

Preliminary Stakeholder Engagement Plan (SEP) March 20, 2020

MONGOLIA COVID-19 EMERGENCY RESPONSE AND HEALTH SYSTEM PREPAREDNESS PROJECT

1. Introduction/Project Description

An outbreak of coronavirus disease (COVID-19) caused by the 2019 novel coronavirus has been spreading rapidly across the world since December 2019, from Wuhan, Hubei Province, China to 88 countries. COVID-19 is one of several emerging infectious diseases outbreaks in recent decades that have emerged from animals in contact with humans, resulting in major outbreaks with significant public health and economic impacts.

Over the coming months, the outbreak has the potential for greater loss of life, significant disruptions in global supply chains, lower commodity prices, and economic losses in both developed and developing countries. The COVID-19 outbreak is affecting supply chains and disrupting manufacturing operations around the world. Economic activity has fallen in the past quarter, especially in China, and is expected to remain depressed for a number of months. The outbreak is taking place at a time when global economic activity is facing uncertainty and governments have limited policy space to act. The length and severity of impacts of the COVID-19 outbreak will depend on the projected length and location(s) of the outbreak, as well as on whether there are a concerted, fast track response to support developing countries, where health systems are often weaker. With proactive containment measures, the loss of life and economic impact of the outbreak could be arrested. It is hence critical for the international community to work together on the underlying factors that are enabling the outbreak, on supporting policy responses, and on strengthening response capacity in developing countries – where health systems are weakest, and hence populations most vulnerable.

As of 18th March 2020, in Mongolia, six confirmed case has been reported and a total of 172 close contacts have been identified and are currently being monitored. Since the report of pneumonia of unknown origin on 3 January 2020, Ministry of Health has been working with WHO, international partners and stakeholders from non-health sectors to ensure preparedness. Rapid risk assessment (RRA) was conducted 5 times to inform decision making and update national COVID-19 response plan and inform public health interventions at points of entries. A fifth multisectoral RRA was performed by ministers and stakeholders of 18 governmental organization and WHO CO and evaluated the risk of insufficient control capacities for COVID-19 community transmission as “High”. Review of national capacities for COVID-19 health facility preparedness (surge capacity, personal protective equipment, emergency medical equipment) has major gaps. Incident Management System (IMS) has been activated at the IHR NFP and number of provinces, however the Ministry of Health (MoH) IMS is not fully functional and there are no procedures to direct tertiary hospitals and provinces according to IMS: draft Disaster protection health procedures haven’t been approved yet.

The Parliament of Mongolia, the Cabinet, State Security Council and State Emergency Council convened several times and issued policy decisions regarding prevention of the possible transmission of COVID-19. Decisions were made to impose temporary travel restrictions, social distancing measures, extend suspension of school and kindergarten and social events. The Government allocated 4.3 billion MNT from the Government's Reserve Fund for the prevention of the novel coronavirus, ensure the preparedness of medical services, and purchase medicines and medical tools, personal protective equipment and other infection prevention and control supplies. Public awareness and knowledge have improved. Socio-economic impacts of the decisions and actions taken internationally and by the government of Mongolia to date are considered severe.

The social economic impacts of the COVID-19 could be severe. Although it is too early to gauge the full spectrum and severity of the social and economic impacts of the outbreak, the disease has already caused a global health crisis, lockdown of megacities, travel restrictions, suspension of schools and universities, disruption of food systems, delays in reopening of production lines, as well as suspension or slowdown of trade, as well as financial panic. The regional impact of Covid-19 and the authorities’ measures to prevent the spread of the outbreak are likely to have

significant negative implications on the Mongolian economy and thus on poverty reduction, education and health outcomes. Given Mongolia's heavy reliance on China for trade and investment, a weaker Chinese economy following the Covid-19 outbreak is likely to reduce Mongolia's external demand. Meanwhile, preventive measures of the authorities have started to squeeze the domestic demand.

COVID-19 will have deep social impact. Social norms—such as expectations that women and girls are responsible for doing domestic chores and nursing sick family members—can expose women and girls to greater health risks. Where healthcare systems are stretched by efforts to contain outbreaks, care responsibilities are frequently “downloaded” onto women and girls, who usually bear responsibility for caring for ill family members and the elderly. Experience with COVID -19 is early but has already shown COVID-19 response has pushed aside many other medical needs, especially in the most affected province Hubei province in China. Pregnant women, including those infected and those who are not, were not able to access antenatal care in the first couple of weeks. School closure and home quarantine are likely pushing more care burden and pressure on caregivers, primarily women. Women constitute over 81.9% of the workers in the health sector in Mongolia and are on the frontlines of the response and face additional challenges including gender pay gaps and specific needs including to meet menstrual hygiene needs.

The proposed project development objective is to strengthen the Government of Mongolia's capacity to prevent and to respond to the COVID-19 outbreak and strengthen national systems for public health preparedness.

The project consist from 4 components:

Component 1: Emergency COVID-19 Response (Total US\$2.5 million IBRD): The aim of this component is to slow down and limit the spread of COVID-19 in the country and improve preparedness for future public health emergencies. This will be achieved through providing immediate support for a comprehensive communication and behavior change intervention, strengthening capacity for active case detection and response, building an enabling platform for One Health and strengthening capacity of the health work force to manage the current and future public health emergencies. It will have four sub-components:

(a) Sub-Component 1.1: Risk Communication and Community Engagement (US\$1.1 million COVID19 FTF):

There will be a comprehensive communication and behavior change intervention to support key prevention behaviors (hand washing, social distancing etc.), including i) developing and testing messages and materials; and ii) further enhancing infrastructure to disseminate information from national to aimag and soum levels, and between the public and private sectors. Community mobilization will take place through existing Government and community institutions such as Aimag/city and Soum/district Governor's offices, health and education sector social workers, local CSOs, and bagh/khoroos (lowest administrative unit) Governors and doctors. Communication campaigns will include messages regarding appropriate care for sick family members, to decrease health risks to caregivers (often female) and provide information on to minimize psychosocial impacts. These modes for communication will include TV, radio, social media and printed materials as well as outreach through the community health workers who will need to be trained and compensated for this activity.

(b) Sub-Component 1.2: Response support (US\$0.45million COVID19 FTF):

This sub-component would help strengthen disease surveillance systems, and epidemiological capacity for early detection and confirmation of cases; combine detection of new cases with active contact tracing; support epidemiological investigation; strengthen risk assessment; and provide on-time data and information for guiding decision making and response and mitigation activities. Additional support will be provided to strengthen health management information systems to facilitate recording and on-time virtual sharing of information. Support under this sub-component will: i) improve management of public health events and emergencies; ii) place incident management systems within the health sector and across other sectors, including local levels; iii) develop M&E system to measure performance of health security systems; iv) improve coordination on public health emergencies and disaster management within the health sector and beyond at national and local levels; v) continue to strengthen system readiness to implement emergency plans, and vi) conduct strategic risk assessment and health risk and resource mapping.

(c) Sub-Component 1.3: Creating an enabling environment for One Health (US\$0.3 million COVID19 FTF):

This subcomponent will strengthen capacities for multi-sectoral response operations to emerging and new infectious diseases. Working with the Ministry of Food, Agriculture, and Light Industry and National Emergency Management Agency it will support capacity for joint response for new and emerging infectious diseases. The project will ensure that health care workers have access to all populations in need, to accommodate surges in health personnel and allow the transport of humanitarian and medical commodities as needed for preparedness and response activities. It will ensure that any movement restrictions relating to COVID-19 account for the needs of different vulnerable groups especially the elderly and women. Further the pandemic preparedness and response plans will be grounded in sound gender analyses and needs of other vulnerable populations. The project will i) enhance institutional policies, plans, procedures and linkages to facilitate improved multi-sectoral communication, coordination and collaboration; ii) strengthen public health law enforcement and review to address inconsistencies; iii) conduct joint surveillance and risk assessments (iv) improve public health emergency preparedness including the health facility preparedness, and v) create joint data sharing platform, both for early warning systems and joint control of disease outbreaks.

(d) Sub-Component 1.4: Human resource development (US\$0.45 million COVID19 FTF):

This component will finance activities related to preparedness, capacity building and trainings. It will enhance human resource capacity in diagnosing and treating the novel coronavirus and conduct epidemiological and clinical research. Key areas will include support for i) training for emergency care doctors, nurses and paramedical staff in diagnosing, triage and providing first aid care; ii) training for intensive care professionals; iii) building diagnostic capacity for COVID-19 at the subnational (regional/state) level; iv) providing psychosocial support to frontline responders v) translating, adapting and disseminating guidance to triage, treat, manage and follow up people with mild suspected COVID-19 disease in primary care settings, non-health facilities, community settings and at home; v) epidemiological and clinical research studies to take stock of the COVID-19 detection and treatment.

Component 2: Health Care Strengthening (Total US\$ 23.75 including US\$10.6 million from COVID-19 FTF, US\$13.8 million IBRD):

The aim of this component is to strengthen essential health care service delivery to be able to provide the best care possible despite a surge in demand. It will also ensure ongoing support for people ill in the community to minimize the overall impact of the disease on society, public services and on the economy. Assistance will be provided to the health care system for preparedness planning to provide optimal medical care, maintain essential lifesaving services and minimize risks for patients and health personnel. Strengthened clinical care capacity will be achieved by establishing specialized units in selected hospitals; publishing treatment guidelines, and hospital infection control interventions; strengthening waste management systems; and procurement of essential additional inputs for treatment such as oxygen delivery systems and medicines. Local containment will be supported through the establishment of local isolation units in hospitals and widespread infection control training and measures will be instituted across health facilities. The Government of Mongolia has several health facilities as the additional designated hospitals where COVID-19 patients will be admitted for treatment. These include i) Medical University Teaching Hospital; ii) Perinatology Center of Ulaanbaatar City; iii) the Third State Central Hospital known Shastin Central Hospital; and iv) all provincial and district general hospitals.

(a) Sub-component 2.1. Provision of medical and laboratory equipment and reagents (Total US\$23.33 million, including US\$8.58 million from COVID-19 FTF, US\$13.8 million IBRD):

This sub-component will upgrade health facilities in 21 provinces and 9 districts of Ulaanbaatar city for diagnostics and treatment of COVID-19 infection capacity through procurement of intensive care unit equipment and devices including ECMO equipment; establishment of oxygen mini-factory; provision of oxygen balloons, emergency beds, laboratory reagents and waste management facilities. This subcomponent will also support short trainings on use of equipment, devices, and tests for health providers and technicians.

(b) Sub-component 2.2. Provision of medical supplies, including PPE and medicines (US\$1.37 million COVID19 FTF):

This subcomponent will support the health system with medical counter measures including

drugs and medical supplies for case management and infection prevention, as well as procurement of drugs such as antivirals, antibiotics and essential medicines for patients with co-morbidity and complications such as CVDs and diabetes.

Component 3: Implementation Management and Monitoring and Evaluation (US\$0.65 million COVID19 FTF): The Project will use currently existing PIU staff of the E-Health Project and include additional expertise as required. This component would also support monitoring and evaluation of prevention and preparedness, building capacity for clinical and public health research, and joint-learning across and within countries. As may be needed, this component will also support third-party monitoring of progress and efficient utilization of project investments.

Component 4: Contingent Emergency Response Component (CERC) (US\$0 million): In the event of an Eligible Crisis or Emergency, the project will contribute to providing immediate and effective response to said crisis or emergency. A zero-value component has been included to ensure funds can be deployed through the project depending on the specific needs that may arise.

The Mongolia COVID-19 Emergency Response and Health Systems Preparedness Project is being prepared under the World Bank's Environment and Social Framework (ESF). As per the Environmental and Social Standard ESS 10 Stakeholders Engagement and Information Disclosure, the implementing agencies should provide stakeholders with timely, relevant, understandable and accessible information, and consult with them in a culturally appropriate manner, which is free of manipulation, interference, coercion, discrimination and intimidation.

Stakeholder Engagement Plan (SEP)

The overall objective of this SEP is to define a program for stakeholder engagement, including public information disclosure and consultation, throughout the entire project cycle. The SEP outlines the ways in which the project team will communicate with stakeholders and includes a mechanism by which people can raise concerns, provide feedback, or make complaints about project and any activities related to the project. The involvement of the local population is essential to the success of the project in order to ensure smooth collaboration between project staff and local communities and to minimize and mitigate environmental and social risks related to the proposed project activities. In the context of infectious diseases, broad, culturally appropriate, and adapted awareness raising activities are particularly important to properly sensitize the communities to the risks related to infectious diseases.

2. Stakeholder identification and analysis

Project stakeholders are defined as individuals, groups or other entities who:

- (i) are impacted or likely to be impacted directly or indirectly, positively or adversely, by the Project (also known as 'affected parties'); and
- (ii) may have an interest in the Project ('interested parties'). They include individuals or groups whose interests may be affected by the Project and who have the potential to influence the Project outcomes in any way.

Cooperation and negotiation with the stakeholders throughout the Project development often also require the identification of persons within the groups who act as legitimate representatives of their respective stakeholder group, i.e. the individuals who have been entrusted by their fellow group members with advocating the groups' interests in the process of engagement with the Project. Community representatives may provide helpful insight into the local settings and act as main conduits for dissemination of the Project-related information and as a primary communication/liaison link between the Project and targeted communities and their established networks. Verification of stakeholder representatives (i.e. the process of confirming that they are legitimate and genuine advocates of the community they represent) remains an important task in establishing contact with the community stakeholders. Legitimacy of the community representatives can be verified by talking informally to a random sample of community members and heeding their views on who can be representing their interests in the most effective way.

2.1 Methodology

In order to meet best practice approaches, the project will apply the following principles for stakeholder engagement:

- *Openness and life-cycle approach*: public consultations for the project(s) will be arranged during the whole life-cycle, carried out in an open manner, free of external manipulation, interference, coercion or intimidation;
- *Informed participation and feedback*: information will be provided to and widely distributed among all stakeholders in an appropriate format; opportunities are provided for communicating stakeholders' feedback, for analyzing and addressing comments and concerns; and
- *Inclusiveness and sensitivity*: stakeholder identification is undertaken to support better communications and build effective relationships. The participation process for the projects is inclusive. All stakeholders at all times encouraged to be involved in the consultation process. Equal access to information is provided to all stakeholders. Sensitivity to stakeholders' needs is the key principle underlying the selection of engagement methods. Special attention is given to vulnerable groups, in particular women, elders, herder families live in remote rural areas, persons with disabilities, youth and ethnic groups live in west part of country and speak/read local language different than Mongolian.

For the purposes of effective and tailored engagement, stakeholders of the proposed project(s) can be divided into the following core categories:

- **Affected Parties** – persons, groups and other entities within the Project Area of Influence (PAI) that are directly influenced (actually or potentially) by the project and/or have been identified as most susceptible to change associated with the project, and who need to be closely engaged in identifying impacts and their significance, as well as in decision-making on mitigation and management measures;
- **Other Interested Parties** – individuals/groups/entities that may not experience direct impacts from the Project but who consider or perceive their interests as being affected by the project and/or who could affect the project and the process of its implementation in some way; and
- **Vulnerable Groups** – persons who may be disproportionately impacted or further disadvantaged by the project(s) as compared with any other groups due to their vulnerable status¹ and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project.

2.2. Affected parties

Affected Parties include local communities, community members and other parties that may be subject to direct impacts from the project. Specifically, the following individuals and groups fall within this category:

- COVID19 infected people
- People under COVID19 quarantine, including workers in the quarantine facilities
- Patients
- Relatives of COVID19 infected people
- Relatives of people under COVID19 quarantine
- Neighboring communities to laboratories, quarantine centers, and screening posts
- People at COVID29 risks (travelers, inhabitants of areas where cases have been identified, etc.)
- Public Health workers and security guard around quarantine center
- Municipal waste collection and disposal workers
- MoH and members of National Emergency Committee
- Other Public authorities
- Airline, and border control staff

¹ Vulnerable status may stem from an individual's or group's race, national, ethnic or social origin, color, gender, language, religion, political or other opinion, property, age, culture, literacy, sickness, physical or mental disability, poverty or economic disadvantage, and dependence on unique natural resources.

- Airlines and other international transport business
- People affected by or otherwise involved in project-supported activities
- Public Healthcare workers in contact or handle the waste

2.3. Other interested parties

The projects' stakeholders also include parties other than the directly affected communities, including:

- Traditional media
- Participants of social media
- Political decision makers including MPs, cabinet members
- Other national and international health organizations
- Other national & International NGOs
- Businesses with international links
- The public at large

2.4. Disadvantaged / vulnerable individuals or groups

It is particularly important to understand whether project impacts may disproportionately fall on disadvantaged or vulnerable individuals or groups, who often do not have a voice to express their concerns or understand the impacts of a project and to ensure that awareness raising and stakeholder engagement with disadvantaged or vulnerable individuals or groups [on infectious diseases and medical treatments in particular,] be adapted to take into account such groups or individuals particular sensitivities, concerns and cultural sensitivities and to ensure a full understanding of project activities and benefits. The vulnerability may stem from person's origin, gender, age, health condition, economic deficiency and financial insecurity, disadvantaged status in the community (e.g. minorities or fringe groups), dependence on other individuals or natural resources, especially those living in remote, insecure or inaccessible areas, etc. Engagement with the vulnerable groups and individuals often requires the application of specific measures and assistance aimed at the facilitation of their participation in the project-related decision making so that their awareness of and input to the overall process are commensurate to those of the other stakeholders.

Within the Project, the vulnerable or disadvantaged groups may include and are not limited to the following:

- Elderly at age 60 or above who stay home or in nursing facilities
- Herder household and children live in remote rural area
- Ethnic minorities
- People with disabilities
- Female/or male-headed households
- Patient with chronic diseases

Vulnerable groups within the communities affected by the project will be further confirmed and consulted through dedicated means, as appropriate. Description of the methods of engagement that will be undertaken by the project is provided in the following sections.

3. Stakeholder Engagement Program

3.1. Summary of stakeholder engagement done during project preparation

The speed and urgency with which this project has been developed to meet the growing threat of COVID-19 in the country, combined with announcement of State Emergency Committee dated 23 Feb,2020 restrictions on gatherings of people until March 30 has limited the project's ability to develop a complete SEP before this project is approved by the World Bank. This initial SEP was developed and disclosed prior to project appraisal, as the starting point of an iterative process to develop a more comprehensive stakeholder engagement strategy and plan. It will be updated

periodically as necessary, with more detail provided in the first update planned for two months from project approval.

3.2. Summary of project stakeholder needs and methods, tools and techniques for stakeholder engagement

The WHO “COVID-19 Strategic Preparedness and Response Plan -- Operational Planning Guidelines to Support Country Preparedness and Response” (2020) will be the primary tool to be used for the Project’s stakeholder engagement. Nonetheless, the precautionary approach will be taken to the consultation process to prevent contagion, given the highly infectious nature of COVID-19. The project will avoid/minimize public gatherings (taking into account national restrictions or advisories), including public hearings, workshops and community meetings. At the same time, other means of communication/awareness methods such as social media, radio or TV will be also considered while public gathering/or event is restricted. The project will work with National Television Association (NTA)² and explore the possibility to prepare a TV programs on topics such as preventing from COVID-19 at personal, householder level and following measures/actions announced by the health professionals.

3.3. Proposed strategy for information disclosure

Project stage	Target stakeholders	List of information to be disclosed	Methods and timing proposed
Implementation	The Government including: State Emergency Committee, MoH, MoFALI, hospital administration (UB, Aimag level), urban and rural level local administration; General public including: elders, single parent headed households; mining and other large infrastructure project workers; patients staying in hospitals, people who are in the facilities were temporary isolated or quarantined; large food market and its vendors and customers; school children est. Rural population including herders and herder households in rural areas; ethnic minorities; International Organizations such as UNDP, WHO, ADB, EBRD, GIZ est.	<ul style="list-style-type: none"> Stakeholder Engagement Plan GRM and its operational procedure Regular project update/information 	<p>Website and FB of the MoH and E-Health Project Every 2 week</p> <p>Daily press conference/COVID-19 update by the MoH, WHO, NCCD</p> <p>TV/Radio programs (throughout the project lifespan)</p> <p>Poster, leaflets and other printed materials (every month)</p>

3.4. Stakeholder engagement plan

In terms of methodology, it will be important that the different activities are inclusive and culturally sensitive, thereby ensuring that the vulnerable groups outlined above will have the chance to participate in the Project

² The NTA is non-government organization that cooperating with Ministry of Education, Science and Sport to record and broadcast on-line classes during the quarantine period where schools are closed. Total 12 TV companies allocated airtime for different learning subjects.

benefits. Given to guidance issued by State Emergency Committee not to hold any public gathering till March 30, 2020, the priority communication channel will be access to information via the Ministry and World Bank website, national TV and radio broadcasting, aimag level TV stations and FM radio. Second is published materials to be displayed in main locations such as shop, bank or health centers. The MoH and E-Health project will ensure to produce information and communication materials in Mongolian as well as Kazakh languages as appropriate.

While country-wide awareness campaigns will be established, specific communication around borders and international airports, major inter-city bus terminals as well as quarantine centres and laboratories will have to be timed according to need and be adjusted to the specific local circumstance.

Project stage	Topic of consultation / message	Method used	Target stakeholders	Responsibilities
Preparation	<i>Purpose and method of preparing ESRS, ESCP and SEP</i>	Virtual consultation Providing background information	<i>Ministry of Health</i> Ministry of Finance	<i>MoH/E-Health PIU</i>
	Draft SEP and identify needed human and financial resources	Virtual consultation Exchange of communication and sharing of documents.	Ministry of Health and E-Health PIU	<i>MoH/ E-Health PIU</i>
Implementation	Updated ESMF/SEP and its implementation Regular project update on status of project implementation Regular update on status of GRM including number & nature of compliance, number of cases and their status of resolve or upscale. Labor Management Plan (LMP) ESMF	Virtual consultation if face-to-face event is prohibited Sharing draft documents via website and other social media channel of the MoH/E - Health project Poster/ or leaflet about GRM and it operations and detailed information on how to access	The Government including: State Emergency Committee, MoH, MoFALI, hospital administration (UB, Aimag level), urban and rural level local administration; General public including: elders, single parent headed households; mining and other large infrastructure project workers; patients staying in hospitals, people who are in the facilities were temporary isolated or quarantined; large food market and its vendors and customers; school children est. Rural population including herders and herder households in rural areas; ethnic minorities;	MoH/E-Health PIU

			International Organizations such as UNDP, WHO, ADB, EBRD, GIZ est.	
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The project includes considerable resources to implement the above actions. The details will be prepared during the update of this SEP. Consultations will be done on final E&S instruments including ESMPs (when prepared).

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3.5 Future of the project

Stakeholders will be kept informed as the project develops, including reporting on project environmental and social performance and implementation of the stakeholder engagement plan and grievance mechanism. This will be important for the wider public, but equally and even more so for suspected and/or identified COVID19 cases as well as their relatives.

4. Resources and Responsibilities for implementing stakeholder engagement activities

4.1. Resources

The Ministry of Health through E-Health PIU will be in charge of stakeholder engagement activities. Beneficiary and stakeholder engagement is a fundamental part of the project management activities. Accordingly, SEP updating, and implementation will be partly funded from the Project Management budget. Additional funds will be available under *Sub-Component 1.1 – Risk Communication and Community Engagement* of the project which has a total budget of US\$1.1 million from COVID-19 fund.

4.2. Management functions and responsibilities

Project management arrangements like those under the E-Health Project (P131290), currently functioning satisfactorily, will be adapted to utilize existing capacity in the MoH and coordinate project activities with all stakeholders. Through its central departments and provincial offices, the MoH will be responsible for implementation of the project, including overall coordination, results monitoring and communicating with the World Bank on all aspects of the project. The Current E-Health Project Steering Committee (PSC), chaired by the Minister of Health will be used for oversight and to provide strategic policy advice and guidance to the Project, as well as to the MoH. Membership of the PSC will be extended to include additional members from MoH, National Center for Communicable Disease, Center for Zoonosis Disease and Public Health Institute. The PSC will also be responsible for ensuring synergies between the project activities and the State emergency preparedness plan. The multisectoral aspects of the COVID-19 response will be guided by Government COVID-19 Response Committee chaired by Vice Prime Minister.

The Director of the Policy and Planning Department of the MoH, will function as the Project Director, will provide oversight and coordinate the project implementation with collaboration of relevant divisions and departments of MoH. The existing E-Health Project Implementation Unit will be expanded and staffed with relevant experts including medical equipment specialist/engineer, emergency officer and will provide all support to the Project implementation. Community engagement and safety specialist will also be recruited to work on implementation of

EMSP and SEP.

A separate Project Implementation Manual (PIM) will be developed by April 2020 to support the PIU to meet its responsibilities for management of the project. The Manual will describe responsibilities of the PIU, operational systems and procedures, project organizational structure, office operations and procedures, finance and accounting procedures (including funds flow and disbursement arrangements), procurement procedures and implementation of project ESMP and SEP per World Bank ESF guidance.

MoH, through E-Health PIU will be responsible for carrying out stakeholder engagement activities, while working closely together with other entities, such as local government units, media outlets, health workers, etc. The stakeholder engagement activities will be documented through quarterly progress reports, to be shared with the Association.

5. Grievance Mechanism

The main objective of a Grievance Redress Mechanism (GRM) is to assist 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. Specifically, the GRM:

- Provides affected people with avenues for making a complaint or resolving any dispute that may arise during the course of the implementation of projects;
- Ensures that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants;
- Ensure that project level GRM should be also culturally appropriate and accessible for IPs; and
- Avoids the need to resort to judicial proceedings.

5.1. Description of GRM

Grievances will be handled at the national level by MoH and E-Health PIU. The GRM will include the following steps:

Step 1: Submission of grievances either orally or in writing to E-Health PIU:

Step 2: Recording of grievance and providing the initial response within 48 hours

Step 3: Investigating the grievance and Communication of the Response within 7 days

Step 4: Complainant Response: either grievance closure or taking further steps if the grievance remains open. If grievance remains open, complainant will be given opportunity to appeal to MoH via email or calling to +976 – 264923.

Once all possible redress has been proposed and if the complainant is still not satisfied then they should be advised of their right to legal recourse including process stated in the Law on Resolving Citizens' Complaint/Petition Addressed to Public Organization or Servant (1995). According to law, the public organization who has accepted grievance expected to respond within 30 days with possible extension another 30 days.

In the instance of the COVID 19 emergency, existing grievance procedures should be used to encourage reporting of co-workers if they show outward symptoms, such as ongoing and severe coughing with fever, and do not voluntarily submit to testing. Once all possible redress has been proposed and if the complainant is still not satisfied then they should be advised of their right to legal recourse.

5.2 Venues to register Grievances - Uptake Channels

A complaint can be registered directly at COVID 19 (GRCs) through any of the following modes and, if necessary, anonymously or through third parties.

- By telephone at +976 – 264923. The list of the contact for services related to COVID-19, the people can contact respective local hospital by visiting <https://covid19.mohs.mn/p/cat/post/52/>
- By e-mail to info@moh.gov.mn or piu@ehp.mn

- By letter directly at provincial health authority/ and provincial contracted NGOs for healthcare services.
- By complaint form to be lodged at any of the address 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 grievance logbook at healthcare facility or suggestion box at clinic/hospitals

Once a complaint has been received, it should be recorded in the complaints logbook or grievance excel-sheet-grievance database.

5.3 GRM Unit for COVID 19

MoH has established a dedicated webpage that contains series of information designed for public use as well as list of hospital and clinic and their contact number. The project will help to strengthen this webpage to ensure that it can be also used for COVID-19 project.

5.4 Grievance for Gender-Based Violence (GBV) issues

There will be specific procedures for addressing GBV including confidential reporting with safe and ethical documenting of GBV cases. Multiple channels will be in place for a complainant to lodge a complaint in connection to GBV issue. Specific GRM considerations for addressing GBV under COVID-19 are:

- a separate GBV GRM system, potentially run by a GBV Services Provider with feedback to the project GRM, similar to that for parallel GRMs will be established. The GRM operators are to be trained on how to collect GBV cases confidentially and empathetically (with no judgment).
- COVID 19 will establish multiple complaint channels, and these must be trusted by those who need to use them.
- No identifiable information on the survivor should be stored in the GRM logbook or GRM database.
- The GRM should not ask for, or record, information on more than three aspects related to the GBV incident:
 - The nature of the complaint (what the complainant says in her/his own words without direct questioning);
 - If, to the best of complainant’s knowledge, the perpetrator was associated with the project; and
 - If possible, the age and sex of the survivor.
- The GRM should assist GBV survivors by referring them to GBV Services Provider(s) for support immediately after receiving a complaint directly from a survivor. This will be possible because a list of service providers will already be available before project work commences as part of the mapping exercise.
- The information in the GRM must be confidential—especially when related to the identity of the complainant. For GBV, the GRM should primarily serve to: (i) refer complainants to the GBV Services Provider; and (ii) record resolution of the complaint.

Data Sharing: The GBV Services Provider will have its own case management process which will be used to gather the necessary detailed data to support the complainant and facilitate resolution of the case referred by the GRM operator. The GBV Services Provider should enter into an information sharing protocol with the GRM Operator to close the case. This information should not go beyond the resolution of the incident, the date the incident was resolved, and that the case is closed. Service providers are under no obligation to provide case data to anyone without the survivor’s consent. If the survivor consents to case data being shared the service provider can share information when and if doing so is safe, meaning the sharing of data will not put the survivor or service provider at risk for experiencing more violence. 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 ministry 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.

6. Monitoring and Reporting

6.1. Involvement of stakeholders in monitoring activities *[if applicable]*

6.2. Reporting back to stakeholder groups

The SEP will be periodically revised and updated as necessary in the course of project implementation in order to ensure that the information presented herein is consistent and is the most recent, and that the identified methods of engagement remain appropriate and effective in relation to the project context and specific phases of the development. Any major changes to the project related activities and to its schedule will be duly reflected in the SEP. Monthly summaries and internal reports on public grievances, enquiries and related incidents, together with the status of implementation of associated corrective/preventative actions will be collated by responsible staff and referred to the senior management of the project. The [monthly] summaries will provide a mechanism for assessing both the number and the nature of complaints and requests for information, along with the Project's ability to address those in a timely and effective manner. Information on public engagement activities undertaken by the Project during the year may be conveyed to the stakeholders in two possible ways:

- Publication of a standalone annual report on project's interaction with the stakeholders.
- A number of Key Performance Indicators (KPIs) will also be monitored by the project on a regular basis.

Further details will be outlined in the Updated SEP, to be prepared within one month of effectiveness.