- Poor understanding of environmental and social issues at the staff and public level

Primary and Secondary Healthcare Department, Punjab[16]

Primary and Secondary Healthcare Department (P&SHD) delivers quality healthcare services to the community through an efficient and effective service delivery system that is accessible, equitable, culturally acceptable, affordable and sustainable. P&SHD aims to improve the health and quality of life of all, particularly women and children, through access to essential health services.

The Primary and Secondary Healthcare Department strives to reform and strengthen the critical aspects of the health systems and enable it to:

- Provide and deliver a basic package of quality essential health care services

[16] https://pshealthpunjab.gov.pk

- Develop and manage competent and committed health care providers
- Generate reliable health information to manage and evaluate health services
- Adopt appropriate health technology to deliver quality services
- Finance the costs of providing basic health care to all
- Reform the health administration to make it accountable to the public

Capacity Assessment

Table 4: Punjab Health Department Capacity Assessment by Enabling Factors

Sr. No.	Enabling Factors	Capacity	Functions
1	Sector policy and strategy	Low	Limited compliance to: - Punjab Solid Waste Management 2014 rules are followed to a certain extent. - Punjab Drinking Water Quality Standards 2016 - Punjab Environmental Quality Standards – PEQS 2016
2	Institutional arrangement	Moderate	- Lack of inter and intra departmental coordination - Punjab Health Facility Management Company (PHFMC) is working in 16 districts. PHFMC has constituted Health Councils at different levels - In Punjab, HICP is under implementation in 26 districts of Punjab. The program has supported the implementation of comprehensive system and infrastructure (including 26 incinerators) for hospital waste management. - Punjab Health Commission is enforcing Minimum Service Delivery Standards (MSDS) at all levels through manuals for health services which also cover waste management and hygiene, and IPC. The Commission also monitors the environmental cleaning, and the cleaning and upkeep of toilets at healthcare facilities
3	Budgeting and financing	Low	- Inadequate financing for PHCs
4	Planning, monitoring and review	Low	- Absence of environmental and social monitoring system
5	Capacity development	Moderate	- Well-developed institutions in the form of Department of Healthcare, Health Company (PPHI), and the Commission. - Dedicated staff for managing environmental and social aspects are not available
6	Broader enabling environment	Low	- Poor understanding of environmental and social issues at the staff and public level

Health Department, Government of Sindh[17]

Health Department, The Provincial Health Ministry, is a standard body for providing Medical Education Training & Employment.

Mission Statement

The overall vision is based on "Health for All "the new Health Policy aims to implement this strategy of protecting peoples against Hazardous Diseases, promoting public health, upgrading curative health facilities, enhancing equity, efficiency and effectiveness in health sector.

Facilitation

This department facilitates for:

- Control of Communicable diseases
- Tuberculosis
- Vaccine-preventable illnesses and Polio eradication
- Malaria and Leishmaniosis
- Blood Safety and Control of HIV / AIDS
- Hepatitis B and C
- Control of Non-communicable diseases
- Cardiac disease, diabetes, Cancer, Mental Illness, Genetic disorders, Snake bite and Dog bite
- Prevention of Blindness (Vision 2020) Program in Sindh
- Take measures to implement Better Maternal and Child Health
- To counter Malnutrition
- To ensure Road Safety

Capacity Assessment

Table 5: Sindh Health Department Capacity Assessment by Enabling Factors

Sr. No.	Enabling Factors	Capacity	Functions
1	Sector policy and strategy	Low	Limited compliance to: - Hospital Waste Management Rules 2005 - National Drinking Water Quality Standards 2008 - National Environmental Quality Standards – NEQS 2000
2	Institutional arrangement	Moderate	- Lack of inter and intra departmental coordination - Health Company (PPIH) is working in all districts.

[17] https://www.sindhhealth.gov.pk

			- Sindh Health Commission is enforcing Minimum Service Delivery Standards (MSDS) at all levels through manuals for health services which also cover waste management and hygiene, and IPC. The Commission also monitors the environmental cleaning, and the cleaning and upkeep of toilets at healthcare facilities
3	Budgeting and financing	Low	- Inadequate financing for PHCs
4	Planning, monitoring and review	Low	- Absence of environmental and social monitoring system
5	Capacity development	Moderate	- Well-developed institutions in the form of the Health Department, PPIH, and the Commission. - Dedicated staff for managing environmental and social aspects are not available
6	Broader enabling environment	Low	- Poor understanding of environmental and social issues at the staff and public level

Health Department, Khyber Pakhtunkhwa[18]

The Department of Health reorganizes the Health Sector services in Khyber Pakhtunkhwa Province with clear distinction between regulation, monitoring and provision of health services in order to achieve the optimum benefit within the available resources for the people of Khyber Pakhtunkhwa Province. The government's role as a guardian for the health of the citizens of Khyber Pakhtunkhwa Province is to regulate according to international standards the quality of health care services and health care providers and medical training institutions

Mission

The mission of this Department is to protect and improve the health and environment for all people in KPK.

Capacity Assessment

Table 6: KPK Health Department Capacity Assessment by Enabling Factors

Sr. No.	Enabling Factors	Capacity	Functions
1	Sector policy and strategy	Low	Limited compliance to: - Hospital Waste Management Rules 2005 - National Drinking Water Quality Standards 2008

[18] https://www.healthkp.gov.pk

			- National Environmental Quality Standards – NEQS 2000
2	Institutional arrangement	Moderate	- Lack of inter and intra departmental coordination - The Health Sector Reform Unit operates under the Department of Healthcare. - KPK Health Commission is enforcing Minimum Service Delivery Standards (MSDS) at all levels. Unlike Punjab and Sindh, the KPK Commission does have well developed service delivery manuals and monitoring regime. The Commission also monitors the environmental cleaning, and the cleaning and upkeep of toilets at healthcare facilities
3	Budgeting and financing	Low	- Inadequate financing for PHCs
4	Planning, monitoring and review	Low	- Absence of environmental and social monitoring system
5	Capacity development	Low	- The technical capacity of the Health Department and the Commission with respect to environmental and social management of health facilities is limited.
6	Broader enabling environment	Low	- Poor understanding of environmental and social issues at the staff and public level

Department of Health, Balochistan [19]

Department of Health works under the Government of Balochistan. 'Minister Health is In-charge. Secretary Health is Head of the Department while Director General, Health Sector (DGHS) is the Head of attached department. The Health Secretariat is the apex management unit for the entire health department.

Capacity Assessment

Table 6: Balochistan Health Department Capacity Assessment by Enabling Factors

Sr. No.	Enabling Factors	Capacity	Functions
1	Sector policy and strategy	Low	Limited compliance to: - Hospital Waste Management Rules 2005

[19] https://balochistan.gov.pk/departments/health/

			- National Drinking Water Quality Standards 2008 - National Environmental Quality Standards – NEQS 2000
2	Institutional arrangement	Low	- Lack of inter and intra departmental coordination - Health Company (PPHI) responsible for managing PHCs. - Balochistan Health Commission is enforcing Minimum Service Delivery Standards (MSDS) at all levels. The Commission does have well developed service delivery manuals and monitoring regime. The Commission also monitors the environmental cleaning, and the cleaning and upkeep of toilets at healthcare facilities
3	Budgeting and financing	Low	- Inadequate financing for PHCs
4	Planning, monitoring and review	Low	- Absence of environmental and social monitoring system
5	Capacity development	Low	- The technical capacity of the Health Department and the Commission with respect to environmental and social management of health facilities is limited.
6	Broader enabling environment	Low	- Poor understanding of environmental and social issues at the staff and public level

Common Capacity of Provincial Health Department

The primary healthcare facilities, providing PHC services, are not able to enforce Hospital Waste Rules in their facilities. Mostly healthcare waste is not segregated. The hazardous waste which is just 15% of the total healthcare waste is not separated from the non-hazardous waste and dumped at the municipal solid waste dumping sites. The sharp waste is not segregated and sealed separately. Waste is not labelled, stored and disposed of as per the prescribed rules.

Healthcare waste is illegally recycled at waste recycling facilities and poses environmental and health risks to the workers involved in waste handling and the communities living around the recycling facilities.

At present there is no system at the Health Department, Khyber Pakhtunkhwa, to undertake free, prior and informed consultations with the Kalash people to determine broad community support for the provision of quality healthcare services to the Kalash valley. Consultation with the Kalash people will be important to give special attention to the rights and interests of the Kalash people. It is required that the Kalash people are given due consideration to cultural appropriateness of, and equitable access to, program benefits.

Provincial Environmental Protection Departments

The mandate of the Provincial Environmental Departments according to the Provincial Environmental Protection Acts is summarized as follows:

Implement rules and regulations prepared under the Act and prepare additional legislation according to the needs of the province, prepare and implement provincial environmental standards, develop provincial systems for the implementation of pollution charges, conduct research and development for most viable environmental technologies, certify laboratories, engage LGs in the implementation of the act, raise environmental awareness and incorporate environmental issues in educational curriculums, prepare provincial-level Environmental Disaster Management Plans (DMPs), collaborate and coordinate with stakeholders for the effective implementation of environmental policies and the Act, entertain inquiries and complaints raised by stakeholders, mobilize national and international financial resources for environmental projects, develop provincial-level fiscal programs and financial incentives for environmental compliance, fix pollution charges, conduct investigations against polluters, assist courts by generating field-level environmental data about polluters, establish environmental laboratories, implementation of IEE/EIA Rules and Regulations and Guidelines, manage hazardous waste under the Hazardous Substance Rules, manage hospital waste under Hospital Management Rules, and monitor vehicles for controlling air pollution.

Generally, healthcare waste is not considered to be hazardous substances, therefore, environmental protection agencies don't consider it to regulate under hazardous substances rules. EPAs have limited resources to enforce hospital waste management rules at healthcare facilities.

Mostly the environmental performance of operation of the incineration facilities is not reported and documented. Limited and scanty data is available for combustion temperatures, emissions, pollution control devices, ash generation and disposal. In case if these facilities don't operate under controlled environment, then these are the contributors of the pollution rather than controlling it. *The EPAs have limited resources or capability to regulate these incinerators.*

EPAs have adequate capacity for review and approval of EIA and other plans and monitoring of their compliance requirements. <u>EPAs are not able to regulate healthcare waste recyclers.</u>

Annex- 6 Grievance Redress and Citizen Engagement

A Grievance Redressal Mechanism:

- 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; and
- Avoids the need to resort to judicial proceedings.

Description of GRM

Existing GRMs of the Bank financed National Immunization Support Project (NISP) and Pandemic Response Effectiveness in Pakistan (PREP) project implemented by the MoNHSR&C (specifically by EPI) may be strengthened as required and used for the project.

Under the World Bank financed National Immunization Support Project (NISP), the EPI had nominated a GRM committee and focal person for proper implementation and monitoring of the NISP GRM. A record of all complaints is also maintained by the EPI. In addition to the helpline, the EPI also receives complaints through the nationwide GRM initiative, covering all services, launched by the federal government called the Pakistan Citizen's Portal. The concerned complaints are forwarded to and addressed by the EPI. A record of complaints received through the citizens portal are maintained as part of the EPI's record of grievances. In addition, GRM Focal officers will be assigned for NHSP.
Measures to mitigate gender-based violence (GBV) will also be taken into account, both as part of the overall project and, more specifically, in the GRM. To promote ownership, the project will put in place strong communication and citizen engagement to provide information as well as receive feedback from beneficiaries, especially women and other vulnerable groups. A Gender and Social Assessment undertaken under PREP may be used to inform the mitigation measures and actions that may be required to address existing and potential gender vulnerabilities and challenges.

MoNHSR&C

Complaints can be registered directly through any of the following modes and, if necessary, anonymously or through third parties.

- By telephone at the MoNHSR&C established Help line, *Sehat Tahaffuz* at 1166, which is available for access from all over Pakistan. Provincial health lines have also been established and are listed as:
    - Sind- 021-99206565
    - Punjab- 0800-99000
    - KP- 091-1700
    - Balochistan- 081-9241 133 22 and WhatsApp 0334-924113
- By WhatsApp[20] at 92-300-1111166
- By e-mail to fedepipakistan@gmail.comto be seen by the national GRM focal point

[20] This is an automated 'chatbot' service, which will allow citizens to get answers to most common questions about coronavirus from the Ministry of Health 24 hours a day. The service will be available in English, Urdu, Punjabi, Pashto, Sindhi, Balochi, Kashmiri and will provide information on topics such as coronavirus prevention and symptoms, the latest number of cases, and other trustworthy health information

- By letter to the healthcare facility/adult vaccination point (at each healthcare facility level)
- By letter directly at provincial DG Health Office to be addressed by the provincial GRM focal point.
- By complaint form to be lodged at any of the addresses listed above- this form will be made available in the relevant healthcare facilities to be used by the complainants and can be filled.
- Walk-ins and registering a complaint on a grievance logbook at the healthcare facility or suggestion box at clinic/hospitals to be monitored by the FBFP
- Social media handles of MoNHSR&C

The "*Sehat Tahaffuz*" help line has been developed to facilitate the community on polio and EPI services. The call centre is currently functioning at the Help line No. 1166. The number of calls on the helpline has increased to over 70,000 in a day. At this point, the helpline is being managed by 250 agents in the three cities of Karachi, Lahore, and Islamabad. The helpline currently operates in two shifts that in total last from 8am to midnight every day, seven days a week[21].

According to the MONHSR&C officials, the helpline helps to remove patients' misconceptions. Most importantly, the feedback received from the calls helps the health ministry to monitor better and correct course, as required, more efficiently and effectively. Inclusion of a benificiary feedback indicator in the project results framework to monitor citizen engagement throughout project implementation is a requirement of Bank supported operations.

This helpline will remain a permanent feature for polio, EPI as well as other health related issues. It will also be utilized for issues pertaining to COVID-19 services and beyond that to cover any complaints during the life of the project. To ensure the requisite emphasis on GRM, the Federal EPI Cell has nominated a GRM committee and a focal person for compliance of GRM procedures. The complaints will be recorded and lodged by Federal EPI accordingly.

Once a complaint has been received, it will be recorded in the complaints logbook or grievance excel based grievance database to be maintained at the national level.

Nomination of GRM Focal Points

- To launch the system, a national GRM focal person will be nominated along with GRM focal persons in the provinces
- At the national level, an Environmental and Social Specialist hired for NHSP will serve as the national GRM focal point
- At the provincial level, the newly hired Environmental and Social Specialist for each province/area will also work as the Provincial GRM Focal Person and will be responsible for maintaining records at the provincial health department (DG Health services office)
- Similarly, one district GRM focal person will be nominated by the District Health Authority and housed at the DHA. The district GRM FP in coordination with ESMP coordinator will maintain the reports at the EDO/DHO/CEO (Health) office
- A Facility Based GRM focal person will also be nominated at each healthcare facility (DHQ, THQ, RHC, BHU) or in tertiary healthcare settings

[21] https://www.dawn.com/news/1569975

Reporting and Lodging Complaints

Records will be maintained at provincial, district and facility level. For recording complaints GRM information boards will be displayed in all healthcare facilities/COVID-19 centers in Urdu and the local language clearly displaying the dedicated tollfree number, 1166. All GRM focal persons will be given training on the Complaint Management System by the National ESMP coordinator in coordination with the provincial ESMP coordinators. This training will also include a component on the handling of complaints pertaining to gender-based violence and sexual harassment and referral mechanisms available in the health and justice sectors.

The complaints will be received on 1166 in the emergency operating cell (EOC) at federal EPI. A total of 85 Call agents are currently engaged in the helpline, of whom 30 are females. However, gender segregated data for callers is not available now. The system will be enhanced for gender and other granular data under PREP, including for data collection and management purposes. The team working under the supervision of the National GRM FP will record the call (caller name & contact (optional), area, district, date, and nature of complaints). The complaints will be lodged to the provincial ESMP coordinator who will facilitate and coordinate/ lodge the complaints to the GRM district focal person at the district health authority. The DFP will maintain the record in a complaint register book (CRB) as directed by the DG Health/ESMP coordinator. The DFP will then lodge the same complaint to the facility based GRM focal person in the relevant health facility.

The facility based focal point (FBFP) will record the complaints in a GRM register and will call the complainant to resolve the complaints. If it is resolved, the FBFP would ask for a signature and a CNIC number to discourage fake complaints. Acknowledgement of a written submission will be issued to the complainant within three working days by FBFPs. After resolving the complaints, the FBFP will inform the district focal point (DFP) that the complaint has been resolved and recorded and the information will then be sent to GRM National focal person. The time frame for processing and responding to complaints is in the process of being determined.

If complaints are not resolved at the facility level, the district focal person will constituent a committee to resolve the complaint.
The committee will comprise of the following members under chairmanship of EDO/DHO/CEO (Health)

- EDO/DHO/CEO(Health)
- Medical Superintendent of the Health Facility
- Social mobilizer, councillor or any community notable of complainant's area.

If the complainant is not satisfied, he/she will have the option to seek redress through Director General Health or Secretary Health. The data regarding complaints to be resolved at any level will be recorded in the CRB and monthly reports will be generated by facility based focal persons and submitted to their respective District departments (DFPs). The DFPs will then forward the compiled data to the provincial level to ensure that data related to complaints is being stored promptly and issues are being resolved at the department level.

Once the complaint has been directed to the facility, district or provincial level as per the complaint received, the GRM process will include the following steps:

- ***Step 0***: Grievance discussed at the respective facility level and resolved. If not then,

- ***Step 1***: Grievance raised with the Grievance Cells at the District level EPI/MoNHSR&C and resolved. If not then,
- ***Step 2:*** Grievance raised with the Provincial EPI/Provincial Health Department or Federal EPI/MoNHSR&C for federal territories and resolved. If not then
- ***Step 3***: Appeal to the MoNHSR&C, DG or Secretary Health.

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

GRM for Health Care Providers

MoNHSR&C Help line for Medical Professionals

A GRM mechanism for health care providers will also be developed by the MoNHSR&C. A dedicated help line will be provided for them to lodge complaints, raise queries and seek redress for any issue they are facing in their work, including gender-based violence, exploitation, and abuse[22]. The information pertaining to the helpline will be prominently displayed in Urdu and the local language in health facilities/COVID -19 centers to provide equal access to all cadres of health workers.

Call centre staff for this toll-free help line and other help lines[23] who are working for the COVID-19 response will be sensitized and provided training on receiving complaints pertaining to sexual harassment, abuse and violence and provided with information on referral mechanisms available in the health and justice sectors. For instance, a referral mechanism that that may be used is the MOHR helpline (1099) which also has a WhatsApp number which responds to cases of domestic violence and abuse and provides health-related information.

As details of this GRM for healthcare workers are finalized, they will be updated in the ESSA and other relevant documents which will be redisclosed.

Grievance Mechanism for Gender-Based Violence (GBV) issues

The project will promote the avoidance of SEA by relying on the WHO Code of Ethics and Professional Conduct for all workers in the health facilities as well as the provision of segregated toilets and well-lit adult vaccination points.

Different types of health care workers (many frontline healthcare workers are women), will be provided with accessible and inclusive means to raise concerns or lodge complaints, via the GRM. The GRM staff will be trained (as appropriate) to sensitize them on GBV (including SEA and SH) and trauma issues to enable them to refer survivors to existing referral mechanisms in the country. The project GRM response will be further strengthened in accordance with the findings of the GBV risk assessment undertaken under PREP. A mass awareness campaign on available GBV services will also be conducted to share information with the public and inform their understanding of redress mechanisms that are available and can be accessed.

[22] A separate gender and social assessment have been done for the PREP project which examines GBV related issues and provides mitigation measures.

– [23] For instance, the Corona Rescue Helpline (1190) and Rescue Service (1122)

There will be specific procedures for addressing GBV including confidential reporting with safe and ethical documenting of GBV cases. Project GRM operators[24] will be trained on how to collect GBV complaints and should assist GBV survivors by referring them to GBV Service Provider(s) for support immediately after receiving a complaint. A list of GBV service providers will be available with the GRM personnel before project work commences as part of the mapping exercise. For GBV, the GRM should primarily serve to: (i) refer complainants to the GBV Services Providers; and (ii) record resolution of the complaint.

For more information on GBV data sharing see: http://www.gbvims.com/gbvims-tools/isp/

The GRM should have in place processes to immediately notify both the relevant Government Entity and the World Bank of any GBV complaints with the consent of the survivor. For World Bank reporting protocol, refer to the Safeguards Incident Response Toolkit.

World Bank Grievance Redress System

Communities and individuals who believe that they are adversely affected by a World Bank supported project may submit complaints to existing project-level grievance redress mechanisms or the World Bank's GRS25. The GRS ensures that complaints received are promptly reviewed in order to address COVID- 19 project-related concerns. Project affected communities and individuals may submit their complaint to the World Bank's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of World Bank non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an oopportunity to respond.

[24] The operators for the helplines for service providers, and the MNHSRC toll free numbers will receive trainings on how to address such complaints.

[25] For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit *http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service*. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Annex- 7 Questionnaires for Capacity Assessment of Stakeholder Institutions

1. **Ministry of National Health Services, Regulations and Coordination**

The purpose of this questionnaire is to focus on the Ministry's rules, procedures, and implementation performance against the core E&S principles of World Bank PforR[26] Policy Section III Paragraph 9.00. Through this questionnaire, we want to establish the status of the Ministry's environmental and social management systems, regulatory frameworks, and system capacity. The point is to share information with the Bank task team on system performance and provide examples of current operational experience.

1	What is the system of environmental and social assessment and management adopted by the Ministry for National Health Services, regulations and coordination, provide brief details of following? - Policies - Standards - Operational procedures - Early screening system - Consideration for the medical waste management generated from primary health facilities - Determination of cumulative impacts - Identification of mitigation measures - Institutional responsibilities for the implementation of mitigation measures - Determination of criteria for choosing the trainees (men and women) - Tools used for Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH) - Stakeholder consultation process and documentation - Grievance redress mechanism
2	What are the major environmental and social issues faced by provincial health departments while operating health services facilities in the province?
3	What is the system for disaster management adopted at operational stages of primary health facilities for managing natural hazards such as floods, hurricanes, earthquakes, weather or climate?
4	What is the system for consultation, disclosure, and decision making for the following: - Ensuring equitable and affordable access of Program benefits to target stakeholders, including disadvantaged and vulnerable groups - Appropriate prior disclosure and access to information about the topics of consultation, - Consultation processes to ensure open exchange of views - Incorporation of stakeholder feedback in the design - Appropriate information about where the stakeholders will be disclosed and consulted - Informed participation and decision making by affected persons
5	What is the capacity of the Ministry of Health for environmental and social management at operational stages of the primary health services? With respect to: - Adequate monitoring systems exist - Adequate number of qualified and skillful staff available for program monitoring

[26] World Bank PforR financial instrument does not support programs or activities within programs that could cause significant harm to the environment or which would have significant adverse social consequences.

	- If capacity does not exist, what are the other alternatives (coordination and collaboration with other departments, outsourcing to consultants and contractors) are adopted
6	What is the system for consulting and coordinating with the provincial Health Departments regarding environmental and social impacts of the primary health services/facilities?
7	How is medical waste from primary health facilities managed (collection, storage, disposal)? Are there any waste management plan/procedure/guidelines/SOPs? (If YES, please share)
8	Do you have any suggestions/proposals regarding the systems to manage and reduce environmental and social risks and impacts associated with the primary health services and facilities? Please state specific mitigation measures for both environmental and social concerns.

2. Primary and Secondary Healthcare Department, Punjab

The purpose of this questionnaire is to focus on the Department's rules, procedures, and implementation performance against the core E&S principles of World Bank PforR[27] Policy Section III Paragraph 9.00. Through this questionnaire, we want to establish status of the Department's environmental and social management systems, regulatory frameworks, and system capacity. The point is to share information with Bank task team on system performance and provide examples of current operational experience.

1	What is the system of environmental and social assessment and management adopted by the Department for the delivery of primary health services in the province, provide brief details of following: - Policies - Standards - Operational procedures - Early screening system - Consideration for the medical waste management generated from primary health facilities - Determination of cumulative impacts - Identification of mitigation measures - Institutional responsibilities for the implementation of mitigation measures - Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH) - Stakeholder consultation process and documentation - Grievance redress mechanism
2	What are the major environmental and social issues faced by the Department while providing primary health services and operating health facilities in the province?
3	What is the system for disaster management adopted at operational stages of primary health facilities for managing natural hazards such as floods, hurricanes, earthquakes, weather or climate?
4	What is the system for disclosure, consultation, disclosure and decision making for the following:

[27] World Bank PforR financial instrument does not support programs or activities within programs that could cause significant harm to the environment or which would have significant adverse social consequences.

	- Ensuring equitable and affordable access of Program benefits to target stakeholders, including disadvantaged and vulnerable groups - Appropriate prior disclosure and access to information about the topics of consultation, - Consultation processes to ensure open exchange of views - Incorporation of stakeholder feedback in the design - Appropriate information about where the stakeholders will be disclosed and consulted - Informed participation and decision making by affected persons
5	What is the capacity of the Department for environmental and social management at operational stage of the primary health services and facilities? With respect to: - Adequate systems exist for program administration and monitoring - Adequate number of qualified and skillful staff available for program administration and monitoring - If capacity does not exist, what are the other alternatives (coordination and collaboration with other departments, outsourcing to consultants and contractors) are adopted - Determination of criteria for choosing the trainees (men and women)
6	What is the system for consulting and coordinating with the Federal Ministry of health regarding environmental and social impacts of the primary health services/facilities?
7	How is medical waste from primary health facilities managed (collection, storage, disposal)? Are there any waste management plan/procedure/Guidelines/SOPs? (If YES, please share)
8	Do you have any suggestions/proposals regarding the systems to manage and reduce environmental and social risks and impacts associated with the primary health services and facilities? Please state specific mitigation measures for both environmental and social concerns.

3. Health Department, Sindh

The purpose of this questionnaire is to focus on the Department's rules, procedures, and implementation performance against the core E&S principles of World Bank PforR Policy Section III Paragraph 9.00. Through this questionnaire, we want to establish status of the Department's environmental and social management systems, regulatory frameworks, and system capacity. The point is to share information with Bank task team on system performance and provide examples of current operational experience.

1	What is the system of environmental and social assessment and management adopted by the Department for the delivery of primary health services in the province, provide brief details of following: - Policies - Standards - Operational procedures - Early screening system - Consideration for the medical waste management generated from primary health facilities - Determination of cumulative impacts - Identification of mitigation measures - Institutional responsibilities for the implementation of mitigation measures

	- Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH) - Stakeholder consultation process and documentation - Grievance redress mechanism
2	What are the major environmental and social issues faced by the Department while providing primary health services and operating health facilities in the province?
3	What is the system for disaster management adopted at operational stages of primary health facilities for managing natural hazards such as floods, hurricanes, earthquakes, weather or climate?
4	What is the system for disclosure, consultation, disclosure and decision making for the following: - Ensuring equitable and affordable access of Program benefits to target stakeholders, including disadvantaged and vulnerable groups - Appropriate prior disclosure and access to information about the topics of consultation, - Consultation processes to ensure open exchange of views - Incorporation of stakeholder feedback in the design - Appropriate information about where the stakeholders will be disclosed and consulted - Informed participation and decision making by affected persons
5	What is the capacity of the Department for environmental and social management at operational stage of primary health services and facilities? With respect to: - Adequate systems exist for program administration and monitoring - Adequate number of qualified and skillful staff available for program administration and monitoring - If capacity does not exist, what are the other alternatives (coordination and collaboration with other departments, outsourcing to consultants and contractors) are adopted - Determination of criteria for choosing the trainees (men and women)
6	What is the system for consulting and coordinating with the Federal Ministry of Health regarding environmental and social impacts of primary health services/facilities?
7	How is medical waste from primary health facilities managed (collection, storage, disposal)? Are there any waste management plan/procedure/Guidelines/SOPs? (If YES, please share)
8	Do you have any suggestions/proposals regarding the systems to manage and reduce environmental and social risks and impacts associated with the primary health services and facilities? Please state specific mitigation measures for both environmental and social concerns.

4. Department of Health, KPK

The purpose of this questionnaire is to focus on the Department's rules, procedures, and implementation performance against the core E&S principles of World Bank PforR Policy Section III Paragraph 9.00. Through this questionnaire, we want to establish status of the Department's environmental and social management systems, regulatory frameworks, and system capacity. The point is to share information with Bank task team on system performance and provide examples of current operational experience.

1	What is the system of environmental and social assessment and management adopted by the Department for the delivery of primary health services in the province, provide brief details of following:

	- Policies - Standards - Operational procedures - Early screening system - Consideration for the medical waste management generated from primary health facilities - Determination of cumulative impacts - Identification of mitigation measures - Institutional responsibilities for the implementation of mitigation measures - Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH) - Stakeholder consultation process and documentation - Grievance redress mechanism
2	What are the major environmental and social issues faced by the Department while providing primary health services and operating health facilities in the province?
3	What is the system for disaster management adopted at operational stages of primary health facilities for managing natural hazards such as floods, hurricanes, earthquakes, weather or climate?
4	What is the system for disclosure, consultation, disclosure and decision making for the following: - Ensuring equitable and affordable access of Program benefits to target stakeholders, including disadvantaged and vulnerable groups - Appropriate prior disclosure and access to information about the topics of consultation, - Consultation processes to ensure open exchange of views - Incorporation of stakeholder feedback in the design - Appropriate information about where the stakeholders will be disclosed and consulted - Informed participation and decision making by affected persons
5	What is the capacity of the Department for environmental and social management at operational stage of the primary health services and health facilities? With respect to: - Adequate systems exist for program administration and monitoring - Adequate number of qualified and skillful staff available for program administration and monitoring - If capacity does not exist, what are the other alternatives (coordination and collaboration with other departments, outsourcing to consultants and contractors) are adopted - Determination of criteria for choosing the trainees (men and women)
6	What is the system for consulting and coordinating with the Federal Ministry regarding environmental and social impacts of primary health services/facilities?
7	How is medical waste from primary health facilities managed (collection, storage, disposal)? Are there any waste management plan/procedure/guidelines/SOPs? (If YES, please share)
8	Do you have any suggestions/proposals regarding the systems to manage and reduce environmental and social risks and impacts associated with primary health services and facilities? Please state specific mitigation measures for both environmental and social concerns.

5. Department of Health, Balochistan

The purpose of this questionnaire is to focus on the Department's rules, procedures, and implementation performance against the core E&S principles of World Bank PforR Policy Section III Paragraph 9.00. Through this questionnaire, we want to establish status of the Department's environmental and social management systems, regulatory frameworks, and system capacity. The point is to share information with Bank task team on system performance and provide examples of current operational experience.

1	What is the system of environmental and social assessment and management adopted by the Department for the delivery of primary health services in the province, provide brief details of following: - Policies - Standards - Operational procedures - Early screening system - Consideration for the medical waste management generated from primary health facilities - Determination of cumulative impacts - Identification of mitigation measures - Institutional responsibilities for the implementation of mitigation measures - Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH) - Stakeholder consultation process and documentation - Grievance redress mechanism
2	What are the major environmental and social issues faced by the Department while providing primary health services and operating health facilities in the province?
3	What is the system for disaster management adopted at operational stages of primary health facilities for managing natural hazards such as floods, hurricanes, earthquakes, weather or climate?
4	What is the system for disclosure, consultation, disclosure and decision making for the following: - Ensuring equitable and affordable access of Program benefits to target stakeholders, including disadvantaged and vulnerable groups - Appropriate prior disclosure and access to information about the topics of consultation, - Consultation processes to ensure open exchange of views - Incorporation of stakeholder feedback in the design - Appropriate information about where the stakeholders will be disclosed and consulted - Informed participation and decision making by affected persons
5	What is the capacity of the Department for environmental and social management at operational stage of primary health services and health facilities? With respect to: - Adequate systems exist for program administration and monitoring - Adequate number of qualified and skillful staff available for program administration and monitoring - If capacity does not exist, what are the other alternatives (coordination and collaboration with other departments, outsourcing to consultants and contractors) are adopted - Determination of criteria for choosing the trainees (men and women)
6	What is the system for consulting and coordinating with the Federal Ministry regarding environmental and social impacts of primary health services/facilities?

7	How is medical waste from primary health facilities managed (collection, storage, disposal)? Are there any waste management plan/procedure/guidelines/SOPs? (If YES, please share)
8	Do you have any suggestions/proposals regarding the systems to manage and reduce environmental and social risks and impacts associated with primary health services and facilities? Please state specific mitigation measures for both environmental and social concerns.

6. Provincial Environmental Protection Agencies (Punjab, Sindh, KPK, Balochistan)

The purpose of this questionnaire is to focus on the agency's rules, procedures, and implementation performance against the core E&S principles of World Bank PforR Policy Section III Paragraph 9.00. Through this questionnaire, we want to establish status of the agency's environmental and social management systems, regulatory frameworks, and system capacity. The point is to share information with Bank task team on system performance and provide examples of current operational experience.

1	What is the system of environmental and social assessment and management adopted by the Agency for primary health facilities, regulations and coordination, provide brief details of following: - Policies - Standards - Operational procedures - Early screening system - Medical waste management generated from primary health facilities - Determination of cumulative impacts - Institutional responsibilities for the implementation of mitigation measures - Monitoring of implementation of mitigation measures - Tools used for Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH) - Stakeholder consultation process and documentation - Grievance redress mechanism
2	What are major issues faced by Agency while evaluating, approving, monitoring of primary health facilities and their waste in the province?
3	Is medical waste generated from the primary health facilities scrutinized under the law?
4	Does the safety of communities, individuals, and workers at operational stages of primary health facilities required as per your mandate?
5	What are the systematic requirements for disaster management adopted at operational stages of primary health facilities for managing natural hazards such as floods, hurricanes, earthquakes, weather or climate?
6	What is the system for consultation, disclosure, and decision making for the following: - Ensuring equitable and affordable access of Program benefits to target stakeholders, including disadvantaged and vulnerable groups - Appropriate prior disclosure and access to information about the topics of consultation, - Consultation processes to ensure open exchange of views - Incorporation of stakeholder feedback - Appropriate information about where the stakeholders will be disclosed and consulted - Informed participation and decision making by affected persons

7	What is the capacity of the Agency for environmental and social management at operational stages of primary health services and health facilities? With respect to: - Adequate systems exist for the review of monitoring of primary health facilities - Adequate number of qualified and skillful staff available for the review and monitoring of primary health facilities - If capacity does not exist, what are the other alternatives (coordination and collaboration with other departments, outsourcing to consultants and contractors) are adopted
8	Do you have any suggestions/proposals regarding the systems to manage and reduce environmental and social risks and impacts associated with the primary health services and facilities? Please state specific mitigation measures for both environmental and social concerns.

Annex- 8 List of Participants for Stakeholder Consultation held in February 2021

S No.	Name	Affiliation	Involvement with the Healthcare System in Pakistan
1	Dr. Mahmood Iqbal	Health Department Government of SINDH	Provincial UHC Coordinator SINDH
2	Ms.Maham Javaid	Punjab Social Protection Authority	Have been engaged with the training requirements of primary health care providers.
3	Mr. Graham Gass	FCDO	Oversee all FCDO's support to the health care system
4	Dr. Nabeela Ali	John Snow Inc.,	JSI is implementing Integrated Health Systems Strengthening-Service Delivery Activity in Pakistan funded by USAID. We work closely with MONHSR&C and Provincial Health Departments.
5	Mr.Ayaz Khan	CERP	Lead advisory projects in the health sector
6	Ms. Sara Shahzad	FCDO	Development expert on Health Systems
7	Mr. Muhammad Mazhar Alam	Pakistan Medical Commission	Designing, implementation and monitoring of health care projects
8	Ms. Javeria Afzal	FCDO	FCDO has a health programme
9	Dr. Naeem Majeed	PSHD	17 years of progressive experience in RMNCAH, nutrition, EPI, and health systems strengthening
10	Dr. Safdar Razia	advisor SDPI	Ex DDG Health MoNHSR&C ,public health expert
11	Mr. Atif Sheikh	Center for Research on Inclusive Development	We have been working to make health system disability inclusive
12	Ms. Khadija Abid	Cesvi	Currently Managing/reporting Primary/secondary health care project funded by an international European donor
13	Mr. Muhammad Sarwat Mirza	HANDS Pakistan	Working as Advisor Health & Research in HANDS. Working in HANDS last 26 years and worked on different projects in Partnership with Health departments and created innovative solutions for outreach Primary health care services in non-LHW areas in rural Sindh, Punjab and KPK
14	Dr. Lubna Hashmat	CHIP	Working on demand generation for immunization since last 10 years at the country and global level
15	Dr. Zaib Dahar	PPHI Sindh	We are managing more than 60% of PHC health facilities and services for Department of health therefore would be also part of implementation of ESSA and other activities
16	Ms.Shandana Khan	RSPN	Largest civil society network. Mobilize communities in rural areas to improve public service delivery and link them to government
17	Dr. Yasmin Qazi	RIZ Consulting	Advocate for Women's health and right issues