**Mizoram Health Systems Strengthening Project (P173958)**

**Stakeholder Engagement Plan**

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| Mizoram Population 2020 | India Happiness Report 2020: Mizoram, Punjab, Andaman and Nicobar Islands  Top List; Maharashtra & Delhi at Bottom | India.com |

**Department of Health and Family Welfare**

**Government of Mizoram**

**October 2020**

**ABBREVIATIONS**

|  |  |
| --- | --- |
| ADC | Autonomous District Council |
| ANM | Auxiliary nurse midwife |
| ASHA | Accredited social health activist |
| BMW | Bio-medical Waste |
| CADC | Chakma Autonomous District Council |
| CERC | Contingent Emergency Response Component |
| CHC | Community Health Centre |
| CMO | Chief Medical Officer |
| CTF | Common treatment facility |
| DH | District Hospital |
| DOHFW | Department of Health and Family Welfare |
| E&S | Environmental and Social |
| ESF | Environmental and Social Framework of World Bank |
| ESMF | Environmental and Social management Framework |
| ESMP | Environmental and Social Management Plan |
| ESS | Environmental and Social Standard |
| FPIC | Free, Prior, and Informed Consent |
| GBV | Gender Based Violence |
| GoI | Government of India |
| GoM | Government of Meghalaya |
| GRM | Grievance Redress Mechanism |
| HCF | Health Care Facility |
| HR | Human Resource |
| HWC | Health and Wellness Centre |
| ICT | Information and communication technology |
| IEC | Information, Education, and Communication |
| IPA | Internal performance agreement |
| IPF | Investment Project Financing |
| IPM | Internal Performance Management |
| IT | Information Technology |
| LADC | Lai Autonomous District Council |
| MARA | Mara Autonomous District Council |
| MHCS | Mizoram Health Care Scheme |
| MMR | Maternal Mortality Rate |
| MO | Medical Officer |
| MOHFW | Ministry of Health and Family Welfare |
| MSPCB | Mizoram State Pollution Control Board |
| NCD | Non-communicable diseases |
| NGO | Non-governmental Organization |
| NHM | National Health Mission |
| NQAS | National Quality Assurance Standards |
| OHS | Occupation and Health Safety |
| OOPE | Out-of-pocket expenditure |
| OSC | One Stop Centre |
| PDO | Project Development Objective |
| PHC | Primary Health Centre |
| PMU | Project Management Unit |
| PPE | Personal Protective equipment |
| PPP | Public Private Partnership |
| RKS | Rogi Kalyan Samiti |
| SBCC | Social and Behaviour Change Communication |
| SC | Sub-Centre |
| SEA | Sexual exploitation and abuse |
| SEP | Stakeholder Engagement Plan |
| SH | Sexual harassment |
| SOP | Standard Operating Procedure |
| VC | Village Council |
| WCD | Women and Child Development |

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**STAKEHOLDER ENGAGEMENT PLAN FOR**

**MIZORAM HEALTH SYSTEMS STRENGTHENING PROJECT (P173958)**

# Introduction

The Government of Mizoram (GoM) recognizes that improvement of the health systems is paramount for a citizen-centric fully functional service provision. Recognising the gaps in current services, GoM plans to strengthen the health systems through a series of measures that can not only bring efficiency in operations but also ensure achievement of short term and long-term goals of having qualified competent staff that can sustainably provide quality service delivery. The Mizoram Health System Strengthening Project (MHSSP) articulates the key measures that the GOM plan to take in strengthening the health system in the state.

The MHSSP is under preparation in accordance with World Bank’s Environment and Social Framework (ESF). In compliance with its requirements under ESS10 on ‘Stakeholder Engagement and Information Disclosure’, this plan has been developed to guide the engagement of various project stakeholders, including affected persons with the project during its life cycle, spell the strategies and approaches that would be in place to ensure that all stakeholders are informed a priori about all proposed project activities and their impacts in a culturally appropriate manner and mechanisms that would be developed by the project to systematically seek their feedback. ESS10 recognises that effective engagement with the stakeholders can significantly improve the project outcomes and their sustainability through better community acceptance and ownership, enhance the environmental and social sustainability of projects, and hence make a significant contribution to successful project implementation.

## Project Background

The proposed project development objective (PDO) is to “**to improve accountability, health insurance program and quality of health services in Mizoram**”. More specifically, the project will improve the quality and responsiveness of health services among public facilities at primary health center (PHC), community health center (CHC) and district hospital levels. This shall be done by creating an ecosystem of increased accountability through intra-governmental Internal Performance Agreements (IPA). IPAs shall be designed both as a management and financing tool for enabling a culture of accountability, which will over time improve utilization of health services. The progress towards achievement of the PDO will be measured by the following results indicators:

1. Percentage of administrative units and facilities signed internal performance agreement. (Percentage) (accountability)
2. Percentage of local fund utilization (including performance grants and Insurance reimbursements) in targeted hospitals. (Percentage) (accountability and health insurance)
3. Increase in percentage coverage of households under health insurance scheme. (Percentage) (health insurance)
4. Increase in percentage of targeted public health facilities getting National Quality Assurance certification. (Percentage) (quality)

## Project Components

**Component 1: Improving accountability and strengthening governance through Internal Performance Agreements.** This component focuses on reforms in governance and management structures through IPAs between the DoHFW and its subsidiaries at the state and sub-state levels. This RBF approach marks a paradigm shift in the financing relationship between state and the sub-state level implementing units. Institutions and health facilities will be incentivized against the performance indicators achieved, instead of sole reliance of line item budgets. The IPAs will foster a spirit of more accountable government, and results-based monitoring, leading to improvements in overall public health function at state level and improve quality of service delivery. The arrangement shall be modelled around the principal-agent as there exists a complete convergence of objectives between participating entities. Receipts through this approach at the facility level will provide resources with a larger pool of flexible funds thereby bypassing the rigidities inherent in the traditional PFM systems within health. This approach will further strengthen ownership of decentralized structures and their autonomy. The arrangements will align the objectives of participating entities. The strategic approach for achieving this are outlined below:

1. **IPAs will be signed at three levels of the state public health system**. Entities with which the DoHFW will sign such agreements are (i) the Directorates and their subsidiary departments including two directorates and Mizoram Health Care Scheme (MHCS); (ii) district-level health administrations and district hospitals; and (iii) health facilities, at both the referral (CHCs) and primary levels (PHCs).
2. **The Directorates will be supported in identifying existing sector-wide gaps in quality of health services and health insurance program, determining the most suitable approaches to address these gaps, developing action plans, and operationalizing those plans**. Funding will be provided to the Directorates, the district-level health offices, eligible subsidiary divisions, and the health insurance program, which will meet pre-conditions reflecting a minimum level of capacity and interest, including development of action plans with agreed targets. This process will build institutional capacity of the decentralized health administrative units at the state and sub-state levels in need-based planning and management of health services.
3. **Performance will be measured against results defined via key indicators that contribute to improved quality of health services and efficiency in health insurance program.** The health insurance programs will be restructured to ensure coordination and synergy with the national program, improve overall design, implementation reforms and achieve accountability and sustainability through reforms. Key indicators will capture human resources for health, timely supply of resources at the district level, availability of medicines at the facility level, regulation of biomedical waste and monitoring of health services, and will be included in the health facility quality scores.
4. **Performance measurement and verification system**. The achievement of performance indicators reported by the administrative units and health facilities who are parties to the IPAs will be confirmed in two ways. (1) An internal verification mechanism will use an existing pool of human resources that are currently tasked with various quality assurance activities. (2) An external verification mechanism will involve a pool of contracted consultants who will independently assess a sample of the reported results as well as the use of financial incentives by different levels. Indicators and targets will be revised based on implementation experience. The health facilities will be empowered to use these incentives for activities that contribute to improvements in health services.

**Component 2:** **Improve design and management of Health insurance programs:**This component shall support the state insurance program and its linkages with the PM-JAY to reduce financial barriers in accessing hospital services, prevent catastrophic out-of-pocket expenditures (OOPE) for health by poor families, and expand coverage. For this, architectural corrections are required in the two health insurance schemes that are running in parallel. The project will finance investments in such corrections at three levels: (a) strengthening policy and design for increased operational efficiency; (b) strengthening institutional capacity, systems and processes of the State insurance agency for greater accountability; and (c) community interventions for improving coverage and demand.

1. ***Strengthening policy and design for increased operational efficiency***. This will include reviewing benefit packages, exploring options for converging benefit packages between the two schemes, exploring options for convergence in the schemes, converting state schemes into a cashless benefit for end-users, maximising the provisions of the PMJAY and reduce financial burden on the MHCS, without losing the distinct identity of the MHCS.
2. ***Strengthening institutional capacity, systems and processes***: Investments will be made in strengthening operational convergence of the two schemes, investing in IT architecture and capacity to convert the state scheme (MHCS) into a paperless transaction system like the central scheme (PM-JAY), and all other systems like the beneficiary identification, hospital empanelment, referrals, portability structures and mechanisms, claim adjudication, financial management, grievance redressal, service quality audits, and overall monitoring. Systems, tools and skills (technical, managerial and soft) shall be developed among scheme administrators at the state, district and facility levels, which may include but not be limited to investments in additional human resource and infrastructure of the scheme administering agency, and learning missions to states / countries with matured health insurance programs.
3. ***Community interventions for improving coverage and demand***: Comprehensive communication campaign and demand side interventions will be supported to improve enrolment under the scheme and increase demand for services. This may include household enumeration. In addition, community-driven pilots in selected districts will be supported by the project to increase awareness about health issues including enhanced focus on health insurance scheme. The interventions will leverage the existing platforms and structures for the same e.g., Village health, sanitation and nutrition committees (VHSNCs), women self-help groups (SHGs) and village health and nutrition day (VHND).

**Component 3:** **Quality of health service and innovations:** This component will improve the quality of health services by: developing a comprehensive quality assurance system; biomedical waste management, augmenting systems for human resource management, and piloting innovations. These investments will improve the capacity of the state government health system to respond to the ongoing COVID-19 pandemic as well as increase preparedness for future outbreaks. Under this component, the project will support development of the HR policy that will clearly define the career pathway, define roles and competency and gender responsive to address specific concerns. Along with quality of services, this component will focus on human resource strengthening and infection prevention as they are, among other areas, important prerequisites for ensuring quality of services.

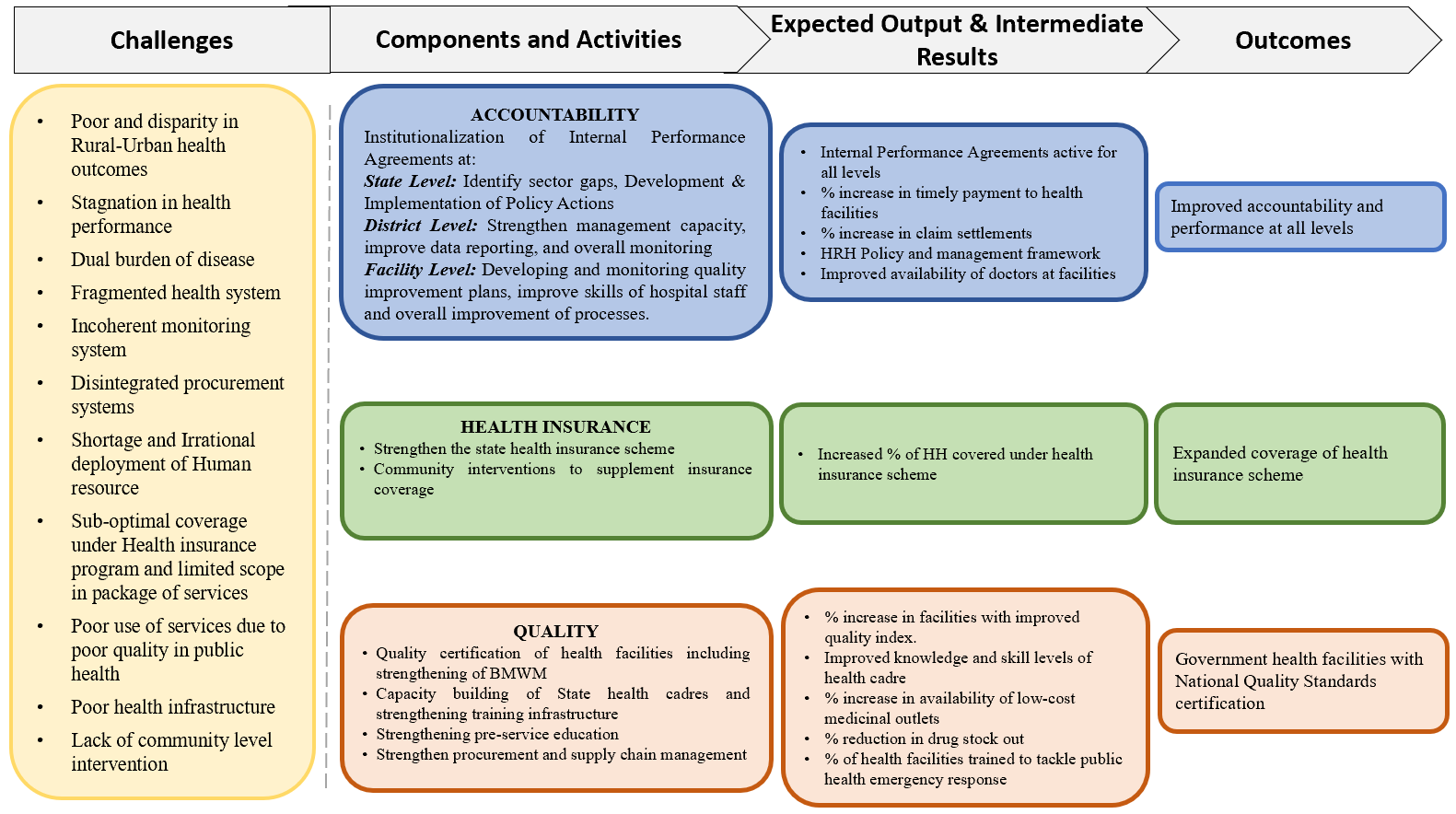
* 1. ***Improvements in the delivery and quality of health services provided by district hospitals, CHCs and PHCs*.** The project will support quality assurance program at the PHC, CHC and district hospital level. This involves implementation of health facility improvement plan, training of teams responsible for periodic assessments, and training of district-level administrators. The project will build on other initiatives supported by the State and central governments, notably NQAS. The project will support preparation of additional health facilities for accreditation. This will involve gap analysis and the necessary training and investments to fill the identified gaps. The project will support Facility Improvement Teams to implement quality initiatives by recruitment of hospital managers and strengthen the district teams. The NQAS quality index used to measure results.
  2. ***Strengthening of biomedical waste management***: The project will develop a strategy for improving management and disposal of biomedical waste generated by both government and private health services, in collaboration with the state Pollution Control Board and municipalities. Improving the biomedical waste management system will be undertaken through a range of activities that will include developing evidence-based strategies and plans, investing in infrastructure and equipment (including maintenance), exploring private sector engagement options, capacity building, and deploying personal protective equipment, infection prevention measures and immunization for health care providers.
  3. ***Health human resource development***: The project will support a multi-pronged approach to institutionalize and strengthen health human resource development and management, starting with support to development of a state level policy for health human resources. The project will support improvements in pre- and in-service training, including quality accrediting, NAC, for college of nursing, revamping training institutions and developing programs for continuing medical and para-medical education. The project will also support the state in developing and implementing strategies to address human resource shortages, including specialists. Human resource management systems will be improved, including through developing and implementing performance metrics for health cadres, and building the capacity of the Department of Health for data-based management of human resources.
  4. ***Testing innovations in service delivery through pilot interventions***. The project will support design, development and piloting of innovative models for service delivery outreach focusing on quality and comprehensiveness of services. Such areas may include but not be limited to engaging community platforms and frontline workers, community / home based palliative care, NCD screening including screening for breast and cervical cancers, comprehensive primary care services through wellness centers (HWC), PPP pilots, use of drones for emergency supplies, use of technology for consultation (telemedicine, etc.).

**Component 4:** **Contingent Emergency Response Component**: Provision of immediate response to an Eligible Crisis or Emergency, as needed.

### Project Beneficiaries

1. The proposed project will benefit the entire state of Mizoram as it aims to strengthen the state public health system. The primary focus will be on strengthening all the 12 district hospitals and Sub-District Hospitals, 7 CHCs and 38 PHCs across the state. Systems will also be strengthened in the Mizoram Health care Scheme which is currently used by 56 percent families in the State.
2. The project will also benefit health sector staff, specifically at the secondary and primary levels, by strengthening their capacity and by providing them skill-based training. Investments at the health facility level to improve infrastructure, private sector partnerships, technology solutions, and improved working conditions, will improve their efficiency and satisfaction levels and lead to better quality care.
3. The community level intervention that follows the integrated approach for child development also provide focused health and nutrition service for mothers. This will benefit the women and child through focused intervention.

### The Result Chain



## Key Environmental and Social Risks and Impacts

The project does not envisage potential large-scale, significant or irreversible environmental impacts. The project does entail a range of minor civil works for infrastructure repair and rehabilitation, but the risks and impacts associated with these activities (such as noise and dust pollution) will be localized and short-term. The funding under the project is entirely geared towards improving the existing State program including utilization and quality of health service delivery at primary and secondary level, strengthening of Health insurance program, and improving the governance and accountability system, and management capacity at the State level for effective planning, implementation, and monitoring health systems.

With the improved utilization of health services through the project, the quantity of bio-medical waste will increase. However, the increase of biomedical waste will not be significant. The biomedical waste management system (BMWM) in the State of Mizoram is functional but needs improvement. The project also plans to strengthen the bio-medical waste management system in the State and plans to improve the overall ecosystem for bio-medical waste management that includes segregation, disinfection, collection and disposable that largely safeguards the environment and contributes in improving the quality of health service and patient safety.

Overall, it is expected that the project will have positive environmental and social impacts, given the project components aims to strengthen the public health function and improve the access to and quality of health service delivery in Mizoram. The key social risks emerge from the risk of exclusion and access to services given the difficult geographic terrain of the state and especially those living in remote and hilly areas.

## Objectives of Stakeholder Engagement Plan (SEP)

SEP seeks to provide a transparent engagement and open communication between and among the project stakeholders to maximize participation and inclusion for project design, implementation, monitoring and evaluation; enhance project acceptance and improve the environmental and social sustainability. A systematic approach to stakeholder engagement will help DoHFW develop and maintain over time a constructive relationship with the stakeholders throughout the duration of the Project.

Specific objective of this SEP is to establish a systematic approach to stakeholder engagement at project level that will:

* Identify stakeholders and build/maintain a constructive relationship with them to enable stakeholders’ views to be considered in project design and environmental and social performance;
* Assess the level of stakeholder interest and support for the project;
* Promote and provide means for effective and inclusive engagement with project affected parties throughout the project life cycle on issues that could potentially affect them;
* Ensure that appropriate project information on environmental and social risks and impacts is disclosed to stakeholders in a timely, understandable, accessible and appropriate manner and format; and
* Provide project-affected parties with accessible and inclusive means to raise issues and grievances and allow DoHFW to respond to and manage such grievances.

## Methodology Adopted in Development the SEP

To inform project design and for development of SEP, consultation with various stakeholders were undertaken including discussions were conducted with key officials in DoFHW. These consultations were largely done in a virtual manner in relation to main environmental and social aspects of the project. This involved:

* Discussion with DoFHW key officials
* Discussion with State pollution control board,
* Directorate of Women and Child
* Department of Social Welfare and Tribal Affairs
* Autonomous development Councils (Lai ADC, Chakma ADC, Mara ADC) to voice the concerns of different tribal groups
* Survey of 112 HCFs including 11 DHs, 9 CHCs, 64 PHCs and 36 SCs to collect baseline on key environmental and social indicators using digital methods.
* Consultation with HCFs key Medical officers using one-to-one phone calls about their issues and concerns as well as issues and concerns with 2 DH, 2 SDH, and 7 PHC.
* Consultation with CBOs (including women groups, elderly groups etc) and NGOs to voice the concerns of women, youth, elderly, and disabled population.
* Consultation with traditional community heads/ village council chairman(s)/ members to voice the concerns of beneficiaries including poor, vulnerable and marginalised groups living in their village.

The key concerns as voiced by various stakeholder groups are presented in Annex-II, and further informed the ESMF and project preparation by instituting specific measures targeting poor and vulnerable population and those living in remote areas.

# STAKEHOLDER IDENTIFICATION AND ANALYSIS

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

1. are impacted or likely to be impacted directly or indirectly, positively or adversely, by the Project (also known as “**affected parties**”); and
2. 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.
3. persons who may be disproportionately impacted or further disadvantaged by the project as compared with any other groups due to their vulnerable status, and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project are categorized as “**vulnerable groups**”).

## Affected Parties

Affected Parties include local communities, community institutions, health care facilities, health care providers etc. who may be subject to direct impacts from the Project and includes:

* Communities living on target areas of the project
* Community institutions such as Village Health and Sanitation Committees (VHSCs), and ASHAs, and ANMs in the villages that coordinate with target health facilities kin providing promotive health care and provide linkages to reproductive, maternal, new-born and child health (RMNCH) services
* Target health facilities i.e. target District Hospitals, Sub-District Hospitals, CHCs, PHCs, and SCs/ HWCs
* Health care workers especially in the target health facilities
* Workers associated with handling, transportation and disposal of BMW
* Department of Health and Family Welfare and all its Directorates

## Interested Parties

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

* Other line departments and agencies such as State pollution control board, Social Welfare and Tribal Affairs Department, Women and Child Development, Autonomous development Councils (Lai ADC, Chakma ADC, Mara ADC) etc.
* NGOs and CBOs including women groups, elderly groups etc.
* INGOs supporting NGOs/ CBOs in Mizoram on health care, disability, gender, and other such issues
* Elected representatives
* Media groups and academia
* The public at large

## Vulnerable Groups

It is important to understand and recognise 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 hence, awareness raising and stakeholder engagement with disadvantaged or vulnerable individuals/ groups on health care services in target areas may be adapted to take into account such groups or individuals’ issues and concerns, cultural sensitivities, and to ensure proper understanding of project activities and benefits. This includes:

* Elderly
* People with disabilities
* Women, especially Young women and girls at heightened risk of gender-based violence
* Scheduled tribes (ST), scheduled castes (SC), and communities living in in remote and hilly locations
* Female-headed households, especially single mothers with underage children
* Illiterate and poor population
* Marginalized minority groups in Mizoram including other smaller tribes, and migrants workers from other states etc.

## Stakeholder Analysis

Stakeholder analysis is the process of identifying the stakeholder groups that are likely to affect or be affected by the project activities and sorting them according to their impact on the project and the impact the project activities will have on them. Stakeholder analysis is an ongoing process, which may evolve as new stakeholders are introduced to the project. The preliminary stakeholder analysis has identified the various interests of stakeholder groups and the influence these groups may have on the project. The analysis also shaped the design of stakeholder consultation activities and which stakeholders to engage and when.

| **Table 1: Stakeholder Analysis** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Stakeholder Group** | **Key Characteristics** | **Stakeholder Interest** | **Language Needs** | **Preferred**  **Means of Communication** | **Specific needs** |
| Community groups including minority population and public at large | Key primary beneficiary seeking quality health services closer to their village/ town | * Quality health services closer to village * Better medical assistance for gynaecological diseases at the PHC/ CHC * Better RMNCH services closer to village * Better geriatric disease treatment locally * Better medical services for disabled population * Improved diagnostic services | English, Mizo | TV, Newspaper, Community meetings | Timings based on community convenience |
| Elderly population and persons with disability | Key primary beneficiary seeking quality health services including geriatric care and with universal access measures being in place at HCFs | * Better medical services closer to village * Better geriatric disease treatment locally * Better medical services for disabled population * Infrastructure supporting universal access for elderly and disabled population * Improved diagnostic services | English, Mizo | Community meetings | Timings based on community convenience |
| Women, especially Young women and girls | Key primary beneficiary seeking quality health services closer to their village/ town | * Quality health services closer to village * Better medical assistance for gynaecological diseases at the PHC/ CHC * Better RMNCH services closer to village including at SC, PHC, and CHC * Availability of gynaecologists and paediatrician * Improved diagnostic services – such as x-ray, ultrasound and laboratory tests * Gender sensitive Infrastructure provisions such as caring for privacy, separate toilets for women etc. | English, Mizo | Community meetings | Timings based on community convenience |
| Poor and vulnerable population | Key primary beneficiary seeking quality health services closer to their village/ town | * Quality health services closer to village * Easily accessible beyond regular OPD hours * Improved diagnostic services at affordable cost * Availability of free medicine | English, Mizo | Community meetings | Timings based on community convenience |
| Health committees associated with HCFs, ASHAs, and ANMs | Institutions and individuals with community linkage involved in outreach services of health | * Better RMNCH services in the village with improved linkages with PHCs/ CHCs * Improved assistance for gynaecological diseases at the PHC/ CHC | English, Mizo | TV, Newspaper, Community meetings | Timings based on community convenience |
| Health Facility staffs including Doctors, Nurses, Paramedics, and other staffs including Workers associated with handling, transportation and disposal of BMW | Main service provider of health services at DH, SDH, CHC, PHC and HWC level | * Establishing an effective primary and secondary healthcare services with improved quality * Improved health facility infrastructure, supply of medicines, diagnostic services where needed, to serve better * better equipments and technologies * Improved reporting mechanism * Receiving support from superior authorities, especially technical support from general practitioners and specialists | English,  Mizo | Official communication, meetings/ workshops, email, Phone, social media e.g. WhatsApp etc. | Outside OPD timings – preferably in the afternoon |
| Representatives at local governing institutions e.g., ADCs, Village/ Town councils, and Traditional Leaders | Key influencers of public opinion and also facilitators of other developmental resources to villages/ towns | * Quality primary and secondary health care services in their area | English, Mizo | Official communication, leaflets/ booklets etc  Meetings/ workshops | Timings based on community convenience |
| Key officials of Department of Health and family Welfare including NHM, Directorate of Hospital and Medical Education (HME), and Directorate of Health Services (DHS) | Main decision makers at State level for provision of various health services in the state | * Quality primary and secondary health care services in the target areas and facilities * Smooth implementation of project activities | English,  Mizo | Official communication, meetings/ workshops | Official working hours |
| Key officials of other line departments/ institutions involved in provision of associated services e.g. State pollution control board, Social Welfare and Tribal Affairs Department, Women and Child Development Department | Main decision makers at State level for implementation of various schemes and provision of various services in the state | * Quality primary and secondary health care services in Mizoram | English,  Mizo | Official communication, meetings/ workshops | Official working hours |
| Elected Representatives | Main policy makers influencing health services; and key influencers of community opinion | * Quality primary and secondary health care services in Mizoram | English, Mizo | Official communication,  Meetings/ workshops | Official working hours |
| NGOs/ CBOs; Media and Academia | Will have a role in providing E&S oversight, creating project related awareness, including its GRM and supporting information disclosure | * Activities undertaken as promised and having positive impact on delivery of services to target population and to poor and vulnerable population. | English, Mizo | Meetings/ workshops | Official working hours |

# Stakeholder Engagement Program

## Purpose of the Stakeholder Engagement Program

The MHSSP project under preparation in accordance with World Bank’s Environment and Social Framework (ESF). In compliance with its requirements under ESS10 on ‘Stakeholder Engagement and Information Disclosure’, this plan has been developed to guide the engagement of various project stakeholders, including affected persons with the project during its life cycle, spell the strategies and approaches that would be in place to ensure that all stakeholders are informed a priori about all proposed project activities and their impacts in a culturally appropriate manner and mechanisms that would be developed by the project to systematically seek their feedback.

ESS10 recognises that effective engagement with the stakeholders can significantly improve the project outcomes and their sustainability through better community acceptance and ownership, enhance the environmental and social sustainability of projects, and hence make a significant contribution to successful project implementation.

This SEP shall serve the following purpose:

* Identify and analyse critical stakeholders of the project. Identify those that are affected and/or able to influence the project and its activities,
* Plan on how the engagement with stakeholders will take place,
* Conduct consultations with project stakeholders and provide reports on the results of the consultations prior the appraisal stage,
* Enhance and/or strengthen the grievance/resolution mechanism for stakeholders making them able to raise their concerns about the project,
* Define reporting and monitoring procedures to stakeholders to ensure the effectiveness of the SEP and periodic review of SEP based on results and findings.

Apart from the requirements under ESS10, this SEP also fulfils the requirements for information disclosure and stakeholder consultation prescribed under two major legislations of the government of India. These are:

* Right to Information Act of 2005
* Environmental Impact Assessment Notification (EIA) of 2006 (including all subsequent amendments) as notified by Ministry of Environment, Forests and Climate Change, GoI

The Right to Information Act, 2005 is a progressive rights-based accountability and transparency enforcement mechanism available to citizens which allows them to seek information related to government programs in personal or larger public interest and mandates the provision of this information within a stipulated timeframe. The Act is implemented in states through the office of the State Information Commissioners and Information officers designated for each public office. It makes the public offices and duty- bearers liable to providing correct and detailed information demanded by the citizen within designated timeframes, with mechanisms for appeals and sanctions if information provided is inadequate or incorrect.

The Environmental Protection Law also recognizes the right of citizens to live in a healthy environment -protected from any adverse environmental impacts and provides detailed protocols and guidance on environment management. It also provides citizens the right to environmental information as well as to participate in developing, adopting, and implementing decisions for managing environmental impacts. It also has provisions for public hearing during the process of project planning to ensure public discussion during project implementation and makes it obligatory for project authorities to incorporate suggestions received from the citizens.

The engagement of stakeholders has already commenced as part of the project preparation. This will continue throughout the project lifecycle, starting as early as possible and continuing throughout planning and installation activities and through the technical advisory components. The nature and frequency of the engagement will be tailored to relevant groups, issues and sub-projects. Details of the planned stakeholder engagement activities (including disclosure and consultation) are included in the following two sections.

## Stakeholder Engagement and Information Disclosure Strategy

There are a variety of engagement methods used to build relationships, gather information, consult, and disseminate project information to stakeholders. This includes formal communication by DOHFW to various stakeholder groups (other than community groups), conduct state level workshop inviting various stakeholders including from civil society, media and academia; and disclosure at DoHFW website. The consultation process will involve inclusive methods, inform about project activities and update, solicit feedbacks, document the process, and communicate follow-up. The timing of stakeholder engagement is broken down by stakeholder and project phase, as provided in Table-3 below. Engagement and consultation will be carried out on an ongoing basis as the nature of issues, impacts, and opportunities evolve.

**Table 2: Stakeholder Consultation Process**

| **Target stakeholders** | **Information to be disclosed** | **Proposed engagement & disclosure method** | **Timing of Engagement** | **Responsible Parties** |
| --- | --- | --- | --- | --- |
| Community groups including minority population and public at large | Project scope  Key project objectives  Broad set of project activities  E & S documents – ESMF, SEP, ESCP etc. | Local/ National News Papers  Community meetings  Surveys | Design Phase  Implementation Phase | PMU  CMO  HCF |
| Elderly population and persons with disability | Project scope  Key project objectives and  Broad set of project activities  E & S documents – ESMF, SEP, ESCP etc. | Local/ National News Papers  Community meetings  Surveys | Design Phase  Implementation Phase | PMU  CMO  HCF |
| Women, especially Young women and girls | Project scope  Key project objectives and  Broad set of project activities  E & S documents – ESMF, SEP, ESCP etc. | Local/ National News Papers  Community meetings  Surveys | Design Phase  Implementation Phase | PMU  CMO  HCF |
| Poor and vulnerable population | Project scope  Key project objectives and  Broad set of project activities  E & S documents – ESMF, SEP, ESCP etc. | Local/ National News Papers  Community meetings  Surveys | Design Phase | PMU  CMO  HCF |
| Health committees associated with HCFs, ASHAs, and ANMs | Project Information  Key project objectives and components  Broad set of project activities  E & S documents – ESMF, SEP, ESCP etc. | Official communication, meetings/ workshops  Local/ National News Papers  Surveys | Design Phase  Implementation Phase  Completion stage | PMU  CMO  HCF |
| Health Facility staffs including Doctors, Nurses, Paramedics, and other staffs including Workers associated with handling, transportation and disposal of BMW | Project Information  Key project objectives and components  Broad set of project activities  E & S documents – ESMF, SEP, ESCP etc. | Official communication, meetings/ workshops  Correspondence by email, phone, social media tools  Surveys | Design Phase  Implementation Phase  Completion stage | PMU  CMO  HCF |
| Representatives at local governing institutions e.g., ADCs, Village/ Town councils, and Traditional Leaders | Project Information  Key project objectives and components  Broad set of project activities  E & S documents – ESMF, SEP, ESCP etc. | Official communication, meetings/ workshops | Design Phase  Implementation Phase  Completion stage | PMU |
| Key officials of Department of Health and family Welfare including NHM, Directorate of Hospital and Medical Education (HME), and Directorate of Health Services (DHS) | Project Information  Key project objectives and components  Broad set of project activities  E & S documents – ESMF, SEP, ESCP etc. | Official communication, meetings/ workshops | Design Phase  Implementation Phase  Completion stage | PMU |
| Key officials of other line departments/ institutions involved in provision of associated services e.g. State pollution control board, Social Welfare and Tribal Affairs Department, Women and Child Development Department | Project Information  Key project objectives and components  Broad set of project activities  E & S documents – ESMF, SEP, ESCP etc. | Official communication, meetings/ workshops | Design Phase  Implementation Phase  Completion stage | PMU |
| Elected Representatives | Project Information  Key project objectives and components  Broad set of project activities  E & S documents – ESMF, SEP, ESCP etc. | Official communication, meetings/ workshops | Design Phase  Implementation Phase  Completion stage | PMJU |
| NGOs/ CBOs; Media and Academia | Project Information  Key project objectives and components  Broad set of project activities  E & S documents – ESMF, SEP, ESCP etc. | Local/ National News Papers  meetings/ workshops | Design Phase  Implementation Phase  Completion stage | PMU  CMO |

A list of stakeholder consultations already undertaken during the design phase is summarised in the Annex-1 of the report.

## Strategy to incorporate the view of vulnerable groups

During preparation, the views of the vulnerable groups are sought through virtual consultations with representative organizations/ institutions and NGOs/ CBOs working with them given the Covid19 situation and associated travel restrictions, social distancing and other advisories on community gathering etc. This included consultations with Mizo Hmeichhe Insuihkhawm Pawl (MHIP) for Women’s issues; Mizo Upa Pawl (MUP) for elderly population issues, Young Mizo Association (YMA) for youth and other general poor population issues; Lai ADC, Mara ADC and Chakma ADC for issues with tribal groups living in different parts of the state; and Village council members from different villages for rural poor and illiterate population. In addition, consultations with sample HCF staffs were also undertaken to understand the issues and concerns of the vulnerable community and the service providers in a virtual manner during the design phase to inform project design. While these consultations could not be directly with the target population during project design phase and will be undertaken during implementation phase. Consultation will also be conducted as part of the social and behaviour change communication and with patients during visit to HCFs through patient satisfaction surveys to voice their feedback on level of satisfaction as well as areas of improvement.

Additional vulnerable groups on this project may be identified during future stages of community engagement, and the plan will be revised accordingly to reflect this identification of new stakeholders.

The project will inherently benefit vulnerable groups by increasing and improving the access opportunities to the health services in the state. However, the project will need to pay special attention in order to address any potential barriers to the most vulnerable groups to meaningfully participate the in the project including using Mizo languages for some of the community engagement activities with local ethnic groups.

## Timelines

The current information on the project timelines are still being discussed and finalised. Hence, the timeline will be updated once the project design is further finalized.

## Review of Comments

Comments, suggestions, clarifications and other information collected will be documented in consultation records, and at the next engagement opportunity, a summary of how they were taken into account will be reported back to the stakeholder group.

This document includes details of the consultations undertaken as part of the project preparation phase, including key discussion points and recommendations to respond to stakeholder feedback in Annex 1. It also includes a summary of all parties and individuals consulted during project preparation. The project design and the Environmental and Social Commitment Plan (ESCP) of the project will be informed by the concerns voiced by the stakeholders, which will be updated over the project lifecycle.

## Responsibilities for Implementing Stakeholder Engagement Activities

At the State level, PMU at the DOHFW shall have an Environment Safeguard Specialist and a Social Safeguard Specialist. Both these specialists will be responsible for implementation of their respective E&S measures- including implementation of the Stakeholder Engagement Plan. At the district level CMO and at the HCF level MO in-charge will be responsible for implementing the SEP. To ensure that the stakeholder engagement plan is effective, DoHFW will hire, train, and deploy qualified personnel with good communication skills to undertake the stakeholder engagement, where needed in addition to the PMU personnel. Ensuring placement of suitable staff for social safeguards will be included in the ESCP as one of the commitments. The roles and responsibilities at different level of project implementation is present below.

**Table 3: Responsibilities for Implementing Stakeholder Engagement Activities**

|  |  |
| --- | --- |
| **Agency / Individual** | **Roles and Responsibilities** |
| Project Director | * Approve the content of the draft SEP (any revisions) * Approve prior to release, all IEC materials used to provide information associated with the project (communication material, PowerPoint, posters, leaflets and brochures, TV and radio insertions) * Approve and authorize all stakeholder engagement events and disclosure of material to support stakeholder engagement events |
| Social Safeguard Specialist and Environmental Safeguard Specialist | * Provide overall guidance and monitoring supervision to the SEP process * Prepare and provide appropriate SBCC, IEC and communication material, information required to be disclosed to different stakeholder categories * Finalize the timing and duration of SEP related information disclosure and stakeholder engagement * Orient the district and HCFs staff on SEP and requirements for its operationalization |
| District and HCF | * Prepare and customize to district requirements the IEC and communication material provided by the PMU and the information required to be disclosed to different stakeholder categories * Ensure that all material/ strategies developed are culturally appropriate and available in a easily comprehendible form to stakeholders (based on their profile and their information needs). Finalize the timing and duration of SEP related information disclosure and stakeholder engagement * Participate either themselves, or identify suitable representative, during all face-to face stakeholder meetings * Review and sign-off minutes of all engagement events; Maintain the stakeholder database. * Assure participation/ inclusion of stakeholders from vulnerable groups |

## Proposed Budget for Stakeholder Engagement Plan

A proposed indicative budget for the stakeholder engagement activities is outlined below:

|  |  |
| --- | --- |
| **Table 4: Indicative Budget for SEP\*** | |
| **Activity** | **Proposed Budget (INR)** |
| SEP Updating and Auditing (consultant) | 10,00,000 |
| General Expenses for SEP implementation | 50,00,000 |
| Expenses related to Stakeholder Engagement activities  (@20 lakhs x 5 year) | 100,00,000 |
| Additional services on stakeholder engagement (consultants, other expenses) (@10 lakhs x 5 year) | 50,00,000 |
| **Total** | **21,000,000**  **(~300,000 USD)** |
| \* Note: Separate budget for strengthening GRM system is included in ESMF | |

# GRIEVANCE REdress MECHANISM (GRM)

The existing grievance redress mechanism (GRM) in Mizoram is using the complaint registration to district CMO and/or to the Health Directorate. The details of the grievance redressal centre including the district wise phone numbers and emails of the concerned officials is also available at [www.health.mizoram.gov.in](http://www.health.mizoram.gov.in). The complaints can be lodge complaints using phone, email, and/or manually in person. The district CMO at district level and the designated nodal person at the Directorate level is responsible for screening, forwarding, tracking and addressing the grievances including responding to the complainant. However, it lacks in systematic mechanism of tracking the grievances, system of escalation, and monitoring and reporting system. In addition, Department of Personnel and Administrative Reforms (DP&AR), government of Mizoram also have centralised public grievance redress mechanism whereby one can register their grievances online and track the same for its redressal at <https://pgportal.gov.in/Home/LodgeGrievance>. Grievances received by this online system is then screened and forwarded to respective department/ directorate/ agencies for addressing.

For health care staffs, as per the GoM notification (vide No.B.12011/20/2009-HFW/ dated 27th August 2015), constituted a Staff Grievance Redressal Committee under National Health Mission (NHM) which is similar in nature with the Tribunal System of the Government, and playing the role of help desk as well for all staff, partners and members of the State Health Society, under the chairmanship of Principal Secretary, DoHFW along with Principal Director (DOHFW) as vice-chairman, Joint Mission Director NHM as the member secretary. The Committee consisting of members including (i) High Power Committee of State Program Management Unit (SPMU) of NHM, (ii) Joint Secretary, Health & Family Welfare, (iii) Representative from Department of Personnel and Administrative Reforms (DP&AR), (iv) Member of Bar Association, and (v) CSO representative. The terms of reference of the committee includes (a) to respond to any grievance of valid nature within 24 hours of receipt; (b) to settle dispute within the sphere of NHM functionaries and its partners, etc; (c) to resolve policies for prevention, care and reduction of staff and beneficiaries grievances; (d) to meet at least once in 3 months; (e) to submit its report on cases and resolution to the State Health Mission Committee. Any grievance by the health staffs can be registered to the Joint Director- Health Services (JDHS) through phone (+91-389-2328045), mail ([dhsmizoram@gmail.com](mailto:dhsmizoram@gmail.com); [drvanlalsoma@gmail.com](mailto:drvanlalsoma@gmail.com)), and/or written complaint manually/ in-person to JDHS office in Aizawl.

Under the project, the GRM system will be further strengthened and will be supported both by a traditional and technology-based approach, for early resolution of complaints and will be applicable for both internal as well as external stakeholders. The SEP further details out the processes to be followed. Till such time, the existing system to be followed including for sub-projects. In addition, social accountability measures such as patient satisfaction surveys, citizen scorecard/ report card or health committees scorecard/ report card will be used for acquiring feedback on performance and recording citizens’ recommendations.

## Objectives of GRM

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; and
* Avoids the need to resort to judicial proceedings (at least at first).

Grievances raised by stakeholders will need to be managed through a transparent process, readily acceptable to all affected communities and other stakeholders, at no cost and without any retribution. The GRM will work within the existing national and state’s legal and cultural frameworks and will provide an additional opportunity to stakeholders and interested parties to resolve their project specific grievances at the local, project, city or state level. The key objectives of this GRM will be:

* Ensure availability of offline as well as online mechanisms which are simple to use and accessible by all the categories of stakeholders and by people with differing levels of literacy and awareness
* To record, categorize and prioritize the grievances.
* Redress grievances via consultation, information disclosure, action with all stakeholders based on the nature of grievances received
* Inform the stakeholders about the action taken or information sought and ensure that the grievances are adequately addressed and resolved within a specified timeframe
* Provide a system of escalation to the higher level of any grievance that remains unresolved or unaddressed within the stipulated timeframe
* Provide an appellate authority within the project management set-up for handling appeals on grievances perceived as being unresolved by the complainant.

## Roles and Responsibility

The Grievances will be handled at the DoHFW by the concerned official(s) designated for the GRM in the PMU using the mechanism for handling public grievances. The GRM includes the following steps:

**Step 0**: Raising and registering the grievances using various mechanism including through Help desk, online using internet, email, Walk-ins and registering a complaint on grievance logbook at healthcare facility or suggestion box at the HCFs/ hospitals.

**Step 1**: Grievance raised is screened and forwarded to respective administrative/ facility level for redressing

**Step 2**: Grievance discussed at the respective administrative/ facility level, and addressed

**Step 3**: If not addressed in stipulated period it is escalated to next level at CMO at the district and finally the DoHFW

**Step 4**: Once addressed, feedback sent to the complainant

**Step 5**: If not satisfied, appeal to the other public authorities

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.

## World Bank GRS Framework

In addition to the project GM, complainants have the option to access the World Bank’s Grievance Redress Service (GRS), with both compliance and grievance functions.

Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB’s Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB’s independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB 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 opportunity to respond. For information on how to submit complaints to the World Bank’s corporate Grievance Redress Service (GRS), please visit <http://www.worldbank.org/GRS>. For information on how to submit complaints to the World Bank Inspection Panel, please visit <http://www.inspectionpanel.org>.

# ANNEX-I: Stakeholder Consultations During Preparation

Below is the list of stakeholders consulted during the project design.

| **SL No** | **Name** | **Designation** | **Department/Organization** |
| --- | --- | --- | --- |
| **Line Departments and Agencies** | | | |
| 1 | Mr. C. Lalduhawma | Member Secretary | Mizoram Pollution Control Board |
| 2 | Ms. P.C. Lalmuanpuii | Assistant Environmental Engineer | Mizoram Pollution Control Board |
| 3 | Mrs. Vanlalpianpuii | Director | Women & Child Development |
| 4 | Mrs. Aileen Vanlalzawni | Joint Director | Social Welfare & Tribal Affairs |
| 5 | Mr. N. Resik | Chief Executive Member | Chakma Autonomous District Council |
| 6 | Mr. LZ Tluanga | Deputy Secretary | Lai Autonomous District Council |
| 7 | Mr. K. Hrahmo | Executive Member | Mara Autonomous District Council |
| **Medical Association** | | | |
| 8 | Dr. Chawnglung-muana | Hony. Secretary | Indian Medical Association, Mizoram State Branch |
| 9 |  | President | Mizoram Government Doctor’s Association (MGDA) |
| **Health Care Facilities** | | | |
| 10 | Dr. John Zohmingthanga | Deputy Medical Superintendent | Aizawl Civil Hospital, Aizawl |
| 11 | Dr. Lalnunpuii | Medical Officer | Lunglei Civil Hospital, Lunglei |
| 12 | Dr. C. Lalrosanga | Medical Superintendent | Siaha Civil Hospital, Siaha |
| 13 | Dr. Lalnithanga | Senior Medical Officer | Tlabung Sub-District Hospital, Tlabung |
| 14 | Dr. Lalrengpuii | Medical Officer i/c | Hnahthial Sub-District Hospital, Hnahthial |
| 15 | Dr Lalremruata | Medical Officer i/c | Kawrthah CHC |
| 16 | Dr Lalruatfela | Medical Officer i/c | Sakawrdai CHC |
| 17 | Dr. Benjamin Lalramchuana | Medical Officer | Farkawn PHC |
| 18 | Dr. C Lalnunpuia | Medical Officer | Kawnpui PHC |
| 19 | Dr. Johnny | Medical Officer | Bungtlang South PHC |
| 20 | Dr. Laldinpuii | Medical Officer | East Lungdar PHC |
| 21 | Dr. Mary | Medical Officer | Sihphir PHC |
| 22 | Dr Lalnunzira | Medical Officer | ITI UPHC |
| 23 | Ms. Lalrinzuali | Health & Wellness Officer | Chaltlang Sub-Centre Health & Wellness Centre |
| 24 | Ms. Julie Lalrinpuii | Health & Wellness Officer | Hriphaw Sub-Centre Health & Wellness Centre |
| **Traditional Community Heads** | | | |
| 25 | Mr. Lalawmpuia | Chairman | Zarkawt Local Council |
| 26 | Mr. Lalramliana | President | Farkawn Village Council |
| 27 | Mr. R. Lalrammawia | President | Vairengte Village Council |
| 28 | Mr. | President | Lawipu Local Council |
| 29 | Mr. Vanlaltluanga | President | Buarpui Village Council |
| 30 | Mr. Lalvula Jongte | President | Phuldungsei Village Council |
| 31 | Mr. Laltanpuia | President | N Vanlaiphai Village Council |
| 32 | Mr. Beireithai | President | Chakhei Village Council |
| **Civil Society - CBOs and NGOs** | | | |
| 33 | Mrs. Lalthlamuani | President | Mizo Hmeichhe Insuihkhawm Pawl (MHIP) - Women’s Group |
| 34 | Mrs. Biaksailovai | Vice-President | Mizo Hmeichhe Insuihkhawm Pawl (MHIP) - Women’s Group |
| 35 | Mr. Zahlira Ralte | General Secretary | Mizo Upa Pawl (MUP) |
| 36 | Prof. Lalnuntluanga | General Secretary | Young Mizo Association (YMA) |

# Annex-2: Stakeholder concerns and suggestions

**Table: Key Issues and Concerns, and Suggestions voiced during consultation**

| **Stakeholder Group** | **Key Issues and Concern** | **Key Suggestions Received** |
| --- | --- | --- |
| Mizoram State Pollution Control Board | Biomedical Medical Waste Management in HCFs  Key issues and factors for an effective BMWM include   * The workers involved in the management of bio-medical wastes must be properly trained and made aware of the importance of BMW. * Provision of Sufficient supply and procurement of consumables/ materials for segregation, treatment and disposal of BMW with installation of full-fledged ETP for liquid waste. * Establishment of public grievance helpline or centre in which the public can submit their grievance on BMW in hospitals thereby also creating awareness about BMW Management among the public.   Key concerns of the board:   * Lack of awareness and training among the employees in health care facilities pose problem in management of BMW. * The written reports from Departments of Health are lacking. Some individual hospitals have mentioned in the Annual Reports of training within their own establishments. The MPCB has organized two state level training in the past year and participated in certain training programs hosted by the hospitals and in workshops under Kalyakalp Scheme as resource. During the pandemic the Department has also been providing training programmes for management of COVID-19. * Provision of adequate funds for procurement of equipment for treatment and disposal of BMW. The existing amount of INR 10000/ in the allocated budget is grossly insufficient. * Improper segregation and collection of wastes in facilities.   Though equipment for collection and storage are available, but the colour coded bags are often not available, weighing machines for wastes weighing purpose and autoclave for wastes are lacking, leading to poor waste management practices.  Covid-19 wastes   * Poor registration in the COVID19 apps and make daily entries of BMW Management. Only 5 facilities have registered in the COVID-19 apps so far. * The health facilities need to ensure proper segregation and disposal of COVID-19 waste in quarantine facilities and provide yellow coloured bags. However, no report received by the Board in this regard.   e-waste and other hazardous wastes management in HCFs   * Lack of awareness among consumers, bulk consumers & stakeholders. * Lack of technical knowhow in the management of e- waste. * Improper segregation and collection of wastes. * No collection, dismantling or recycling facility in the state. Aizawl Municipal Corporation is reported to have initiated setting up of collection centre for Aizawl city. As there is no collection centre in the state, the Mizoram Pollution Control Board has been encouraging two CPCB approved Producer Responsibility Organizations (PRO) to set up centres for management of e-waste. | BMW Management  For improving the BMW Management first and foremost step is by conducting physical verification or inspection of each facilities or conducting complete inventory in order to quantify and chalk out a policy or plan for developing an environmentally sound and economically feasible waste management practices.  In order to improve the Bio- Medical waste management the following plan is proposed by the Board:   1. A separate cell in the Health Department for Bio- Medical Waste Management. 2. Dedicated staff and committee for waste management in all health care facilities. 3. Strengthening of staff for checking or verifying the status of waste management in all facilities. 4. Proposal of funds either from the Central or State Government for management of Bio- Medical wastes. 5. Routine employee training, continuing education, and hospital management evaluation processes for systems and personnel involved in bio-medical waste management. 6. Physical inspection of health care facilities in the whole state for the purpose of inventory and chalking out the plan/ policies for proper management of BMW. 7. Providing all necessary aid in setting up of CBMWTF. 8. Co-ordinate with Government department for development of an environmentally sound and cost effective infrastructure for BMW / Solid Waste & hazardous treatment, disposal and recycling facilities. 9. Develop a web system where all Health care Facilities make daily entries of BMW generated and treated per day. 10. Conducting waste audits in Health Care facilities.   e-waste and other hazardous wastes management   * Creating awareness at consumer, village and government levels. * To make a system of inventory of e-wastes in the state * Setting up of proper Collection centre * Proper segregation of e-waste * Strict implementation of buy-back system and channelization of e-waste by the dealer. |
| Indian Medical Association (IMA), Mizoram | * Both communicable diseases and non-communicable diseases are increasing at alarming rate. * The health care delivery especially in rural and remote and areas have poor accessibility. Also, HCF staffs deployment and vacant posts in these areas need to be reviewed properly. * While there is good improvement in private sector in providing health care in urban areas, the public health care services need to improve in providing affordable quality health care. In rural areas and even district hospitals excluding those in bigger towns need substantial improvement especially with placement of key specialists. * CHC, PHC, and UHCs need to be improved both in terms of staffing and basic diagnostic services. Also, referral system needs to be strengthened. | * Partnership with other agencies like NGOs and CBOs can help in strengthening the system. * Continued medical education of the staffs are important and need to be strengthened. * Capacity building of health care providers through specialized training is very much needed to improve quality of services. |
| Health Care Facilities - District Hospitals, CHCs, PHCs and UHCs. | * The ley challenges include - follow up with patients, registration system, IT management, staff constraints, and infrastructure related issues. It includes, space constraint, overcrowding. lack of group-D staff, lack of technical man-power (Lab Tech, X-ray tech etc), weak centralized hospital information management system. * RKS is in place and involved in decision making, management of HCF, monitoring performance, resource mobilization, cleanliness drive and other such matters. Though, many HCFs report minimal involvement. * Hospitals do have Grievance redressal Committee, Suggestion/ Complaint Box including for HCF staffs and public/ patients, and patient satisfactory survey for both OPDs and IPDs. * IPHS norm not being followed for staffs in Sub-district hospitals and CHCs with limited or no specialists. * Lack of awareness about utilization of healthcare services - poor health seeking behavior among community. * Inadequate provision of healthcare workers, hospital equipment and laboratories in other than district hospitals. * Inadequate infrastructure for infection management as with crowding the risk factor increases. * Village council and community is very supportive, however, there is no mechanism for sustained collaboration. * Power supply is an issue and need proper backup system to function smoothly. * Most of the HCFs lack labor room and operation theatre as prescribed under IPHS norms, where it has to maintain clean and sterile zone with bathroom and changing room attached. * Shortage of basic equipments and medicines are there in most of the HCFs * Many HCF lack proper biomedical waste management system as well as and general wastes as there is no proper waste collection system in place. Also, there is no proper drainage for liquid waste. | * The project could focus on improving upon Emergency Medical Services (EMS); Infrastructure, Equipment, Technical Manpower. * Infrastructure at HCF needs to be improved including sanitation facilities, waiting areas, diagnostic services etc. * At least a minimum set of specialists (e.g. medicine, gynaecologist, paediatrician, and a surgeon) should be posted in SDHs and CHCs. * Expand RKS with more community members and include RKS members in planning, review/ update and project implementation meetings. * Role and responsibility of RKS need to be reviewed and members need to be made aware of the same. * Setting up of diagnostic and investigatory facilities in close proximity with the OPD for easy access for the patient. * Changing and rest rooms for doctors and other staff at the vicinity of the OPD to serve better. * Infrastructure improvement required looking at the serviced provision mechanism and proximity to the place they are needed. * Services and equipments needs to be provided such as Ultrasound, ECG, ICU beds etc. * BMWM to be improved in all HCFs |
| CBOs/ NGOs  (Mizo Hmeichhe Insuihkhawm Pawl (MHIP) - Women’s group; Mizo Upa Pawl (Elderly group), Young Mizo Association (YMA) | * There is lack of awareness regarding the risk factors for diseases among women. * Cleanliness and hygiene management are a big concern in HCFs * Many people find it difficult to communicate adequately with healthcare staffs, and even feel intimidated sometimes. * There is a lot of difference in how poor and rich are treated in the HCFs | * There is need to conduct awareness program about risk factors and diseases to make behaviour change. * Department can take help of NGOs in awareness generation. * Cleanliness and hygiene management need to improve in HCFs * HCF staffs needs to be oriented to be inclusive and sensitive towards patients. |
| Village Council members | * Level of awareness among Village council members and people in general is quite low about RKS or any other health committee associated with HCF. * Diagnostic services are inadequate in PHCs. Also, there is lack of medicine at PHCs. And hence, many people have to go to district headquarters to access care. * Given Sub-centres work only for mother and childcare, for all other health needs people go to private clinics. * Shortage of health care staffs at PHCs and CHCs are a major concern. * The diagnostic and ambulatory services also need improvement at CHCs and PHCs. * Infrastructure of HCFs mainly CHCs, PHCs, and SCs are quite in poor condition and need urgent repair, and renovation. * Vacancy/ Absenteeism of health staffs in the HCFs in remote areas are another big concern. | * Infrastructure and human resource in all HCFs require immediate attention. * Placement of staffs to be reviewed and ensured their availability at the HCF. * Review of essential list of medicines from time to time. |
| Autonomous District Councils – (1) Lai ADC; (2) Mara ADC; (3) Chakma ADC | * Though health & nutrition as a subject is not within the purview of Autonomous District Councils (ADCs), there are many needs such as repair and renovation of HCFs and living quarters as being in bad shape; hygiene management is a priority area for improvement; better cold chain equipments to ensure quality vaccination; good transport arrangement for vaccination drive; awareness campaign on behavior change required to deal with many diseases; and health staffs absenteeism is cited as a major concern in some of the remote area. * Some ADCs have also provided financial support for running of HCFs and are concerned about the overall resource provisioning to HCF for proper health care. * Most HCFs need to improve on diagnostic services, also, the diagnostic equipments such as X-ray machine etc are quite old and non-functional in some cases. | * The key suggestions includes improvement in infrastructure condition, proper placement of health staffs in all areas, and improvement in diagnostic care along with necessary equipments. |
| Department of Social Welfare (Women and Child Development, Social Justice and Empowerment, Tribal Affairs and Minority Affairs) | * Training/ Workshops and awareness programmes is found to be inadequate for sensitizing on gender and GBV and has not reached to some areas and the target population. | * Training/ sensitizing HCF Staff on gender and gender-based violence needed. * Large scale awareness program to be initiated for gender sensitization and GBV for awareness among target population. * Additional guidance to be provided to department along with directives for formation of ICC under sexual harassment at workplace act. |