Stakeholder Engagment Plan

Child Nutrition & Social Protection Project (P174637)

9 November 2021

Government of Papua New Guinea

National Department of Health, Department for Community Development & Religion, Department of Justice and Attorney General.

DRAFT

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Acronyms

CNSP	Child Nutrition and Social Protection
DCDC	District Community Development Centre
DFAT	Department of Foreign Affairs and Trade
DfCDR	Department for Community Development and Religion
DJAG	Department of Justice and Attorney General
DNPM	Department of National Planning and Monitoring
E&S	Environmental and Social
ECD	Early Child Development
ESCP	Environmental and Social Commitment Plan
ESF	World Bank's Environmental and Social Framework (ESF)
ESRS	Environmental and Social Review Summary
ESS	Environmental and Social Standard
FTI	Fast Track Initiative
GoPNG	Government of Papua New Guinea
IA	Implementing Agency
LLHA	Local Level Health Authority
LMP	Labour Management Plan
M&E	Monitoring and Evaluation
NGO	Non Government Organisations
NDoH	National Department of Health
OH&S	Occupational Health and Safety
PDO	Project Development Objective
PHA	Provincial Health Authority
PSP	Payment Service Providers
PNG	Papua New Guinea
SA	Social Assessment
SA/MP	Social Assessment and Social Management Plan
SBCC	Social Behaviour Change Communication
SEA	Sexual Exploitation and Abuse
SEP	Stakeholder Engagement Plan
SLOS	Social and Law & Order Sector
SH	Sexual Harassment
TA	Technical Assistance
VAW	Violence Against Women
VHA	Village Health Assistant
VHV	Village Health Volunteers
WASH	Water Sanitation and Hygiene
WB	World Bank

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1 Introduction

1.1 Introduction to this plan

This Stakeholder Engagement Plan (SEP) defines a programme for stakeholder engagement for the Child Nutrition and Social Protection (CNSP) Project. This SEP was developed during the initial design phase of the project and will be implemented in accordance with the Government of PNG (GoPNG) and the World Bank's requirements for stakeholder engagement. The project will commence building a social protection safety net system to address high poverty rates and strengthen the delivery of frontline health and nutrition outreach services in PNG.

1.2 Context

With half of all children in PNG currently being stunted, stunting can and must be prevented. Reducing stunting will enhance human development and result in long terms gains for the citizens of PNG. The GoPNG has requested World Bank financing for the CNSP project which will be implemented in accordance with relevant PNG laws and the World Bank's Environmental and Social Framework (ESF) – including Environmental and Social Standard (ESS) 10 - Stakeholder Engagement.

1.3 Project description

The design of the project is outlined in the draft PAD dated November 2021. A summary is provided below.

The Project Development Objective is to increase utilization of **priority nutrition interventions** and **purchasing power** of first thousand-day households in selected provinces.

The three (3) key results indicators are:

a) Percentage point increase in the proportion of children at two years of age who have received two doses of Vitamin A supplement;

b) Proportion (%) of first 1,000-day households receiving child nutrition grant; and

c) Percentage point increase in proportion of mothers/caregivers who demonstrate adequate infant and young child feeding practices.

The direct beneficiaries are the first 1,000 days households covered by the project. While the pregnant women or the mothers of infants under 2 would be the recipients of the child nutrition grant, their family members would also benefit from the project in terms of more and better-quality food and exposure to SBCC. The secondary beneficiaries are health workers that would receive training for delivering essential health and nutrition services. The national and sub-national government officials that are involved in the FTI planning and implementation would also benefit from capacity building activities and coordination mechanism established by the project.

The project will be implemented through three components:

- **Component 1: Implementing Community-based Approaches to Reduce and End Stunting (PNG CARES)** - This component seeks to promote critical nutrition behaviors including use of health services, early stimulation and positive parenting behaviors among first 1,000-day households and to support the convergence of multi-sectoral nutrition-relevant services. Since health systems capacity to deliver nutrition-specific health services at health facilities and through outreach is a critical bottleneck to the use of these services, this component also seeks to strengthen capacity to deliver these services and integrate them into routine health service delivery and outreach. Sub-components include:

- *1.1 Community-level Multi-sectoral Actions for Nutrition and Early Childhood Development*- involving sub-grants between NDOH and church health organizations for i) community mobilisation; ii) action planning and progress monitoring using village score cards; iii behaviour change communication for child feeding and hygiene practices; iv) promoting use of nutrion services through the PNG health system; advocating pro-nutrition health and WASH investments; promoting kitchen gardens and small livestock rearing to promote diet diversification; and Early Stimulation and Positive Parenting programs to empower parents to improve the quality of their interactions and play with their children through early stimulation and positive parenting.
- *1.2 Strengthening Health* Systems – including the procurement of digital tools (i.e. phones, tablets etc.) and technical assistance, training, and associated operational costs to improve the collection and use of data related to nutrition as well as for the management and oversight of service delivery. In addition, this sub-component will finance mass media-based advocacy campaign on child stunting. Activities will include: (i) development and rollout of a nation-wide stunting-focused advocacy and awareness campaign; (ii) high-level policy events and summits (national and sub-national level); and (iii) nationwide advocacy and awareness activities focused on early stimulation and positive parenting.

- **Component 2: Implementing a Nutrition-Sensitive Child Grant** – This component, implemented by the Department for Community Development and Religion (DfCDR), seeks to address the affordability dimension of food security among the first 1,000 days families and incentivize the adoption of healthy and positive behaviours and feeding practices. Sub-components include:
  - *2.1 Provision of Child Nutrition Grant* – Targeted towards pregnant women or children under 2 years old. The parameters of this child grant such as benefit level will be determined during the project preparation;
  - *2.2 Improving Delivery Systems and Capacity Building for Child Grant* – involving the development of systems and management capacity to deliver the child grant; and District and subnational staff (i.e Community Development Officers) training to facilitate the child grant activities and monitor the implementation progress. A small number of district Community Development Centres will serve as a venue for communication, coordination & training to support the project.

- **Component 3: Advocacy, Coordination, and Project Management** – The objective of this component is to support advocacy of the FTI agenda, oversight and coordination of nutrition relevant interventions, and overall project management and M&E.

  This component will finance the operational costs needed to advocate and coordinate nutrition policies and programs, the consultancy support to carry out a series of project monitoring surveys and thematic studies, and the personnel costs for managing project related financial management (FM), procurement, M&E and learning, and safeguards to facilitate project implementation. The support will include: (i) strengthening the Department of Justice and Attorney General (DJAG), the Special SLOS Working Group on Nutrition (SSLOSWG-N), and the SLOS Secretariat housed in DJAG to enhance coordination among FTI stakeholders related to the project implementation and to build institutional capacity for the oversight, coordination and monitoring of the FTI; (ii) organizing National Nutrition Summits to highlight the importance of child stunting reduction, its determinants, and review the progress; (iii) facilitating the planning and implementation of FTI activities at the province and district level; (iv) developing and coordinating the implementation of a unified monitoring and evaluation (M&E) strategy with common indicators across implementing levels - provinces, district, wards down to villages; and (v) managing the project M&E, reporting, and planning. The proposed M&E strategy will capitalize on existing systems, particularly the electronic National Health Information System (e-NHIS) to improve the tracking of progress made on stunting

as well as information systems in other sectors and across levels of Government. In addition, it will also seek to document and provide robust evidence on the effectiveness of both Government-financed and Project-supported actions to reduce stunting and promote ECD, and capture lessons learned to support cross-learning on good practices both within PNG and with other countries.

1.4 Institutional arrangements

The CNSP Project will be implemented through a multi-sector approach (refer to Figure 1). The Social and Law & Order Sector (SLOS) Ministerial Committee with the convening power to coordinate across sectors including at the subnational level, and the mandate to lead, coordinate, and oversee the Fast Track Initiative (FTI), will serve as the Steering Committee for the CNSP Project. The Project will consist of three implementation agencies (IAs). DJAG which houses the SLOS secretariat will establish a Project Coordination Unit (PCU) and will be responsible for implementing Component 3. NDoH and DfCD&R will be responsible for implementing components 1 and 2 respectively. Component Management Unit (CMU)s will be established within both these departments. As a core part of the public health system in PNG, church health organizations will be engaged through subgrants to support the delivery of project activities identified in Components 1 and 2. The subgrants will be supported by Memoranda of Understanding or MoAs to cover incremental implementation costs of project activities over and above the existing scope of work of church health organizations. Agreements will also be established with selected Payment Service Providers (PSPs) to make payments on behalf of the IA for the CN Grant.

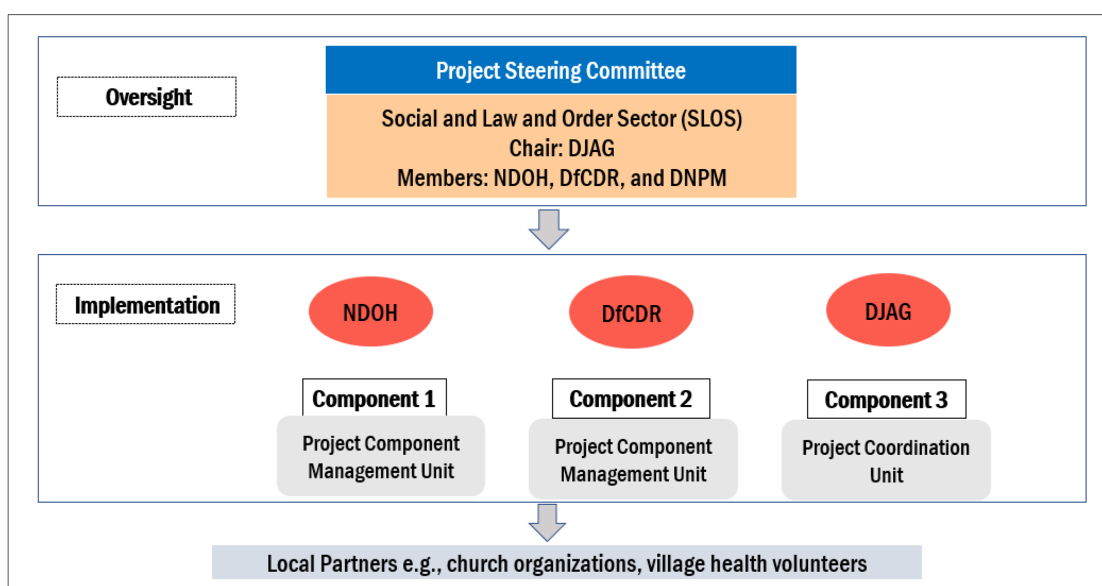

Figure 1 CNSP Project Institutional Arrangements

1.5 Project Implementation schedule

The CNSP Project is being implemented through a phased approach This SEP has assessed the project design outlined in the draft PAD dated November 2021, draws upon a review of key secondary sources and inputs from stakeholder consultations (see Table 1) conducted during the design period. Phase 1 implementation is due to commence in four (4) provinces in early 2022 where project governance arrangements, activity design, as well as social (and environmental) controls outlined in this SA/SMP will be tested. The Project will seek to scale up coverage within provinces in the first phase and additional provinces in a second phase. The second phase is proposed to start following the Mid Term Review of the project (tentatively scheduled for year 3 of implementation) and will be subject to satisfactory implementation.

1.6 Candidate provinces

Stunting impacts all provinces in PNG and a phased approach is being implemented to address this. Financed by a grant from the Australian Government's Department of Foreign Affairs and Trade (DFAT), the project will commence in four provinces which include East New Britain, Madang, Simbu and Western Province. During the initial design stage of the project New Ireland, Bougainville, West New Britain, Milne Bay, Central, Morobe, Eastern Highlands, Western Highlands, Gulf and Oro provinces were also confirmed by the Implementing Agencies to be eligible for inclusion in the CNSP Project. The criteria used to identify the eligible provinces was (i) the importance of regional representation, political commitment from the sub-national government, (ii) high stunting rates and a range of (iii) supply-side implementation capacity. GoPNG also discussed the possibility of a demand-driven approach to select the final set of provinces to be included in the project. Following project approval by the World Bank Board, eligible provinces from the 13 provinces identified above could be invited to submit an Expression of Interest (EoI) for participation in the project. The selection of the final provinces would be undertaken by the Project Steering Committee based on pre-specified evaluation criteria. Upon receiving the Bank's no objection, the Committee will notify selected provinces.

1.7 Stakeholder engagement objectives

The overall purpose of this SEP is to define an iterative program for stakeholder engagement, including public information disclosure and consultation for the implementation phases of the project. The SEP describes the methods the IAs and implementing partners will utilise to communicate with stakeholders; and establishes a mechanism through which concerns about any activities related to the Project can be raised and resolved. Stakeholder engagement is key to ensuring the project is designed and implemented beneficially and sustainably. This includes reaching out to disadvantaged and vulnerable groups, overcoming barriers to access services and programs provided through the project (such as poor literacy, stigma, marginalisation), and creating accountability against misallocation, discrimination and corruption.

The objectives of this SEP are to:

1. Provide an analysis of stakeholders who will be impacted and engaged during the implementation of the Project.
2. Encourage equal participation by marginalized and vulnerable groups in the delivery of services, programs and other activities delivered through the Project.
3. Outline strategies to encourage equal participation of all affected groups in the consultation, monitoring and reporting processes.
4. Provide a program for the engagement of stakeholders, including the disclosure of any environmental or social impacts incurred by the Project with proposed mitigation measures.
5. Provide a mechanism to address any stakeholder concerns and provide feedback to issues raised by stakeholders through the establishment of a Grievance Redress Mechanism (GRM) to satisfactorily redress any Project-related grievances.

2 Stakeholder identification and analysis

Project stakeholders consist of individuals, groups or other entities who:

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

Cooperation and negotiation with the stakeholders throughout the design and implementation phases of the project will assist to deliver services and project activities to meet the Project objective. Furthermore, input from stakeholders can support the design and project delivery teams to establish trust relationships and identify persons within a group 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. This will enable implementing partners and community representatives to provide helpful insight into the local context and act as conduits for the dissemination of the Project-related information. 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. The legitimacy of the community representatives and levels of influence 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. Community representatives, religious groups, youth organisations and cultural, village and women leaders may also be helpful for the dissemination of information in a culturally appropriate manner and helping to build trust for government programs and service delivery in the candidate provinces.

2.1 Methodology

For the purpose 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 status.

2.2 Affected parties

Affected Parties include local communities/community members and other parties that may experience direct impacts from the Project. Specifically, the following individuals and groups fall within this category:

Local communities/community members:

- Target communities (i.e. wards/villages)
- 1000 day households;
- Nursing mothers;
- Families of stunted and malnourished children;
- Village and community leaders & volunteers;
- Village Health Volunteers/Assistants;
- Women leaders and women's groups;
- Youth and disability organisations.
- Religious and custodial leaders;

Other affected parties

- Governments (National, Provincial and Local);
- Health and social protection workers
- Civil Society Organisations (CSO);

- Early Childhood and Community Development Centres;
- Church organisations;
- Office of Child and Family Services (OC&FS);
- Payment service providers (Banks, micro-banks, mobile money operators);
- Provincial Health Authorities (PHA);
- Schools and educational institutions;
- Training organisations

2.3 Other interested parties

Other Interested Parties include individuals/groups/entities that may not experience direct impacts from the Project but who may 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. Other interest parties for the Projects include:

- International donor organisations;
- Businesses with international links;
- Church health providers;
- Local and international non-governmental organizations (NGOs);
- Local businesses;
- Other media sources;
- Other national and international health and social protection organizations;
- Participants of social media;
- Politicians;
- The research community;
- The public;
- Traditional media.

2.4 Vulnerable individuals and groups

Vulnerable individuals and groups include persons who may be disproportionately impacted or further disadvantaged by the project(s) as compared with any other groups due to their vulnerable status. Targeted engagement strategies to encourage equal representation and participation by this group will be required in the design of the project and during the delivery of consultation and evaluation processes. Requirements to improve access by these groups to health services provided through PNG CARES and the CN Grant are outlined in this plan. The vulnerable or disadvantaged groups within the Project may include but is not limited to the following:

- Displaced people;
- Minority clan gorups;
- People living in settlements or outside theircustomary land/ communities;
- People living in poverty;
- People living in rural locations;
- People with disabilities;
- People with existing illnesses;
- People with low levels of literacy (i.e. reading and writing);
- Single parent households;
- Women;
- Youth.

Additional vulnerable groups may be confirmed during project implementation. A description of the engagement methods to be utilised during the project is provided in section 4.1.

Any changes, including the extension or adjustment of services provided through the CNSP Project will require the SEP to be updated to include targeted, culturally appropriate and meaningful consultations for disadvantaged and vulnerable groups before project activities are implemented.

3 Stakeholder engagement program

3.1 Stakeholder engagement principles

To ensure a best practice approach in stakeholder engagement is delivered, 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 will be provided for communicating stakeholders' feedback, for analyzing and addressing their comments and concerns.
- **Inclusiveness and sensitivity**: Stakeholder identification will be undertaken to support inclusive communications and build effective relationships. Equal access to information will be provided to all stakeholders with all impacted stakeholders to be encouraged at all times to be involved in consultation processes. Sensitivity to stakeholders' needs will be the key principle underlying the selection of engagement methods with special attention given to vulnerable groups (people living in poverty, in settlements or outside their traditional communities, remote or inaccessible areas, women, youth, elderly, people with disabilities, those with underlying health issues and culturally diverse ethnic groups).

3.2 COVID-19 safe engagement

The PNG Government has taken measures to restrict public gatherings, meetings and movement both within PNG and between PNG and neighbouring countries. The general public is also increasingly concerned about the risks of transmission, particularly through social interactions. Given the highly infectious nature of COVID-19, the Project has developed a COVID-19 Safety Protocol for Project implementation (see Annex 1). This Protocol identifies COVID-19 transmission risks associated with the implementation of the Project; outlines appropriate risk mitigation measures; and assigns roles and responsibilities for their implementation. With the COVID-19 risk situation continuing to evolve, the Project will remain flexible and adapt its strategy to minimise COVID-19 infection risks in line with the National Department of Health's Emergency Response Plan.

3.3 Stakeholder engagement during the initial design

During the initial design stages of the Project the design team have identified and analysed potential implementing partners to be engaged in the design and delivery of the CNSP Project.

An indicative consultation and dissemination plan was developed to assist the design process which resulted in a series of consultations with Civil Society Organisations (CSOs) and community groups undertaking child nutrition and social protection projects in PNG. The discussions provided insight into some of the successes and challenges of delivering child nutrition and social protection programs in Papua New Guinea. Strategy for consultation during Implementation.

A summary of consultation activities during project preparation is provided in Table 3-1

Table 3-1 Consultation summary during the design stage

Type of activity and date	Stakeholders involved	Aim

Start up meetings (Mar-May 2021)	WB, NDoH, DFCD&R, DJAG	For GoPNG & the WB to discuss the Project requirements including environmental & social risks.
Social Assessment virtual consultations (Apr 2021)	World Bank, World Vision, Menzies Institute, UNICEF, Angau Hospital.	To discuss lessons learned from relevant child nutrition and social protection projects being delivered in PNG.
Environmental & Social Risk meeting (May - Aug 2021)	World Bank, DfCD&R, NDoH.	To discuss potential E&S benefits and risks resulting from the Project.
High level Consultation Workshop (31 August 2021)	NDoH, DFCD&R, DJAG, DNPM, World Bank, DFAT	To discuss design for the CNSP project
Virtual Meetings (late Aug -Early Sep 2021)	World Bank, NDoH, DFCD&R, DJAG, DNPM, DFAT, Catholic Health Services, Christian Health Service, UNICEF.	To discuss design for the CNSP project, environmental & social risks and service level agreements.
Environmental & Social Consultation Workshop on draft E&S Instruments (Oct 2021)	World Bank, NDoH, DFCD&R, DJAG, DNPM	To review & finalise E&S Risk Management Tools.
Technical design workshop to review project design details (TBC)	World Bank, NDoH, DFCD&R, DJAG, DNPM.	To review & discuss the preliminary design, process, roles & responsibilities of all parties including through subgrant arrangements.

3.4 Strategy for consultation during Implementation

Two-way mechanisms for ongoing consultation will operate throughout the life of the Project, to disclose information and seek feedback. Dedicated channels for information dissemination will be established to ensure consistent communication at national, provincial and local levels throughout the Project.

Stakeholder consultation for each project component during the project implementation is provided in Table 3-2

Table 3-2 Stakeholder Consultation during Implementation

Subcomponent	**Method**	**Targeted stakeholders**	**Responsibility**
Component 1: Implementing Community-based approaches to Reduce and End Stunting (PNG CARES).			
1.1: Community-level Multi-sectoral Actions for Nutrition	• Negotiate contracts with churches to include vulnerable groups. • Community engagement meetings with VHV/ women's, village, youth & community groups. • Group sessions, counselling sessions and/or home visits. • Community outreach / engagement to provide immunization, health services; promoting kitchen gardens. • Co-development of village action plans; • On-the-job mentoring and supervision to VHVs or other community actors; • Meetings with local decision makers for pro-nutrition health & WASH. • Meetings to promote early stimulation & positive parenting with stakeholders (i.e. PHAs, leaders, vulnerable groups).	• 1000 day households. • VHV/As • PHA/LLHA • Church organizations. • Community leaders. • Women leaders and women's groups. • Health workers & facilities. • Volunteer organisations. • Community Development & Early Childhood Centres. • Education & training organisations.	• NDOH.

Subcomponent	Method	Targeted stakeholders	Responsibility
	• Distribution of materials on infant & young child feeding practice, hygiene early stimulation & positive parenting practices. • Feedback forms.		
1.2: Strengthening Health Systems	• Training, supervision & technical assistance to frontline community workers (VHVs), other community volunteers & Church health organisations. • Provision of nutrition-specific services at the facility level. • Training health facility staff • Feedback forms. • Confidentiality agreements.	• VHV/As • PHA • Church Health Organisations • Nutrition coordinators • P/LLG & Health Services. • Village & community leaders. • Women's organisations. • Education & training organisations. • Early Childhood Centres. • Volunteers. • DNPM.	• NDOH
1.2 Nationwide Advocacy and Awareness	• Mass media nation-wide advocacy & awareness campaign. • High-level policy events & summits • Community champions/spokespersons. • Healthy eating cooking competitions. • Nutrition sessions/events/roadshows/ summits. • Feedback forms.	• P/LLGs & P/LLHAs • Village & community leaders. • Families with pregnant & lactating women & young children. • Women's organisations. • National Advisory Council on Disability, National Youth Commission. • Early Childhood & CDCs. • International donors. • Church organisations. • Training organisations.	• NDOH
Component 2: Implementing a nutrition sensitive Child Grant			
Subcomponent	**Methods**	**Targeted stakeholders**	**Responsibility**
2.1 Provision of Child Nutrition (CN) Grant	• Meetings with stakeholders in Provinces (i.e. PHAs, leaders, vulnerable groups). • Promotion, registration and administration of CN Grant Program. • Registration & enrollment of beneficiaries. • Positive parenting sessions. • Consultation on improving financial inclusion & empowering women. • Online workshops to access cash grants. • ANC Check ups.	• 1000 day households. • Mothers & pregnant women. • Children under 2 years old • Health service providers. • PG, LLGs, DLGs. • DCDCs. • Pregnant & lactating	• DfCDR

Subcomponent	Method	Targeted stakeholders	Responsibility
	• Feedback forms.	women • Young children • Families. • Caregivers. • Village & community leaders • Families with young children. • Women's organisations.	
2.2 Improving Delivery Systems and Capacity Building for Child Grant **- Establishment of Child Nutrition Grant Delivery Systems**	• Execution of CN Grant confidentiality agreements with beneficiaries. • Facilitation of SBCC sessions. • Discussions with commercial banks, micro-banks & telecom operators. • Training Departmental Staff. • Negotations with payment service providers.	• DJAG. • DfCDR. • P/LLHAs • NGOS • Church organisations • PSPs.	• DfCDR
2.2 Improving Delivery Systems and Capacity Building for Child Grant **-District Level Capacity Building**	• Community outreach strategies to increase awareness and promote public understanding of the child grant Monitoring of implementation. • Establish Component Management Unit (CMU) for Component 2. • Hire relevant technical staff to support the design and implementation of the project, through Technical Assistance (TA) funding (hiring of a Project Manager, MIS Specialist/IT Officer, SP Payments Specialist/Officer, SP Operations Specialist/Officer, SP Compliance Specialist/Officer etc, • Reporting to DfCRD management. • Consultation with CDC's to equip facilities to serve the needs of the project implementation as a venue for communication, coordination, and training.	• District level Community Development Officers. • Sub national governments • Training organisations.	• DfCDR
Component 3: Advocacy, coordination and project management			
Advocacy, coordination and project management	• Training. • M&E (interviews/surveys/focus groups, etc) • SLOS & Steering Committee meetings. • Reports/newsletters/media. • GRM.	• NOC&FS. • P/LLHAs • Church Groups. • Women's groups. • Youth & Disability organisations. • Universities. • Early Childhood Centres.	• SLOS • DJAG • DNPM

3.5 Strategy for information disclosure during implementation

The Project will ensure that all stakeholder engagement activities, including the disclosure of information, remain inclusive and culturally sensitive for the duration of the project's implementation. Specifically targeted provisions to encourage vulnerable groups to participate and benefit from Project activities are to be included in the design phases. Further, while country-wide awareness campaigns will be established through mainstream and social media, specific communications will be conducted in target provinces and districts, including the distribution of information through government offices, schools, hospitals, community & health centres and churches.

The Project strategy for information disclosure for three components of the project is described in Table 3-3 below. If the CERC is triggered a revisited strategy for information disclosure could be developed should these circumstances arise.

Table 3-3 Information Disclosure Strategy

Component 1. PNG CARES - : Implementing Community-based approaches to Reduce and End Stunting (PNG CARES).		
Project Component	**Target Stakeholders**	**Information to be disclosed**
1.1 Community-level Multi-sectoral Actions for Nutrition	• 1000 day households. • VHV/As. • P/LLHA's. • Church organisations. • Vulnerable groups. • Village & community leaders. • Women leaders & women's groups. • Health workers & facilities. • Volunteer organisations. • Community Development & Early Childhood Centres. • Fathers • Women • Couples • Care givers & support persons • Education &training organisations. • Youth. • Village and community leaders. • Male and female leadership groups	• Sub grants. • Meeting agendas & minutes of meetings with communities and local decision makers (WaSH, VHVs). • Village action plans. • Pamphlets, flyers & information on infant and young child feeding practice, hygiene early stimulation & positive parenting practices. • Village scorecards. • Report cards. • Risk communication materials to reduce risk of COVID-19. • GRM.
Sub-component 1.2: Strengthening Health Systems.	• VHV/As. • PHAs • Church health organisations • Nutrition coordinators • P/LLGs • Village & community leaders. • Women's organisations. • Education and training organisations. • Early Childhood Centres. • Volunteer organisations. • DNPM.	• Procurement materials (scope of works, ToRs, contracts, invoices, receipts, etc). • Health workers curricula • Training materials. • Technical information. • Digital tools. • Data. • Village scorecards. • Report cards. • Feedback forms. • Confidentiality agreements.
Sub-component 1.2: Strengthening Health Systems. (National Advocacy)	• All Papua New Guinea citizens. • P/LLHA's and governments. • Village & community leaders. • Families with pregnant & lactating women.	• Media campaigns (radio/television transcripts, articles, media releases, advertisements) • Speeches, schedules, letters,

	• Young children. • Women's organisations. • National Advisory Council on Disability, National Youth Commission. • Early Childhood & CDCs. • International donors. • Church organisations. • Training organisations. • Subnational governments.	emails. • Scripts & materials for healthy eating cooking competitions. • Materials on nutrition. • Report cards. • Surveys/feedback forms.
Component 2: Child Nutrition Grant: Implementing a nutrition-sensitive Child Grant.		
Project Component	**Target Stakeholders**	**Information to be disclosed**
Sub-component 2.1: Provision of Child Nutrition Grant.	• 1000 day households. • Mothers & pregnant women. • Women's organisations.Children under 2 years old • Health service providers. • Provincial, district & local level government officials. • DCDCs. • Pregnant & lactating women • Young children • Families. • Caregivers. • Village & community leaders.	• Sub grant agreements.. • CN Grant program information (criteria, forms, advertisement, community notices, radio). • GRM. • Registration & enrollment information. • Positive parenting, financial inclusion & empowering women information. • Agendas / minutes of meetings. • Education materials i.e. flyers, community information sessions, online events to access cash grants. • Registers & materials from ANC Check ups & other services. • Village scorecards. • Report cards. • Feedback forms.
Sub-component 2.2 Improving Delivery Systems and Capacity Building for Child Grant **(Establishment of Child Nutrition Grant Delivery Systems)**	• DJAG. • DfCD&R. • P/LLHAs • NGOs • Subnational government staff. • Church organisations • PSPs.	• Procurement materials (scope of works, ToRs, contracts, invoices, receipts, etc). • CN Grant & Community Development Centre Manuals. • Confidentiality agreements. • MIS • Training materials. • SBCC participation records. • Map & register of vulnerable persons.
Sub-component 2.2 - Improving Delivery Systems and Capacity Building for Child Grant **(District level Capacity Building)**	• DCDC Officers • DFCD&R • Training organisations.	• Training materials. • Community outreach strategies & materials. • Employement contracts. • Reports to DFCD&R.
Component 3: Advocacy, coordination and project management		
Project Component	**Target Stakeholders**	**Information to be disclosed**

Advocacy, coordination and project management	• NOCFS/ PLLHAs/ subnational government staff. • Church Groups. • Women's groups. • Youth & Disability organisations. • Universities. • Early Childhood Centres. • Health workers and experts • Project Steering Committee	• Reports . • M&E framework • Stakeholder registers, register of vulnerable groups & grievances. • Project Report & Score Cards. • Project Steering Committee Agendas, minutes, reports, etc.

The responsible government Implementing Agencies will ensure that information to be disclosed:

- Is accurate, up-to-date and easily accessible;
- Relies on best available scientific evidence;
- Emphasizes shared social values;
- The information provided is suitable for and distributed to vulnerable groups;
- Includes explanation of measures that will be used to ensure voluntary consent, or if measures are mandatory that they are reasonable, follow due process, do not include punitive measures and have a means for grievances to be addressed;
- Includes where people can go to get more information, ask questions and provide feedback; and
- Is communicated in formats taking into account language, literacy and cultural aspects.

Over time, based on feedback received through the Grievance Mechanism and other channels, information disclosed should also answer frequently asked questions by the public and the different concerns raised by stakeholders.

Misinformation can spread quickly, especially on social media. During implementation, the Implementing Agencies will assign dedicated staff to monitor social media regularly for any such misinformation about the project. The monitoring should cover all languages used in the country. In response, the Project Coordination Unit located at DJAG will disseminate communications to counter such misinformation through different platforms in a timely manner. These will also be in relevant local languages.

3.6 Strategy for engaging vulnerable groups during implementation

The Project will carry out targeted engagement with vulnerable groups to ensure they are fully informed of the Project and to understand their concerns/ needs in terms of accessing information, services and grant programs and other challenges they face at home, at workplaces and in their communities. Special attention will be paid to engage with women and women's groups as intermediaries. In addition to specific consultations with vulnerable groups and women, the Project will seek to engage with children and parents to understand their concerns, fears and needs. The strategies adopted to engage and communicate to vulnerable groups will include:

- Displaced peoples: Ensure project communications and services are made accessible to people who have been displaced by visiting settlement areas and using communicaiton channel which are commonly used by this group.
- Women: The Project will ensure that community engagement teams are gender-balanced and promote women's leadership within these teams, design online and in-person surveys and other engagement activities so that women in unpaid care work can participate; consider provisions for childcare, transport, and safety for any in-person community engagement activities.

- Pregnant women: The Project will develop educational materials for pregnant women on basic hygiene practices, infection precautions, and how and where to seek care based on their questions and concerns.
- Youth: To use effective technologies and messaging to engage with youth.
- People with low levels of literacy: Information will be generated in a number of formats including using radio, facebook, television and other media platforms.
- Vulnerable groups: To undertake mapping and develop inclusive strategies to engage vulnerable groups in all project activities. A central register will be maintained at the PCU and a grant specific register maintained for CN Grant.
- People with disabilities: The Project will provide information in accessible formats, like braille, large print; offer multiple forms of communication, such as text captioning or signed videos, choose meeting locations with consideration for people with mobility impairment, use text captioning and online materials for hearing impaired.
- Children: The Project will design information and communication materials in a child-friendly manner.
- People living in rural locations: Resourcing budgets and communications strategies will include strategies and provisions to ensure people living in rural locations can access programs and services being delivered through the project.

The Project will ensure that awareness raising and stakeholder engagement with disadvantaged or vulnerable individuals or groups. The project will take into account particular sensitivities, concerns and cultural characteristics to ensure a full understanding of Project activities and benefits is captured. 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 etc. Engagement with vulnerable groups and individuals require the application of specific measures and assistance designed to facilitate their participation in Project-related decision making so that their awareness of, and input to, the overall process is commensurate to those of the other stakeholders.

The Project will ensure that vulnerable groups have the opportunity to participate in, and benefit from Project activities. Where service delivery is extended and provided by church groups, civil society organizations and other implementing partners, they will be required to engage vulnerable groups including in remote areas. In addition, they are required to adapt engagement and communication strategies to the specific needs of vulnerable groups and households, including, for example, household-outreach in Tok Pisin, Motu or Tok Ples where necessary, through SMS, telephone calls, etc., depending on the social distancing requirements, and the use of verbal communication, audio-visuals or pictures instead of text.

3.7 Strategy for engaging ethnic groups during implementation

PNG is one of the most culturally diverse countries in the world with over 800 languages and over 1,000 distinct ethnic groups and not one dominant group. Despite this diversity common elements exist between groups and navigating differences in language, culture and custom is part of everyday life in PNG and national programs are adept at dealing with this. The Project will ensure that stakeholder engagement and information disclosure activities are designed and implemented using culturally appropriate approaches to identify and address any economic or social constraints that may limit opportunities to benefit from or participate in the project.

Strategies will include:

- Utilization the strengths of the PNG state and commonalities between ethnic groups in target provinces such as government structures/organizations, shared language (i.e. Tok Pisin or Motu) and shared religion/beliefs (i.e. Christianity/animism) to guide broader communication and engagement approaches.
- Conducting rapid assessments in target provinces and communities to identify cultural groups (both traditional communities and settlers) and their language, decision-making structures and traditional communication channels and inform the design of nuanced community level communication and engagement approaches.
- Utilise the strengths of implementing partners such as church groups and other CSOs located within target provinces and communities to input into the design and lead delivery of community level communication and engagement approaches.

The Project will ensure that awareness raising and stakeholder engagement with disadvantaged or vulnerable individuals or groups take account of such groups or individuals' particular sensitivities, concerns and cultural sensitivities and ensures a full understanding of Project activities and benefits. Vulnerability may stem from a 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 etc. Engagement with vulnerable groups and individuals will require the application of specific measures and assistance designed to facilitate their participation in Project-related decision making so that their awareness of, and input to, the overall process is commensurate to those of the other stakeholders.

4 Resources and Responsibilities for implementing stakeholder engagement activities

4.1 Resources

The PCU/CMU managers within the three Implementing Agencies (DJAG, NDoH, DfCDR) will be responsible for implementing the SEP for their respective components. Day-to-day operationalisation of the SEP will be delegated to the Social, Environmental and Engagement Specialist specialists engaged within each IA who will be responsible for:

- The timely coordinaiton and delivery of all consultation activities.
- Developing and implmenting processes for the disclosure of information.
- Managing the GRM, and;
- Meeting monitoring and reporting requirements for the respective component.

The Environment and Social Risk and Community Engagement Coordintor located in the DJAG will ensure all efforts to engage and communicate with stakeholders during the life of the project by IA's are coordinated and improved where possible.

Implementing Agencies and Implementing Partners

The **Department of Justice and Attourney General** is responsible for the overall project coordination which will require leadership by and high level strategic support to the SLOS Secretariat and CNSP Project Steering Committee to effectively coordinate and implement the project. The DJAG is also responsible for the implmentation of Component 3 which includes nationalwide advocacy and project monitoring and evaluation. This will require establishing effective communication and reporting structures with other implementing agencies and implementing partners to monitor and report on progress.

The **National Department of Health** will be responsible for the implementation of Component 1 PNG CARES which aims to address the multi-sectoral drivers of stunting. This will require training service providers to strengthen services such as VHV/As, PHAs and frontline community workers, in addition to engaging Church Organisations and other implementing partners to deliver services to 1000 day householders, women,

children and families. It will also require effectively engaging PHAs who will provide technical support and oversight of implementation of sub-grants in Project provinces in keeping with their role as stewards of the health system at the province level and below. The PHA's would also support coordination with other key sub-national stakeholders including District Development Authorities.

The **Department for Community Development and Religion** is responsible for the implementation of Component 3 the CN Grant. The component is focussed on strengthening the capacity of the DFCD&R to deliver the grant and the delivery of cash grants to families to imporve nutrition and SBCC change. This will require the effective engagement of a Church Organisation and other implementing partners to assist with establishing the operational systems, the onboarding of participants and negotiations with payment service providers. The DFCD&R will also be responsible for the establishment and maintainance of a vulnerable persons register to ensure vulnerable communities are engaged and benefit from the project.

A Project Operational Manual (POM) will be established which describes detailed arrangements and procedures for the implementation of the Project, such as responsibilities of IAs, operational systems and procedures, Project organizational structure, office operations and procedures, finance and accounting procedures (including funds flow and disbursement arrangements), procurement procedures, personal data collection and processing, as well as E&S procedures.

4. Grievance Mechanism

The GRM was developed in consultation with IAs during project preparation. The procedure provides clear roles for IAs, implementing partners and their sub-contractors to follow to manage grievances during the delivery of the CNSP project. A separate workers grievance redress mechanism (WGRM) has also been developed and is outlined in the project's LMP.

The main objective of the GRM is to resolve complaints and grievances in a timely, effective and efficient manner that satisfies all parties involved. 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 implementation of Projects.
- Ensures that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants.
- Avoids the need to resort to judicial proceedings.

The Project's GRM also outlines a process for handling cases of SEA/SH. A GBV response protocol is also outlined to ensure a survivor-centric approach to the management of grievances, including a focus on referring survivors to GBV services (also refer Annex B Gender and GBV Action Plan).

The GRM will be operationaised before commencement of Phase 1 and and will be further strengthened during project implementation.

4.1 Overview of GRM implementation process

The Project GRM allows Project affected people/beneficiaries, project staff/volunteers and other stakeholders to seek satisfactory resolution to grievances they may have in relation to implementation of the Project. The GRM helps to ensure that rights and interests of affected people/beneficiaries are protected, and concerns are adequately addressed. The grievance process is based upon the premise that it imposes no cost to those raising the grievances (i.e., Complainants); that concerns arising from project

implementation are adequately addressed in a timely manner; and that participation in the grievance process does not preclude pursuit of legal remedies under national law.

The GRM is implemented through a fair and equitable process through four levels.

Complainants can submit grievances either orally or in writing. A variety of channels will be established including community representatives, suggestion/complaint box, telephone, SMS, or email. Complaints may be made anonymously, and confidentiality will be ensured in all instances, including when the person making the complaint is known All grievances received will be appropriately initially assessed, documented (using the project's GRM form) and directed to the appropriate level.

The GRM operates through the following levels:

- Level 1: At the local level, grievances will be managed by the relevant implementation partner. Upon receipt, the implementing partner shall formally acknowledge1 the receipt of the grievance and then ensure the complaint is appropriately assessed, documented and registered. The Implementing Partner IA ensure that the grievance is investigated and a proposed resolution is provided within 30 days of receipt. If the complaint is not able to be resolved2 within the allocated time, the complaint will be referred to Level 2. Any serious or sensitive grievances3 will be elevated to the relevant IA Manager immediately.
- Level 2 complaints will be handled by relevant IAs. The Implementing Agency shall formally acknowledge the receipt of the grievance and then will ensure that the complaint has been appropriately assessed, documented (using the project's GRM form) and registered. This includes classifying the grievance based on the typology of complaint and providing the initial response4 as quickly as possible. The classification will be based on the characteristics of the complainant (e.g., vulnerable groups, persons with disabilities, people with language barriers, etc.) and also the nature of the complaint (e.g. inability to access the information provided on CN Grant program; inability to receive adequate medical care/attention, etc.). Any serious or sensitive grievances will be elevated to the relevant CMU Manager immediately. For all other grievances, the respective IA ensures that the grievance is investigated and a proposed resolution is provided within 15 days. If the complaint is not able to be resolved within the allocated time, the complaint will be referred to Level 3
- Level 3 complaints will be handled by the DJAG PCU on behalf of the Project Steering Committee. Upon receipt, the DJAG PCU will formally acknowledge the receipt of the grievance, ensure that all documentation is in order, and then elevate the grievance to the CNSP Project Steering Committee to consider and propose a resolution within 90 days.
- Level 4 if the aggrieved person is still dissatisfied following review by the grievance committee, the case may be referred to legal proceedings in accordance with national laws and procedures.

In the early stages of engagement, project stakeholders and affected communities must be made aware: (i) of how they can access the GRM; (ii) who to lodge a formal complaint to; (iii) timeframes for response; (iv) that the process must be confidential, responsive and transparent; and (v) alternative avenues where conflicts of interest occur.

[1] Acknowledged - the complaint is formally acknowledged and registered.
2 Resolved - a complainant accepts proposed resolution and grievances is closed.
3 Complaints relating to SEA/SH issues or other issues that have caused or may cause significant harm to people or the environment; or where complainants feel that the relevant institutions cannot assist in the resolution of grievances because they include an individual or individuals who have themselves abused the process.
[4] Response - steps are taken to investigate and a proposed resolution is presented to the complainant.

4.2 GRM operation

The project GRM is implemented by each IA and coordinated by the PCU's SE&ECoordinator working under the supervision of the Project Director and the Project Manager. The Contractors, sub-contractors and all implementing partners engaged to deliver the CNSP Project are required to implement the project's GRM.

Each IA is responsible for ensuring that:

- Roles and responsibilities for grievance management are properly documented and training is provided to ensure capacity to undertake this task;
- Details about the GRM, how it works and how to access it is communicated and distributed widely to project affected people/beneficiaries;
- Grievances raised with Implementing Agencies, Implementing Partners, contractors, provincial and local level health offices, organisations or individuals directly involved with the CNSP Project are to be recorded and responded to in accordance with the project's GRM principles and process.
- Monthly/semi-annual reports are prepared providing summaries of complaints, types, actions taken and progress made in terms of resolving pending issues, and draw on information from the GRM register. GRM information from semi-annual CNSP Project reports are submitted for review by all Project partners and the CNSP Project Steering Committee.

Reports on the GRM will inform the ongoing revision of the SEP and help to identify the need for change in Project focus, strategies and implementation.

5. Monitoring and Reporting

5.1 Monitoring and reporting of risks

The SEP will be periodically revised and updated as necessary in the course of Project implementation to ensure the information presented remains current and reflects the evolving nature of the different phases of the Project. Any major changes to Project activities or the consultation and information schedules will be updated in the SEP. In addition, stakeholder engagement activities delivered to support the Project's implementation will be documented through semi annual progress reports and shared with the World Bank.

Semi-annual summaries and internal reports on grievances, enquiries and related incidents, together with the status of implementation of associated corrective/preventative actions, will be collated by the designated GRM officer, and referred to the Project Manager and Project Steering Committee. The semi-annual 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 will be communicated to stakeholders through the publication of an annual report which will be made available on the lead Implementing Agency websites.

The project has now included a citizen engagement indicator "Complaints to the Grievance Redress Mechanism (GRM) responded to within the specified timeframe" to monitor the implementation of the GRM.

Annex 1 COVID-19 Safety Protocol: Project Implementation

Purpose

The purpose of this Protocol is to identify COVID-19 transmission risks associated with the implementation of the Child Nutrition and Social Protection Project (CNSP); outline appropriate risk mitigation measures; and assign roles and responsibilities for their implementation.

Context

An outbreak of the coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has spread rapidly across the world since December 2019. On 11 March 2020, the World Health Organization (WHO) declared a global pandemic. By 18 June 2021, the WHO had reported over 177 million confirmed cases and 3,840,000 deaths worldwide.

The first COVID case in PNG was recorded in March 2020. The GoPNG activated the National Emergency Response Operation Committees (NEOCs) on the 27th of January 2020. COVID-19 was declared a national emergency on March 11, 2020. A Joint Agency Task Force for COVID 19 under the National Control Centre has been established to coordinate the national response. The official website is: *https://covid19.info.gov.pg/*.

NDoH in partnership with the World Health Organisation published the Niupela Pasin Transitioning to a 'New Normal' Handbook.

The Department of Treasury has produced a guide, Treasury Niupela Pasin, outlining the Department of Treasury's approach to operating safely within an environment where COVID-19 is present. The guide outlines practices put in place by the Department of Treasury to continue to work and operate safely and maintain physical distancing wherever possible.

The Government of Papua New Guinea (PNG) through the National Department of Health (NDOH) has also developed a preparedness and response plan that outlines the strategic components for managing a public health response to COVID-19.

COVID-19 Transmission Risks

CNSP project will engage project workers including government staff, contractors, consultants, implementing partners and individuals to deliver child nutrition and stunting prevention activities across PNG.

The project's design includes:

- Conduct of meetings, workshops and community engagements;
- Technical assistance for community outreach activities and the monitoring and evaluation of project activities;
- Support for knowledge sharing, training and worker-readiness activities, and;
- Technical assistance provided by in-country consultants (located in the PCU and CMU's and/or regional administrations).

These engagements present a high risk of COVID-19 transmission i) between project workers, ii) from project workers to target beneficiaries, and iii) amongst targeted beneficiaries. The risk of transfer between outside project workers to communities is viewed as the greatest risk.

COVID-19 Transmission Mitigation Measures

The Project will implement the following measures to mitigate the risk of virus transmission during project implementation:

- Routinely review the national, provincial and district COVID-19 situation and the restrictions put in place by the government to contain virus spread and send updates to all Implementing Agencies and Partners[5] on a bi-weekly basis or sooner if the situation has changed;
- Ensure that all project workers including government, PCU and CMU staff, consultants and other implementing partners undertake regular COVID-19 risk awareness and mitigation training and commit, through the project's code of conduct, to managing COVID-19 risks associated with project activities;
- Ensure project beneficiaries are made aware of COVID-19 transmission risks and prevention measures (general and project-specific) throughout project implementation by utilizing project communication channels including website, Facebook page, community notice boards; and before the commencement of on-ground project consultations/activities;
- Conduct all project activities as per the national restrictions or advisories including staying home when sick, good hygiene and social distancing, and minimize direct interaction between project agencies and beneficiaries / affected people where possible;
- Ensure that project workers do not conduct face-to-face activities when they are feeling unwell or have been identified as a close contact of a COVID-19 case. Support Government, CMU staff and consultants to get tested for COVID-19 before recommencing face-to-face activities. In the event that a case is identified by medical experts, the CMU must be notified immediately and will work closely with medical staff and authorities to ensure support is given to the officer/consultant to go through the necessary protocols including isolation and treatment
- Monitor and report on the implementation of project COVID-19 prevention measures during the conduct of project activities through the project's existing monitoring and reporting framework.

Roles and responsibilities

The Head of the PCU located in the DJAG, with the support of a nominated manager located within each Component Management Unit located within the NDoH & DFCD&R to be responsible for ensuring the implementation of the Plan.

All Project workers, external contractors and partners engaged by the project including government staff, project staff, church organisations and consultants are required to carry out their duties in accordance with this Plan.

Resources

GoPNG COVID19 situation reports and advisory: *https://www.health.gov.pg/subindex.php?news=1*

GoPNG COVID19 awareness-raising resources: *https://covid19.info.gov.pg/index.php/covid-19-awareness/*

Tools

The following tools will be developed/utilized by project management staff to ensure COVID-19 mitigation measures are complied with:

- CNSP project Pre Mission Checklist / Project Worker Health Certification
- CNSP project Training Record
- CNSP project COVID Safe Meeting Guidance

[5] Implementing Parties are organisations and individual contracted or engaged in another formal or informal manner for the purposes of the project, such as Churches, womens groups, schools, etc.

- CNSP project Consultation Record (to be updated with COVID 19 awareness and COVID 19 safe meeting check box) and attendance/participant health certification.