Republic of Rwanda

Ministry of Health

ADDITIONAL FINANCING FOR THE RWANDA STUNTING PREVENTION AND REDUCTION PROJECT (P179499)

DRAFT

STAKEHOLDER ENGAGEMENT PLAN (SEP)

November 2022

Contents

STUNTING PREVENTION AND REDUCTION PROJECT (SPRP) 3

1. Introduction/Project Description 3

2. Stakeholder identification and analysis 13

2.1 Methodology 13

2.2. Affected parties 14

2.4. Disadvantaged / vulnerable individuals or groups 14

3. Stakeholder Engagement Program 14

3.1. Summary of stakeholder engagement done during project preparation 14

3.2. Summary of project stakeholder needs and methods, tools and techniques for stakeholder engagement 16

3.3. Proposed strategy for information disclosure 16

3.4. Stakeholder engagement plan 18

3.5. Proposed strategy to incorporate the view of vulnerable groups 22

3.6 Reporting back to stakeholders 22

4. Resources and Responsibilities for implementing stakeholder engagement activities 22

4.1. Resources 22

4.2. Management functions and responsibilities 22

5. Grievance Mechanism 23

5.1. Description of GRM 23

6. Monitoring and Reporting 24

7. Annexes 26

7.1 Abbreviations and Acronyms 27

7.2. Documents Consulted and Resource Material 28

7.3. Summary of discussions with stakeholders during the consultation meetings in SPRP districts (Kayonza, Huye, Nyamagabe, Nyaruguru, Ruhango, Nyabihu and Rubavu) -from November 7th to 30th, 2022. 29

7.4 List of participants 31

STUNTING PREVENTION AND REDUCTION PROJECT (SPRP)

1. Introduction/Project Description

A. Project Development Objective(s)

The proposed Project Development Objective (PDO) is to contribute to the reduction in the stunting rate among children under five years of age (with a focus on those under two) in the targeted districts.

B. Project Beneficiaries

The main project beneficiaries will consist of children under five (particularly children under two to reach them in the critical 1,000-day window of opportunity, before stunting becomes largely irreversible), as well as pregnant and lactating women in 13 districts with high levels of stunting that government has prioritized for World Bank support. Other beneficiaries will include adolescent girls, to reach women early and improve their health and nutrition status prior to entering their reproductive health years. The poorest households will benefit from improvements in access to clean water and improved sanitation facilities, and the public at large will benefit from national media campaigns and revamped behavioral change communications.

C. PDO-Level Results Indicators

Progress towards stunting reduction will be monitored through appropriate impact indicators and intermediate indicators that focus on practices and behaviors that are known to have an impact on the nutritional status of infants and children and pregnant and lactating women. The main PDO level indicators will include: (1a) percentage of children under five years with height-for-age z-score below -2 standard deviations of the median for the WHO reference population; (1b) percentage of children under 2 years with height-for-age z-score below -2 standard deviations of the median for the WHO reference population. (2) percentage of children 6-23 months old who are fed a diverse diet; (3) percentage of women who attended four or more antenatal care visits during their most recent pregnancy; and (4) number of beneficiaries of project interventions. All indicators will be calculated based on denominators in the geographic areas covered by the project and disaggregated by district and gender, as relevant.

The Results Framework (Annex I) was discussed and finalized during negotiations. On the stunting reduction target, the government team noted that all districts are expected to reach the 19 percent target by 2024, in line with 2018-2024 Health Sector Strategic Plan. Given that the 13 districts currently have an average stunting rate for children under five of about 43.6 percent (37.1 percent for children under two), based on global evidence, it may prove exceedingly difficult to attain this ambitious 19 percent target in such a short time span, albeit it may be possible to do so over a longer time frame. In the spirit of bending the arc, and better aligning the targets for the 13 districts with the national target, it was discussed and agreed during negotiations to set an ambitious target of 32.0 percent for the 13 districts by the end of the five-year period. This scenario assumes complementary funding from other development partners and from the broader World Bank program; enhanced multi-sectoral coordination; a rapid start-up with immediate and significant effect of these interventions on stunting; and no exogenous shocks that undermine food security in the 13 districts. Finally, it was agreed that the baseline data would be collected for the 13 districts, using the forthcoming Comprehensive Food Security and Vulnerability Analysis Survey. This will serve as the basis for updating the baseline and target figures.

The project will also support the achievement of key indicators through the national performance based financing scheme, including: (i) percentage of women who attended four or more antenatal care visits during their most recent pregnancy (PDO indicator); (ii) percentage of women and children who attended at least four postnatal care visits after delivery; (iii) percentage of women who use modern contraceptives; (iv) percentage of children participating in height monitoring and growth promotion at health facilities and followed up by CHWs; (v) number of pregnancies identified by CHWs during the first trimester; and (vi) percentage of CHWs who receive a quarterly supervision visit from health facility.

D. Project Components

The project will support the government to adopt and implement a bold, new national strategy to improve the visibility of stunting in Rwanda, and to deliver harmonized behavior change messages across various platforms. While other development partners have engaged in important ways to combat malnutrition, what is transformational and ambitious in this project is the engagement in interventions across multiple sectors, leveraging and strengthening existing and new institutional structures to mobilize stakeholders; improve ownership and accountability; and ensure convergence of key interventions at the household and individual levels. Interventions span the full 1,000 days window, with innovations to also target the health and nutrition of adolescent girls.

The project will strengthen accountability by aligning incentives and actions at several critical levels: (i) incentivizing frontline CHWs; (ii) improving accountability of health personnel through the national PBF schemes; (iii) providing grant funds to district authorities to support the convergence agenda, build capacity to mount the multi-sectoral response, and ensure effective implementation and monitoring of the DPEMs; and (iv) incorporating nutrition indicators in the imihigo contracts between the President and respective mayors. The project will adopt a phased, learn-by-doing approach, underpinned by a solid operational research agenda around convergence, behavioral change, and performance-based approaches.

The grant funds from the MDTF and GFF will co-finance IDA credit resources for both this project and the social protection operation, two projects that have been prepared in tandem, and to be implemented in a coordinated fashion. With respect to the Stunting Prevention and Reduction Project, the MDTF grant will fund the full scale up of the delivery of a package of high impact health nutrition specific interventions; and co-finance communication campaigns and learning, knowledge sharing, and monitoring and evaluation (M&E). The GFF grant will co-finance the: (i) CHW program; (ii) district multi-sectoral response; and (ii) learning, knowledge sharing and M&E. The IDA credit will fund the bulk of the remaining activities under component 1; and project management.

The GFF will bring about several key benefits for Rwanda. First, it will strengthen multi-sectoral coordination, promote evidence-based multi-sectoral interventions, and leverage/improve key platforms (CHW), to implement the convergence approach. Second, it will support the government to improve efficiency and expand spending on high-impact, evidence-based nutrition specific and nutrition sensitive interventions. Third, it will put in place mechanisms for measuring and tracking progress, as well as supporting continuous learning and knowledge sharing on innovations supported through the World Bank project/program. The GFF process will be guided by an investment case that includes well-prioritized high impact multi-sectoral interventions to address stunting with a clear focus on results and alignment of financing to the priorities. The design, implementation and monitoring of the investment case will be driven by a government-led country platform that brings together key stakeholders.

The Results Chain in Annex I depicts the proposed activities and expected results. It illustrates how the project will leverage two of Rwanda's strongest platforms (i.e. CHW, PBF); improve knowledge and promote behavior change; reach key beneficiaries with a comprehensive set of interventions; and strengthen home-based ECD to contribute to stunting prevention at the community level. DPEMs will serve as the basis for financing activities at the decentralized level. Districts will be expected to prepare updated, consolidated work plans for financing under the project, with clear strategies and targets, showing what other partners are financing and what gaps persist. The project bolsters coordination, strengthens country systems, and empowers and mobilizes local stakeholders.

The Government of Rwanda has selected 13 priority districts for World Bank support, based on three criteria: (i) high stunting levels; (ii) proportion of the population who are poor or extremely poor; and (iii) percent of households with moderate or severe food insecurity, with the highest weight given to stunting prevalence. The proposed districts are as follows: Nyabihu, Ngororero, Karongi, Rubavu, Rutsiro, Rusizi, Nyamagabe, Huye, Nyaruguru, Ruhango, Gakenke, Kayonza, and Bugesera. Three of the districts (Nyabihu, Karongi, and Kayonza) are part of the World Bank-funded agriculture project, allowing for targeted complementary interventions at the household level. The social protection project is designed to target poor and vulnerable households with pregnant women and young children in selected sectors of the same districts, thereby reaching beneficiaries with an appropriate mix of supply and demand side interventions. Figure 3 (Annex II) illustrates the geographic coverage of the program. Interventions to be funded under each component are described below.

Component 1: Prevention of Stunting at Community & Household Levels (US$35.0 million equivalent)

This component will support the government to improve awareness of stunting, and deliver harmonized behavior change messages at all levels (i.e. national, local government, and household) and across several key sectors (i.e. health, social protection, agriculture, water and sanitation). It will support the Ministry of Health (MoH)/RBC to implement, monitor and evaluate the revamped national, multisectoral behavioral change communication strategy, building on work funded by USAID and the European Union.

This component will boost the productivity and performance of CHWs and explore options for professionalizing them. CHWs will benefit from enhanced training on a revised curriculum focused on reinforcing household behavior change on complementary feeding, early childhood stimulation, and hygiene; improved supportive supervision and mentorship; innovative technologies to enhance their effectiveness and strengthen links to the health system; will be incentivized through the PBF scheme; and will benefit from strengthening of the commodity supply chain. These interventions, to be supported at scale by both the World Bank and other partners, are critical for enhancing the performance of CHWs and driving the program's success. CHWs will continue playing a role in raising awareness about stunting, carrying outgrowth promotion activities, and sensitizing ECD caregivers and communities on the importance of proper child growth.

In addition, a $10 million Recipient Executed Grant from the Early Learning Partnership Trust Fund (ELP) will co-finance the proposed AF by supporting the establishment of additional childcare settings including model, center-based and community-based ECD settings; training of caregivers and other stakeholders involved in ECD service provision at all levels (from village to central levels); provision of tools and materials to existing home-based and newly established ECD settings in the Project districts, and; support peer-to-peer learning amongst home-based ECD centers to promote innovative practices. This support

will thus contribute to bridging the gap in quality of ECD service provision across the different ECD settings and as well as increasing to ECD services to more children.

In parallel, the World Bank team is sharing with the Rwandan authorities the experience of other countries in professionalizing CHWs and has engaged in a policy dialogue to explore different options. These inputs will enable the generation of empirical lessons from implementation experiences and inform the government on the pros and cons of different models. The World Bank team is currently discussing several strategies that could be tested as part of the project, including (a) designing a new cadre of CHWs with higher qualifications, diplomas/certificates, who are remunerated; and (b) revamping the current CHW cooperative model to generate more income and better incentivize the delivery of priority health interventions. Given the fast-track preparation of this project, and the intrinsically complex nature of these issues, the goal is to incorporate these activities as part of the learning agenda that allows for innovation, continuous assessment and incorporation of lessons learned into the national program.

Component 1 will also roll out different community-based approaches and strategies for bringing about behavioral change such as home-based early childhood development models and positive deviance strategy. While the bulk of the proposed interventions address behavioral change, to address deficits in access to clean water and improve sanitation facilities that contribute to the high stunting rates, the component will also support complementary WASH interventions targeted to the most vulnerable groups (ubudehe 1 households) in the 13 participating districts. Finally, Component 1 will strengthen accountability mechanisms and governance structures at the community and district levels to bolster the multisectoral response. More specifically, the project will: (i) support the design and implementation of a new national communication strategy, including a state of the art media campaign and innovative communications tools customized to the Rwandan context; (ii) train, mentor, and equip CHWs to conduct growth promotion, including early identification and follow-up of children falling behind; behavior change communications on enhanced infant and young child care, feeding, and WASH practices; health and nutrition education for pregnant and lactating women and early referral to health facilities for nutrition services and health checkups; and to work closely with agricultural officers and the Twigire Muhinzi extension model, the local adaptation of the Farmer Field School (FFS) approach, on nutrition related content for extension services, such as nutrition-sensitive agriculture practices, and food preparation, processing and cooking demonstrations, and hygiene and sanitation during food preparation to maintain nutrition value of foods); this would include developing strategies and approaches based on the positive deviance methodology (i.e. focusing on factors that explain nutritional success rather than failure), in collaboration with other key stakeholders (i.e. Ministry of Local Government, MINALOC, Ministry of Gender and Family Promotion, MIGEPROF, Ministry of Agriculture and Animal Resources, MINAGRI); likewise, the component would also support innovations to improve pre-conceptional nutrition of women through support for the development and testing of strategies for reaching adolescent girls with nutrition counseling and weekly iron and folic acid supplementation; (iii) incentivize CHWs through the performance-based financing scheme; (iv) strengthen and/or establish home-based, early childhood development models of care that serve as platforms for enhanced infant and child feeding, hygiene and sanitation practices and early learning and stimulation (Box 3); (v) provide targeted support to vulnerable households with young children to improve access to WASH interventions (i.e. sanitary latrines, handwashing stations with soap, household water treatment and safe water storage); and (vi) strengthen multi-sectoral district planning, budgeting, coordination, supervision, and monitoring.

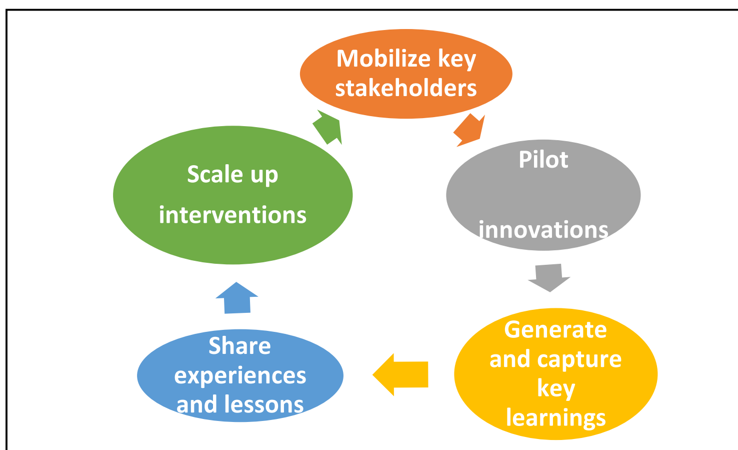
Component 2: High-impact Health and Nutrition Services (US$14.5 million equivalent)

To address key gaps in service delivery, health centers in the targeted districts will be supported and incentivized to improve utilization and coverage of an enhanced package of high-impact nutrition and health interventions. These interventions include those identified in the government's Acceleration of Reduction of Stunting Strategy which are in line with the 2008/2013 Lancet recommendations: (i) height monitoring and growth promotion and effective tracking of faltering children, early initiation and exclusive breast feeding, deworming, micronutrient supplementation (i.e. Vitamin A supplementation; therapeutic zinc supplementation with ORS; multiple micronutrient supplement powders); and (ii) critical nutrition and health interventions for women (i.e. four antenatal care visits, four postnatal care, iron/folic acid supplementation, family planning, counseling on child care, complementary feeding and hygiene). Health facilities will be held accountable and incentivized to provide these interventions through the national PBF program. The project will also support health facilities with training, information technologies, and logistical support from the national level. To this end, support will be provided for the design and roll out of new information technologies (i.e. two-way messaging system using smart phones and tablets) and interactive systems for tracking every pregnant woman and child, ensuring prompt identification of growth faltering and effective response at the facility and household levels. Performance Based Payments to the Health Centers (and also to CHWs under Component 1 of the Project) will be provided in accordance with the PBF Manual and a Supplemental PBF Manual for the Targeted Districts to be prepared by RBC that summarizes the proposed indicators; unit costs; weights; source of data; and verification/ counter verification procedures, along with a financial analysis of the impact of the incremental revenues for participating facilities and CHW cooperatives, prior to disbursing the PBF funds.

Component 3: M&E and Project Management (US$5.5 million equivalent)

This component will support M&E, and project management. To this end, it will support the following activities: (i) conducting rigorous evaluations to draw timely lessons on what works, how much it costs, and how it can be scaled up; (ii) facilitating learning and knowledge sharing at both the community and district level; and (iii)supervising, coordinating and providing oversight. As participating districts scale up interventions, the project will support learning and knowledge sharing as depicted in Figure 2 and discussed in Box 4.

Figure 2: Learning and Knowledge Sharing



Box 4: ***Learning Agenda for Stunting Reduction Program***

Given that the proposed project is an integral part of the larger World Bank Program to address childhood stunting, a joint learning agenda is being developed. The learning agenda focuses on three key dimensions: (a) *convergence* between nutrition specific (health project) and nutrition sensitive interventions (social protection and agriculture operations); (b) *innovations* in behavior change communications; and (c) *performance-based financing* approach to stunting prevention. The goal is to: (i) mobilize and empower local stakeholders to assess the stunting situation in their districts; (ii) pilot innovations; (iii) take stock of experiences, practices and lessons learned through case studies, operational research and evaluations; (iv) share innovations and lessons through regular coordination meetings, newsletters, exchange visits, documentaries, and radio talk programs; and (v) take corrective action and scale up, replicate and/or generalize good practices. Key research questions to be addressed are summarized below.

Convergence*:* One of the key goals of the joint learning agenda will be to understand the value added of the convergence of different interventions, targeting the same geographic areas, reaching the same households, and focusing on the 1,000 day window. While global evidence on the importance of well-coordinated investments is strong, much remains to be learned about which interventions work best in different contexts, which interventions are most cost effective, and what combination and or sequence of interventions have the greatest impact in terms of both reducing both poverty and stunting.

-*Social Protection*: In line with global evidence, the proposed conditional nutrition grants are expected to improve the utilization of health and nutrition services (e.g., height monitoring and growth promotion, four antenatal care visits, postnatal care visits, post-partum family planning) while the Expanded Public Works Program, home-based ECD model, is expected to improve parenting skills, infant, child feeding, hygiene and sanitation practices, and cognitive development.

-*WASH*: Given the importance of environmental health, the proposed WASH interventions are also expected to contribute to stunting prevention. While behavioral change communications will take place under both the social protection and health operations, the latter also includes improved access to latrines, handwashing stations, household water treatment and safe water storage, providing an opportunity to assess the relative contributions of both demand and supply side interventions.

-*Agriculture*: Considering the well documented potential impacts of agriculture sensitive interventions on food adequacy, the learning agenda also aims to explore the most efficient pathways by which agriculture interventions can impact nutrition. Given the focus of the agriculture project on both increasing production of nutritious food (i.e. through biofortification, kitchen gardens, small livestock) and improving incomes (i.e. income generating activities) this provides an opportunity to determine the relative impact of nutrition sensitive agriculture interventions combined with supply side health actions. This might also be an opportunity to meet the research gaps that the ongoing Rwanda Country Strategic Review for Food and Nutrition Security has identified. Specifically, on linkages between agricultural markets and nutrition, and linkages between nutrition and gender in agriculture.

Behavior Change Communications**:** Given the multitude of BCC interventions to be supported under the World Bank program (e.g. CHW interventions, interpersonal counseling with parents and caretakers, rural radio and talk shows, *umuganda* day campaigns, electronic messaging, this offers an opportunity to undertake qualitative research to assess the appropriateness and impact of these different channels and modalities for improving knowledge of stunting. Notable innovations include: new approaches to visualize child height growth at the community level, in the form of life-size drawings of a child mountain gorilla in which children can stand and see if they are reaching their height potential. The home based ECD model will offer an opportunity to assess the impact and efficiency of using group communication over home-based visits; and best mechanisms to deliver messages, and applying positive deviance methodologies in group settings.

> ***Performance-based financing**:* The proposed application of PBF to address stunting offers a unique opportunity to ascertain the impact of incentive payments on the coverage and quality of a package of high-impact nutrition and health interventions. While many development partners in Rwanda support input financing, the application of PBF modalities focused on stunting is new. Building on a strong PBF national scheme that has been in effect since the early 2000s, this health project will support the introduction of a core set of nutrition indicators to incentivize both CHWs and health facility personnel and hold them responsible for the desired results under a supplemental PBF Manual for the 13 Targeted Districts. A quality score card will be developed and introduced to monitor progress and remunerate providers accordingly. An important part of the learning agenda will be to compare districts with the PBF scheme with those without the scheme.

E. Project Cost and Financing

1. The proposed total project cost of US$55.0 million is supported through Investment Project Financing over five years. The project will be co-financed by a US$20.0 million recipient-executed grant from the MDTF Scaling Up Nutrition to Achieve Scale, and US$10.0 million recipient executed grant through the GFF. The estimated project costs along with the sources of funding are provided in Table 1.

Table 1: Project Costs, by Component and Source of Funding

Project Components	Project cost	IDA Financing	Trust Funds MDTF	Trust Funds GFF
Component 1: Prevention of Stunting at Community and Household Levels	**35.0**	**24.0**	**3.0**	**8.0**
-Communication Campaigns	4.0	1.0	3.0	0.0
-CHW Program and community-led approaches	6.5	2.0	0.0	4.5
-Home-based ECD models	8.2	8.2	0.0	0.0
-WASH Interventions	4.5	4.5	0.0	0.0
-District multi-sectoral response	5.5	2.0	0.0	3.5
-Community PBF	6.3	6.3	0.0	0.0
Component 2: High-impact Health and Nutrition Services	**14.5**	0.0	**14.5**	**0.0**
-Supply Chain & Staff Training	11.0	0.0	11.0	0.0
-Facility PBF	3.5	0.0	3.5	0.0
Component 3: M&E, and Project Management	**5.5**	**1.0**	**2.5**	**2.0**
-M&E, Learning & Knowledge Sharing	4.5	0.0	2.5	2.0
-Project Management	1.0	1.0	0.0	0.0
Total Costs	**55.0**	**25.0**	**20.0**	**10.0**

E. Lessons Reflected in the Project Design

The project design draws on best practices and innovative approaches from Rwanda and lessons learned from countries that have mounted successful programs to substantially reduce stunting.

Key lessons incorporated into the design are as follows:

Strong government commitment combined with appropriate policies, and secure financing, are critical elements. Countries that have mounted successful national stunting reduction programs have demonstrated how a combination of factors can achieve significant changes, including: (i) political commitment coupled with the adoption of clear and ambitious targets and evidence-based interventions; (ii) strong coordination between government ministries, health professionals and non-governmental organizations; (iii) broad societal participation; (iv) increased government spending; and (v) strategies focused on targeting the most vulnerable groups. The proposed Rwanda program also benefits from a strong enabling environment with authorities putting in place all critical ingredients. The high-level political commitment to the elimination of stunting and investing in the Early Years is mobilizing local actors and re-energizing the national agenda. The involvement of the World Bank, in partnership with the MDTF and the GFF, will result in a substantial increase in financing targeted to high-stunting districts and needy families. The political will combine with secure financing will enable local stakeholders to assume greater responsibility for addressing childhood stunting.

The adoption of a multi-sectoral approach that brings together all relevant sectors and includes an appropriate mix of supply and demand of services has proven essential to dealing with the underlying determinants of stunting. Even though there is no blueprint for the package of interventions that result in the greatest reductions in stunting, with countries using different approaches, it is well recognized that involvement of a maximum number of sectors, and convergence of interventions in the same geographic areas will be important. The Government of Rwanda has adopted a national multi-sectoral strategy that aims to involve all critical sectors and all actors at the national, community and household levels. The updating of the national mapping of all government and donor-funded interventions will provide valuable information to enhance multi-sectoral programming. The World Bank Program offers an opportunity for a well-coordinated, harmonized approach to stunting reduction.

Modern mass media campaigns and behavior change communications with appropriate cultural messages can potentially play an important role in making stunting no longer a silent killer. Rwandese authorities recognize that a paradigm shift is needed to change the way people think about stunting. As was done for other public health problems (i.e. HIV/AIDS) in the previous decade, a similar state of the art mass media campaign about the causes and implications of stunting has now become a national priority. The media campaign will use multiple channels that are appropriate to the local context (i.e. rural radio, umuganda day campaigns). Building on the awareness raised, high quality interpersonal counseling that draws on locally appropriate behavior change strategies (e.g. positive deviance, peer support groups) and global lessons, will bring about the behavior change needed to prevent stunting.

Strengthened incentive structures and agile information systems have proven to be additional important ingredients of successful programs in Rwanda and in other countries. Rwanda has been a leader in Africa on performance-based financing in the health sector. Impact evaluations have shown the potential of financial incentives for both improving coverage and quality of key interventions. The imihigo contracts between the President of the Republic and local district authorities have proven to be an additional effective mechanism for enhancing accountability and will now be used to address childhood stunting. The proposed inclusion of a comprehensive set of nutrition indicators in the national PBF program is expected to align resources with results. Likewise, the proposed nutrition grants to be delivered through

the social protection project will serve as an important demand side measure to the supply side interventions under this project. Efforts are also underway to review and revitalize information systems, introduce interactive technologies for enhanced tracking, monitoring and follow up vulnerable children, women, and families, and ensure availability and use of timely data.

Strategic planning and effective coordination combined with community based approaches have been identified as national priorities for stunting reduction. The government aims to strengthen strategic planning and coordination through the recently appointed ECD Coordinator who will manage both nutrition and the national ECDP that will promote greater involvement of families and parents. Countries such as Senegal and Ghana have demonstrated the benefits of community-based approaches.

Community health workers play a pivotal role in increasing awareness about stunting and in sensitizing caregivers. To this end, it is important to ensure that the ratio of CHWs to households is appropriate, allowing for regular and timely visits. Global evidence and experience from Rwanda has shown the importance of high quality training, mentoring and supervision, with a focus on a respectful and supportive attitude of CHWs, ensuring that counselling is tailored to the circumstances of the household. Other key emerging lessons point to the importance of community engagement in the management of CHWs, such as recruitment, selection, collaborative supervision, integrated monitoring system, and provision of non-financial incentives. Innovative tools that help communities, households, and caregivers visualize children's growth progress is key to behavior change.

A review of complementary feeding interventions in Rwanda and in other countries shows that education programs that highlight feeding children a diverse diet seem promising, along with other messages about timing, amounts, and hygienic food preparation methods. Two interventions that demonstrate positive results include providing key messages to mothers, fathers, grandmothers and other household members through peer support groups, and the positive deviance approach to behavior change. The latter approach is a very direct way of meeting the goals of community-based participation and involves identifying positive practices that are unique to that context, such as Vietnamese mothers collecting shrimp for their children while working in rice paddies, or Ecuadorian women pre-masticating meat before giving it to their children. In addition, both approaches involve supporting CHWs and other influencers from within the communities to act as role models, which can result in greater community engagement, thereby ensuring ownership of the process and outcomes and leading to sustainability of the intervention through the development of community support structures.

International research on successful approaches to combatting child malnutrition, including those in Rwanda, indicates that holistic early childhood development programs that enhance not only nutrition, but also health and early stimulation are more likely to support children reaching their full developmental potential. Integrating nutrition and ECD programs in the first two years of life has many advantages, including using the same personnel, the same platforms, and the same points of contact, thereby offering opportunities to engage in multiple complementary interventions with the same group of children, mothers, and caregivers, resulting in cost-effectiveness and synergistic effects. In the context of the proposed project, the home-based ECD program includes early stimulation as well as nutrition and health interventions that are critical to a child's physical and cognitive development. Specifically, the home-based ECD centers will provide opportunities for CHWs to engage in education and training of facilitators, mothers and caregivers on proper care, feeding, hygiene, and sanitation practices, as well as monitoring

progress of these children, leading to increased demand for essential services and improved nutrition knowledge.

2. Stakeholder identification and analysis

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

(i) are impacted or likely to be impacted directly or indirectly, positively or adversely, by the Project (also known as 'affected parties'); and

(ii) may have an interest in the Project ('interested parties'). They include individuals or groups whose interests may be affected by the Project and who have the potential to influence the Project outcomes in any way.

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

2.1 Methodology

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

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

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

- **Affected Parties** – persons, groups and other entities within the Project Area of Influence (PAI) that are directly influenced (actually or potentially) by the project and/or have been identified as most susceptible to change associated with the project, and who need to be closely engaged in identifying impacts and their significance, as well as in decision-making on mitigation and management measures;
- **Other Interested Parties** – individuals/groups/entities that may not experience direct impacts from the Project but who consider or perceive their interests as being affected by the project and/or who could affect the project and the process of its implementation in some way; and

- **Vulnerable Groups** – persons who may be disproportionately impacted or further disadvantaged by the project(s) as compared with any other groups due to their vulnerable status[1,] and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project.

2.2. Affected parties

The World Bank Integrated Safeguards Data Sheet (ISDS) recognizes that Rwanda has over 30 Districts and the project only targets 13 Districts.

Affected Parties include:

- Children under five years of age with focus to those under two in the 13 targeted districts
- Client/beneficiary parents, caregivers and workers of ECDs
- Pregnant and lactating mothers in 13 districts
- Adolescent girls
- 17 untargeted districts

2.3. Other interested parties

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

- District officials working in the health sector, social protection, agriculture, water and sanitation
- Government institutions (e.g.: NCDA, WASAC)
- NGOs, CSOs and DPs engaged in ECD and community health

2.4. Disadvantaged / vulnerable individuals or groups

It is not anticipated that there are any individuals or groups that could potentially be disproportionately or further disadvantaged by project activities. However, vulnerabilities of women, especially the CHWs, in workplace situations such as pregnancy, childcare and transport and safety are recognized, and the SEP will ensure that engagements will cover these issues. Engagements will also prioritize strategies to reach and address issues for the disadvantaged / vulnerable individuals or groups.

3. Stakeholder Engagement Program

3.1. Summary of stakeholder engagement done during project preparation

The RBC team organized public and stakeholder consultations in September/October 2017 to collect views and concerns with respect to the project design and discuss proposals to remedy potential adverse impacts. Participants were briefed on the scope and content of the project, and local authorities, CHWs, and opinion leaders in targeted districts were given the opportunity to share their insights. Most stakeholders raised concerns with respect to the challenge of changing the "mindset on stunting", challenges of families with many children who are at high risk of stunting, lack of regular growth monitoring and health screening, family conflict and polygamy, difficulties of health personnel to conduct visits at community and household level, and the absence of nutritionists at the health center level. Among the key recommendations were the need to strengthen outreach activities to reach families and children who do not attend health facilities regularly, and support and reinforce village-level activities, such as kitchen gardens and parent evenings.

Citizen Engagement: The World Bank mission noted that the project offers numerous opportunities for citizen engagement, such as: (i) community sensitization/mobilization and awareness campaigns; (ii) community outreach activities; (iii) community dialogues; (iv) district study tours; (v) radio programs; and (vi) home-based ECD centers. To further enhance citizen participation, the RBC/MoH team proposes to use platforms available at decentralized level to enable effective citizen participation. These include community meetings during umuganda, and other open days organized at district level to facilitate access to information. Beneficiary feedback on services and activities will be annually collected through an independent survey of beneficiaries using score cards. The Results Framework includes the specific citizen engagement indicator to be monitored and tracked during implementation.

Physical/face-to-face consultation meetings were conducted within SPRP districts including Kayonza, Huye, Nyaruguru, Nyamagabe, Ruhango, Nyabihu and Rubavu from the 7th to the 30th of November 2022. The participants included and Vice Mayors in Charge of Social Affairs, Directors of Health Unit, Director General of Hospitals, CHWs Supervisors at Hospital level, Environmental Health Officers (EHOs) at Hospital level, Sector Executive Secretaries (ES), Head of Health Centers, and CHWs Coordinators among others. Specifically, the following attended the meeting:

- Vice Mayors in Charge of Social Affairs: 7
- Directors of Health Unit: 7
- Director General of Hospital 7
- CHWs Supervisors: 7
- Environmental Health Officers (EHOs): 8
- Sector Executive Secretaries: 78
- Head of Health Centre: 95
- CHWs Coordinators: 452

The participants expressed gratitude to the Government of Rwanda through RBC and emphasized on the benefits of SPRP in their respective districts. Some mentioned that there is now sense of security with their children being left at the ECD centers which give them a chance at basic education and nutrition and allow parents the opportunity to work for them. They highlighted more effort is needed to change minds about stunting and food security as parents take more responsibility to provide nutritious food to their kids and give to the markets after their families have been well catered for.

Other interactive discussions included clarifications on the Grievance Redress Committees and their responsibilities. They sought to understand the time frame of these committees since the project was ongoing and the reporting procedures. The CHW coordinators requested clarifications on the indicators to be used while giving them PBF since already had other indicators they report on under this project. They pointed out that these should be well explained during the upcoming training to ensure everyone understands the operationalization of the GRM. The RBC E&S risk management team provided answers and clarifications to the issues raised and ensured the participants that they will gain even deeper explanations in the training. A Summary of Key Issues Raised in the Stakeholder Consultation meetings from the 7th to the 30th of November 2022 is provided in Annex III.

The stakeholder engagement process and related information will be documented in the project deliverables and implementation progress reports.

Photos showing consultation meetings with stakeholders in SPRP districts

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

The project shall be implemented in 13 Districts and involves different stakeholders. Therefore, the project implementation shall engage various stakeholders through inclusive and consultative processes using technical meetings, workshops, and knowledge-sharing forums, among others. The Rwanda Health Communication Centre (RHCC) is a unit of the RBC/MoH mandated with the coordination of health promotion interventions, and handling media and public relations within the country's health sector. The RHCC identifies and develops effective messaging to reach the sector's communication objectives. It manages social media handles and websites of RBC/MoH to continuously inform the public. The RHCC operates the 114 Hotline call center for healthcare information, counseling, and facilitates access to health services to the population from Monday to Saturday of every week. The Center operates a Documentation Centre as a clearing house for health sector information and resources including social behavior change communication materials with electronic, print and audio-visual tools.

The RHCC is fully deployed in the implementation of Rwanda's WHO-developed the Risk Communication and Community Engagement (RCCE) whose primary audiences include CHWs, disseminating messages and obtaining feedback through national radio, TV, mobile phone SMS and social media platforms. RCCE will be deployed in implementing this SEP. The potential stakeholders include government organizations, including Districts, National Child Development Agency (NCDA), Ministry of Agriculture, Rwanda Agricultural Board (RAB), and local government offices, and MoH.

3.3. Proposed strategy for information disclosure

The parent project considered it important that the different activities are inclusive and culturally sensitive, thereby ensuring that the vulnerable groups outlined above have the chance to participate in the Project benefits. This would include household-outreach and focus-group discussions in addition to village consultations, the use of verbal communication in Kinyarwanda or pictures, etc. The project would thereby have to adapt to different requirements. While SPRP has been widely known for stunting reduction in the 13 districts from the parent project, an Environmental and Social Management Framework (ESMF), Environment and Social Commitment Plan (ESCP) and Stakeholder Engagement Plan (SEP) for the Rwanda Stunting Prevention and Reduction Program would be disclosed prior to formal consultations. The RBC-SPIU allocated funds for the stakeholder engagement activities once the activities were elaborated and logistical requirements determined. The first SPRP AF will adapt to different situations, project stages, and requirements as they develop to disclose information regarding stunting

reduction and its components (Table 1). Information will build on the project objective to reduce stunting and will focus specifically on risks associated with project activities

Table 1 Proposed information disclosure strategy for the Rwanda First SPRP AF.

PROJECT STAGE	TARGET STAKEHOLDERS	INFORMATION TO BE DISCLOSED	METHODS AND TIMING PROPOSED
PREPARATION STAGE	Government representatives	Project objectives, Beneficiary selection guidelines E&S principles and obligations, Consultation process/SEP including GRM procedure, project information	Electronic publications (as applicable) in English and Kinyarwanda. Timing: Preparation stage of the project and after any change of the information to be disclosed
	Parents/guardians of children under five and two, Lactating mothers, pregnant women, and adolescent girls	Project objectives, Beneficiary selection guidelines E&S principles and obligations, Consultation process/SEP and GRM procedures	Outreach campaign, Public notices, press releases in the local media and on the project website, information leaflets and brochures at health facilities, English and Kinyarwanda. Airing of messages through health programs through local FM radio, emails, text messages Timing: Preparation stage of the project and after any change of the information to be disclosed
CONSTRUCTIONN STAGE	Beneficiaries: ECD client/ beneficiary parents, caregivers and workers; Parents/ guardians of children under five and two, lactating mothers; CHWs	Project objectives, Beneficiary selection guidelines E&S principles and obligations, Consultation process/SEP including GRM procedure, project information	Face-to-face meetings including focus group discussions in Kinyarwanda; Timing: At the start/launch of project activities and quarterly thereafter
	Government representatives, NGOs, development partners	Scope of project and activities, Timing and locations of SPRP project activities, SEP and GRM procedures.	Outreach campaign, Project Update Reports, Emails, Radio and print Electronic publications Timing: At the start/launch of project activities and quarterly thereafter
	Neighboring communities	E&S principles and obligations, Consultation process/SEP including GRM procedure, project information	Outreach campaign, Project Update Reports, Emails, Radio and print Electronic publications
IMPLEMENTATION	Beneficiaries: ECD client/ beneficiary parents;	Project objectives, Beneficiary selection guidelines	Face-to-face meetings including focus group discussions in Kinyarwanda;

PROJECT STAGE	TARGET STAKEHOLDERS	INFORMATION TO BE DISCLOSED	METHODS AND TIMING PROPOSED
	Parents/ guardians of children under five and two, lactating mothers; CHWs	E&S principles and obligations, Consultation process/SEP and GRM procedures	Timing: At the start/launch of project activities and half-yearly thereafter
	Government representatives, NGOs, development partners	Scope of project and activities, Timing and locations of SPRP project activities, SEP and GRM procedures.	Outreach campaign, Project Update Reports, Emails, Radio and print Electronic publications Timing: At the start/launch of project activities and half-yearly thereafter
	Neighboring communities	Scope of project and activities, Timing and locations of SPRP project activities, SEP and GRM procedures.	Outreach campaign, Information boards, project websites, project leaflets Electronic publications and dissemination of hard copies. Timing: At the start/launch of project activities and half-yearly thereafter

In order to prevent misconceptions about the project, RBC will ensure that information to be disclosed:

- Is accurate, up-to-date and easily accessible;
- Emphasizes shared social values;
- Includes where people can go to get more information, ask questions and provide feedback;
- Is communicated in formats taking into account language, literacy and cultural aspects.
- Over time, based on feedback received through the Grievance Redress 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 of the SPRP parent project, RBC assigned staff to monitor and mitigated social media regularly for any such misinformation about the project objectives, its components and beneficiaries. The monitoring covers all languages used in the country. This team will include the SPRP first AF in the monitoring to avoid such misconceptions.

3.4. Stakeholder engagement plan

Stakeholder engagement for the project will be carried out through inclusive and consultative processes using technical meetings, workshops, and knowledge sharing forums based on the RCCE as described above and summarized in Table 2 below.

Table 2 Stakeholder engagement procedure in compliance with ESS10 based on the Rwanda RCCE plan methods

Stakeholder Group	Engagement Methods
GoR Ministries, Institutions and Agencies: • MoH/RBC • NCDA • MINALOC/LODA/DISTRICTS	Email and text messages Formal Video Conference meetings Electronic Factsheets with text message feedback contact details One-On-One phone conversations

Stakeholder Group	Engagement Methods
Project Affected Persons/groups • Parents/guardians of children under five and two in the 13 targeted districts • Pregnant and lactating women in 13 districts • Adolescent girls	Radio and TV Public Service Announcements; social medial announcements; text messaging; Focus Group Discussions; One-On-One phone conversations Electronic Factsheets with text message feedback contact details
Other Stakeholders: • 17 untargeted districts • Other GoR institutions with social and economic development mandates • NGOs	Radio and TV Public Service Announcements; social medial announcements; text messaging; Focus Group Discussions. One-On-One phone conversations Electronic Factsheets with text message feedback contact details
Disadvantaged/ Vulnerable Individuals or Groups: • Women • Persons with disabilities	Focus Group Discussions affected persons Focus Group Discussions with local influencers and local network reps One-On-One phone conversations
Other Affected/Interested Groups: • District officials working in the health sector, social protection, agriculture, water, and sanitation • Higher Education Institutions • National and international health/development organizations • Politicians • The public at large	Radio and TV talk show with a phone-in feedback facility Electronic Factsheets with text message feedback contact details Short video broadcasts with text message feedback contact details One-On-One phone conversations

Overall supervision of project SEP is the responsibility of the RBC-MoH. Consultations between the preparation team of the SEP and members of the MoH and RBC-SPIU confirmed adequate capacity for the required implementation requirements was available within the existing human resources and operational structures of the Ministry and within environmental health officials in beneficiary district administrations, hospitals and health centers. The project Social Specialist arranges and carries out SEP activities assisted by District Hygiene and Sanitation Officers (DHSOs) at District Administration level, by Hospital Environmental Health Officers (EHOs) at Referral, Provincial and Districts hospital levels and by Community Environmental Health Officers (C-EHOs) at Health Centre level. The level, method and activity of engagement to be applied will be selected by the Social Specialist from the SEP plan in Table 2 under the supervision of the RBC-SPIU as the project implementation unit (PUI) before contacting target stakeholders. The Social Specialist is responsible for the documentation of the stakeholder engagement activities and is responsible for quarterly reporting on the SEP.

A Social Specialist and an Environmental Specialist will be responsible for overseeing the implementation of E&S instruments for Environmental and Social risk management under the project.

The Stakeholder engagement plan for the project is proposed in Table 3 below. The plan features a matrix for the preparation and implementation stages, respective target stakeholders, engagement topics, appropriate methods to be used, location, and frequency of engagement. It should be noted that all stakeholder engagement activities are the responsibility of the RBC-SPIU as the project implementing institution on behalf of the MoH/GoR.

Table 3 Stakeholder engagement plan for the Rwanda SPRP

Stage	Target stakeholders	Topic(s) of engagement	Method(s) used	Frequency
Stage 1: Project preparation	Project Affected People and beneficiaries	SEP; Project scope and rationale; Project E&S principles; Grievance Redress Mechanism process, Schedule and Work Plan	Face-to-face meetings, separate meetings for women and the vulnerable groups. Mass/social media communication (as needed) Disclosure of written information: brochures, posters, flyers, website, Local newspaper Information boards or desks Grievance Redress Mechanism	The ES team under the supervision of the RBC-SPIU (PIU) will select appropriate methods and carry out consultations with the target stakeholders throughout the project preparation stage
	Other Interested Parties	SEP disclosure. Project scope, rationale and E&S principles, Grievance Redress Mechanism process, Schedule, and Work Plan	Face-to-face meetings. Joint public/community meetings with PAPs.	The ES team under the supervision of the RBC-SPIU (PIU) will select appropriate methods and carry out consultations with the target stakeholders throughout the project preparation stage
	Other Interested Parties Press and media Local NGOs, Different Government Departments District Health Admin, etc. General public	SEP disclosure. Project scope, rationale and E&S principles, Grievance Redress Mechanism process, Schedule, and Work Plan	Public meetings, trainings/workshops (separate meetings specifically for women and vulnerable people as needed) Mass/social media communication Disclosure of written information: Brochures, posters, flyers, website, Information boards, Grievance Redress Mechanism, Notice board for employment recruitment	The ES team under the supervision of the RBC-SPIU (PIU) will select appropriate methods and carry out consultations with the target stakeholders throughout the project preparation stage
	Other Interested Parties Other Government Departments from which permissions/clearances are required;	Legal compliance issues Project scope, rationale and E&S principles, Grievance Redress Mechanism process, Schedule and Work Plan	Face-to-face meetings, Invitations to public/community meetings Submission of required reports	Disclosure meetings Reports as required
STAGE 2: Implementation Phase	Project Affected People /Beneficiaries	Grievance Redress Mechanism Health and safety impacts Progress on Schedule and Work Plan Project status	Public meetings, trainings/workshops Separate meetings as needed for women and vulnerable group Individual outreach to PAPs as needed	Quarterly meetings when ES team of the RBC-SPIU (PIU) deems it feasible and Communication through mass/social media as appropriate;

Stage	Target stakeholders	Topic(s) of engagement	Method(s) used	Frequency
			Disclosure of written information: brochures, posters, flyers, website Information boards. Notice board(s) Grievance Redress Mechanism Local monthly newsletter	Notice boards updated weekly Brochures in local offices
	Other Interested Parties	Project scope, rationale, and E&S principles Grievance Redress Mechanism Project status Progress on Schedule and Work Plan	Online meeting, Face-to-face meetings Joint public/community meetings with PAPs	Quarterly meetings when ES team of the RBC-SPIU (PIU) deems it feasible and Communication through mass/social media as appropriate. Notice boards updated weekly Brochures in local offices
	Other Interested Parties Press and media Various Government Departments General public, migrants	Project information - scope and rationale and E&S principles, Project status Health and safety impacts Progress on Schedule and Work Plan Environmental concerns GBV-related consultation, Grievance Redress Mechanism process	Public meetings, open houses, training/workshops Disclosure of written information: brochures, posters, flyers, website, Information boards Notice board(s) Grievance Redress Mechanism GBV-related issues.	Quarterly meetings when ES team of the RBC-SPIU (PIU); and Communication through mass/social media as appropriate. Notice boards updated weekly Brochures in local offices

3.5. Proposed strategy to incorporate the view of vulnerable groups

The project will carry out targeted stakeholder engagement with vulnerable groups. The engagement with the identified vulnerable groups aims to understand concerns/needs in terms of accessing information, social facilities and services and other challenges they face at home, at workplaces and in their communities. Special attention will be paid to engage women with the vulnerabilities that include considerations for pregnant and lactating mothers, childcare, transport, and safety. Appropriate method for effective engagement and communication to vulnerable group will be adopted from the RCCE as discussed earlier in this SEP.

3.6 Reporting back to stakeholders

Stakeholders will be kept informed as the project develops, including reporting on project environmental and social performance and implementation of the stakeholder engagement plan and Grievance Redress Mechanism.

4. Resources and Responsibilities for implementing stakeholder engagement activities

4.1. Resources

The MoH is in charge of stakeholder engagement activities through the RBC-SPIU as the project PIU. A budget has been estimated for the implementation of the SEP whose cost items mainly entail the costs for activities of consultations, grievance redress services, and capacity building. A total of **USD 45, 000** is estimated for ES risk management activities. An itemized cost breakdown is featured in Table 4 below.

Table 4 Estimated budget for the implementation of the SEP of the Rwanda SPRP

ES Risk Management Activity	Up to Sep 2025 (USD)
Stakeholder Engagement:	
Consultations, Materials, Dissemination, radio, meetings etc.	15,000
GRM:	
Support for the establishment and operationalization of Grievance Redress Committees and Community Verifiers	30,000
Sub Total	***45,000***
Total	**45,000**

4.2. Management functions and responsibilities

The institutional, implementation and coordination arrangements for the project will leverage existing capacity for the implementation of the project. **RBC,** the nation's central health implementation agency under the MoH is responsible for overall project management through the Single Project Implementation Unit (SPIU) which has a long-standing soundtrack record of implementing several World Bank-funded health investment operations. The RBC/SPIU as the PIU handles the following functions of the project: (i) financial management, including the flow of funds to different stakeholders; (ii) procurement of goods, equipment, and supplies to ensure economies of scale and efficiencies; (iii) securing consultant services, and (iv) oversight of Environmental and Social risk management in projects.

5. Grievance Mechanism

The main objective of a Grievance Redress Mechanism (GRM) is to assist to resolve complaints and grievances in a timely, effective and efficient manner that satisfies all parties involved. Specifically, it provides a transparent and credible process for fair, effective and lasting outcomes. It also builds trust and cooperation as an integral component of broader community consultation that facilitates corrective actions. Specifically, the GRM:

- Provides affected people with avenues for making a complaint or resolving any dispute that may arise during the 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.

5.1. Description of GRM

A proposal to use the existing CHWs framework to take on the additional duties of project Grievance Committees was recommended. CHW are well-trained individuals established under a legal structure. The rationale behind this includes the fact that the CHWs are elected by the communities among which they live and are well-trained individuals and are accountable to the villages they serve. Adopting CHW framework has various benefits including the assurance of legitimacy as well as saving time and resources. Grievance Redress Committees (GRCs) comprise a **core team** of the cell-level CHW Coordinator as the Chairperson and the 3-village level CHW serving as Vice Chairperson, Women Representative, and Youth Representative. The committee includes ex-official members comprising the RBC-SPIU Social Specialist, the Village Leader of the village in which an aggrieved party (complainant) resides, and the Cell Executive Secretary to which the aggrieved party's village administratively belongs. Figure 2 summarizes the GRM for the Rwanda SPRP first AF. The GRC core team escalates the grievance if it is not resolved at the cell level to the Health Committee of the sector in which the aggrieved party belongs. The 7 member Health Committee is constituted by the Sector Council representative (a sector is administratively governed by an elected council), the Sector Executive Secretary, the Civil Society representative, the Private Sector Federation representative, the Hospital representative (the hospital in whose catchment the aggrieved party's Health Centre belongs), Head of the nearest Health Post where the aggrieved party's residence and the representative of CHWs in the sector.

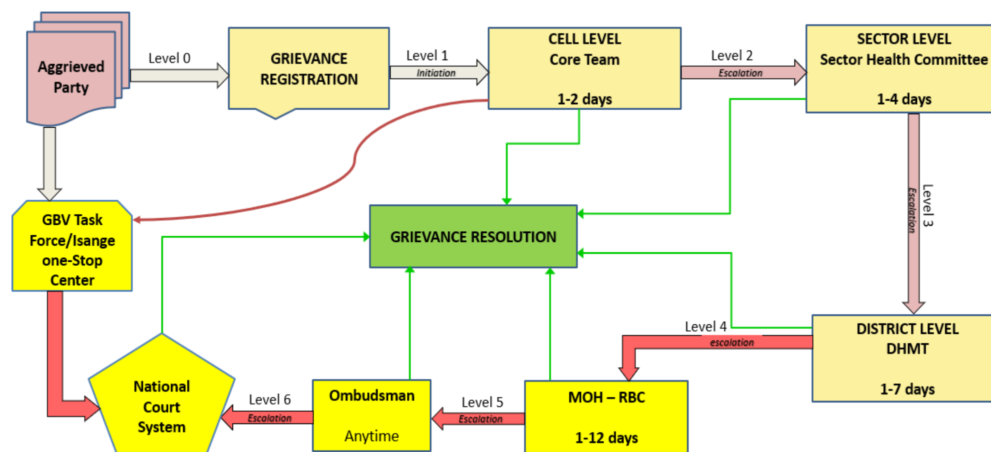


Figure 2. Escalation flow

Core team escalates the grievance to the District Health Management Team (DHMT) if not resolved at sector level. The DHMT comprises 13 members chaired by the Vice Mayor for social affairs. Other members include: The Director General of jurisdictional District/Provincial/Referral Hospital, District Director of Health Unit, District Director of Planning, Health Promotion and Prevention Officer, Chair of Joint Action Development Forum (JADF) Health Commission, the District Branch Manager of the Rwanda Social Security Board (RSSB), the representative of the jurisdictional heads of Health Centers, the Director of the District Pharmacy, the representative of Private Pharmacies, the representative of Private Health Facilities, The representative of the jurisdictional Health Posts, the representative of CHWs at the district level, and the representative of the Faith-Based Organization s(FBO) jurisdictional health facilities.

The core team escalates the grievance to the RBC-SPIU if not resolved at the district level. The RBC SPIU team for grievance redress comprised the SPIU coordinator, the Program Manager for the project, the Environmental Specialist, and the Social Specialist that already serves with the core GRC team in an ex officio capacity. The SPIU Coordinator will seek the guidance of the RBC Senior Management and MoH if deemed necessary on the grievance at hand.

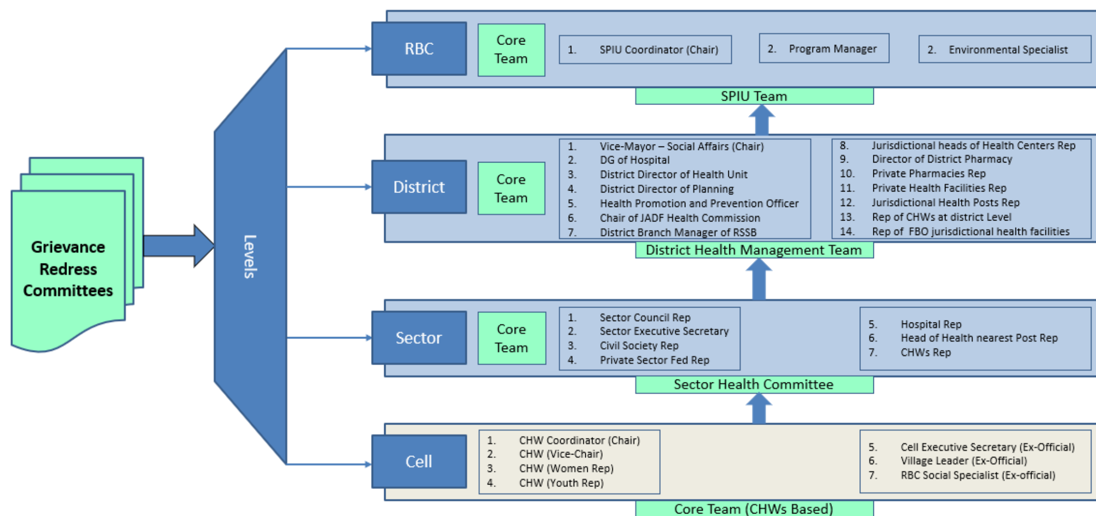


Figure 3. Grievance Redress Committees (GRCs)

6. Monitoring and Reporting

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

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

The following KPIs will be monitored:

- Number of consultation activities and other public interactive engagements with stakeholders conducted within a reporting period (e.g. monthly, quarterly, or annually);
- Frequency of public engagement activities.
- Number of participants in different engagement activities (where applicable)
- Number of public grievances received within a reporting period (e.g. monthly, quarterly, or annually) and number of those resolved within the prescribed timeline;
- Type of public grievances received; and
- Number of press materials published/broadcast by type of media.

7. Annexes

I. Abbreviations and Acronyms
II. Documents Consulted
III. Record of consultation events and participant lists
IV. Summary of key issues raised in Stakeholder Consultations

7.1 Abbreviations and Acronyms

CCH	Coordinator of Community-based Environmental Health Promotion Program
COVID-19	Coronavirus Disease 2019
DSHO	District Sanitation & Hygiene Officer
EHO	Environmental Health Officer
ESF	Environmental and Social Framework
GBV	Gender Based Violence
HCF	Healthcare Facility
IOSC	Isange One-Stop-Center
LODA	Local Administrative Entities Development Agency
MINALOC	Ministry of Local Government
MINECOFIN	Ministry of Economic Planning and Finance
MINEMA	Ministry in Charge of Emergency Management
MINICOM	Ministry of Trade and Industry
MOE	Ministry of Environment
MOH	Ministry of Health
NGO	Non-Governmental Organizations
PIU	Project Implementation Unit
RBC	Rwanda Biomedical Centre
RCCE	Risk Communication and Community Engagement
RDB	Rwanda Development Board
REMA	Rwanda Environment Management Authority
RCA	Rwanda Cooperative Agency
RHCC	Rwanda Health Communication Centre
SMS	Short Message System
SPIU	Single Project Implementation Unit
TV	Television
SEA	Sexual Exploitation and Abuse
SH	Sexual Harassment
SEP	Stakeholder Engagement Plan
WB	World Bank
WHO	World Health Organization

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7.2. Documents Consulted and Resource Material

WHO technical guidance at: *https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance*

- Risk Communication and Community Engagement (RCCE) Action Plan Guidance Preparedness and Response
- Risk Communication and Community engagement (RCCE) readiness and response

Word Bank technical notes and deriving project E&S risk management instruments

- Stunting Prevention and Reduction Project (SPRP) – Project Appraisal Document (2018)
- ESMF for CERC for the SPRP (2020)
- Medical Waste Management Plan (MWMP) Prepared for the Stunting Prevention and Reduction Project (2017)

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7.3. Summary of discussions with stakeholders during the consultation meetings in SPRP districts (Kayonza, Huye, Nyamagabe, Nyaruguru, Ruhango, Nyabihu and Rubavu) -from November 7th to 30th, 2022.

Comments and Issues raised	Stakeholder Category that raised the issue	Reply from RBC E&S Team
Regarding GRM, what indicators will be reported on?	Executive secretary - Kayonza	The E&S risk management team replied that the indicators on GRM will be developed and shared during the training of GRCs. An example given was an indicator on the number of grievances resolved within stipulated time.
How are we going to differentiate issues caused by the SPRP-AF project from other health projects?	CHW coordinator-Kayonza	The team replied that categories that will be used while solving these issues will be shared in the upcoming GRCs training.
Where will the GRCs start? Since there might be issues from the beginning of the SPRP-AF project that were not captured?	CHW coordinator-Kayonza	It was explained that the committees will start from where they have been trained and declared operational.
Will there be any motivation/incentives? If so, who will get the PBF?	CHW coordinator-Nyaruguru	It was explained that the CHWs that will be selected amongst others will get the incentives on the added indicators on GRM.
Who will elect/select the committee members?	CHW coordinator - Nyaruguru	It was explained that since CHWs are elected by the public and are under the government structure, the CHW coordinator will lead the elections amongst the existing CHWs at the cell level to select those to become dedicated members of GRCs.
You mentioned that there will be an online reporting system for grievances, have you considered providing us with devices to use?	CHW-Nyaruguru	It was explained that the Ministry of Health has a project that will include this item, however this will be harmonized and communicated by the time of reporting.
This was just to appreciate that stakeholders are consulted on relevant projects and that they look forward to receiving more benefits from the project.	Head of Health center-Nyaruguru	This was appreciated by the team.
An issue regarding the communities that are in category three that need to be moved to categories two and one and be able to access the FBF.	CHW coordinator-Nyaruguru	This was well explained that this is being done through the support of LODA[2] which will have the issue solved soon and have the right communities moved to the right categories.
What will be the reporting framework on grievances? Will there be support in terms of logistics for sitting arrangements?	CHW coordinator - Nyamagabe	It was explained that the committee will be sitting every month and report monthly on the raised grievances. There is a facilitation fee that will be provided for the smooth operation of the committee.
Some of the cells do not have CHWs within the youth category, how will we get youth representatives?	CHW coordinator-Nyamagabe	The team explained that the CHWs that are still energetic and socially friendly with the youth community can be selected for this

[2] Local Administrative Entities Development Agency (LODA - Rwanda)

Comments and Issues raised	Stakeholder Category that raised the issue	Reply from RBC E&S Team
		role in cells that do not have CHWs in this category.
There is an issue with materials to assist the CHWs to ensure smooth operationalization such as registrars, overalls, and torches for when an issue needs immediate investigation.	Head of Health Center-Rubavu	The team explained that these will be put into consideration and the registrars together with KoBo Toolbox online system will be shared with GRCs to assist them in reporting.
Stockouts that have been experienced at HCs add unintended budget and burden to HCs-Is this going to change?	Head of Health center-Rubavu	The team assured the participants that these were challenges that came along with the pandemic however measures have been put in place to ensure it doesn't happen again. The team also apologized for the inconvenience caused.

7.4 List of participants

MINISTRY OF HEALTH

Biomedical Centre

Healthy People, Healthy Nation

Consultation Meeting with Stakeholders on Covid-19 ERP Environmental and Social Safeguard Instruments at Nyaruguru District

ATTENDANCE LIST: 21st /11/2022

S/N	Name	Title	Sector (Health Center)	Bank Account	Bank Name	Telephone	Signature
1.	NIMURERE	C/S Coordinator	RUHERU	485190814010162	B.P.R	0780398185	
2.	NKURIMANA S.	C/S Coordinator	RUHERU	Coop. GIRUBUZIMA RUHERU 4853305657101 95	B.P.R	0785488017	
3.	RURANGWA Jeremie	C/S Coordinator	RUHERU	485330567101 95	BPR	0781176499	
4.	NSHIMIRYAYO Maurice	S/C Coordinator	RUHERU	4813305671 0195	BPR	0783051834	
5.	NTAKIRUTIMANA Faustin	S/C Coordinator	RUHERU	4853305671 0195	BPR	0788566005	
6.	MBARUBUKEYE Reverien	S/C Coordinator	KIVU	475331850610 [illegible] Koperative Duharanira Ubuzima Bwiza KIVU	B.P. Kibeho	0782200251	
7.	J. Paul UWIRINGIRO	C/S Coordinator	NYAMYUMBA	47533173585 101	B.P.R	0782200317	
8.	Jean Damascene Maniraho	C/S Coord	CS Kabilizi	4753326090 10166	BPR	0788200926	
9.	ALEXIS MURINZIRABIGWI	C/S Coord.	CS KABILIZI	4753326090 10166	BPR	0780981577	
10.	Thomas Ndindabahizi	CS Coordinator	CS Runyombyi	48533077710 155	BPR	0787993593	
11.	Berthilde Mukamuzima	C.S coordinatrice	C.S Maraba	4753312480 10167	BPR	0787392416	
12.	Félicien SERUGENDO	CS Coordinator	CS Mata	475331248010 7	BPR	0782200764 0782346727	
13.	NDAGIJIMANA FELICIEN	Titulaire	C.S MUNINI	00285006894153	BK	0785316029	
14.	MUHAWENIMANA Emmanuel	Titulaire	CS Kivu	00285069820794	BK	0783948978	
15.	KARITARAMA Véreine	CS Coordinator	CS KIVU	47533-18506 10151	BPR	0782200289	
16.	UWIMEYIMANA Fanny	CS Coordinator	CS KIVU	475331850610151	BPR	0780444394	
17.	Nyirayumviriza Thérèse	Cordinatrice COSA	C.S. Kivu	4753318506 10 151	B.P.R	0782200273	
18.	Alphonsine Mukeshimana	Coordinatrice	CS Kibeho	475331850610 151	B.P.R.	0782945905	
19.	Mireille [illegible]	CPS (Private Sector)	Munini	40082115550 96	Equity Bank	0785163516	
20.	HAGENIMANA Francois Xavier	Sector Exec.	Ruheru	00285006847 2127	BK	0788161899	
21.	Caritas Mukabagwiza	Coordinatrice	Kibeho	47533-1627310 138	Umurenge BPR Ubuzima Kibeho	0781898032	
22.	Geoffroi Niyonsenga	Coordinateur	Kibeho	4753316273 10 138	TURENGERE UBUZIMA Kibeho BPR	0781372952	

2

Claude DHU

23.	KABAYITA Caniss	Cell Cordinateur	CS NGOMA	GIRUBUZIMA KIYONZA 475 2321600 10 166	BPR	0789197681	
24.	NYABYENDA Gregoire	cell coordinator	CS NGOMA	475 2321600 10 166 GIRUBUZIMA KIYONZA	BPR	0785063330	
25.	BUCYANA Fask	Cell codinat	CS NGOMA	GIRUBUZIMA KIYONZA	BPR	0782203091	
26.	Vianney Mumpanzya	Cell Codinat	CS NGOMA	GIRUBUZIMA KIYONZA	BPR	0783998914	
27.	Beatrice Mukamugema	Cell cordinator	CS Nyantanga	475 331586710 142 Turengerubuzima Nyantanga	BPR	0785873831	
28.	NSHIMIYIMANA Patrice	Cell Coordinator	CS Nyantanga	475 331586710 142 Turengerebuzima Nyantanga	BPR	0782200572	
29.	MUKARUZIGA Josephine	Cell Coordinator	HC Nyantanga	475 331586710142 Turengerebuzima Nyantanga	BPR	0786899721	
30.	UWIZEYEMUNGU Joseph	Cell Coordinator	HC Nyantanga	475 331586710 142 Turengerebuzima Nyantanga	BPR	0785561779	
31.	LOVE Callixte	Cell Coordinator	HC Runyombyi	485 330 7771 10 155 TURENGERUBUZIMA	BPR	0781147012	
32.	NSEKANABO Philippe	Cell Coordinator	HC Runyombyi	485 330 777 110 155 TURENGERUBUZIMA	BPR	0787993286	
33.	HABIMANA François	Cell Coordinator	HC Runyombyi	485 330 777 110 155 TURENGERUBUZIMA	BPR	0781359379	
34.	NGIRIMANA Vincent	Cell Coordinator	HC Runyombyi	485 330 777 10 155 TURENGERUBUZIMA	BPR	0788619346	
35.	MUKARUBUGA Chantal	Cell Coordinator	HC Maraba	475 331248010 167 ABAKUNDA MURIMO MBAGUZI	BPR	0786095123	
36.	MUKAKARAMIRA Mediatrice	Cell Coordinator	HC Maraba	475 331248010 167 ABAKUNDA MURIMO NYAGISOZI	BPR	0721033619	
37.	Célestin Kayabunda	Coordinateur	Coko	475 332 9088 10 179 HARANIRUBUZIMA	BPR	0782200454	
38.	mukantwali Patricie	Cell cordinator	Coko	475 332 9088 10 179 HARANIRUBUZIMA	BPR	0782900178	

Claude Dht

39.	NDIKUBWIMANA Cyprien	Titulaire Adjoint	RURAMBA HC	481138770210 176	BPR	0788792443	
40.	NDABAZI François	Coordinateur ASC	RURAMBA	475331642710 177	BPR	0726555794	
41.	MUNYANEZA Damascène	Coordinateur ASC	RURAMBA	475331194261 0198	BPR	0786516160	
42.	MUREKEZI Dominique	Coordinateur ASC	RURAMBA	475331192610198	BPR	0785121994	
43.	HAKIZIMANA Venantie	Coordinateur ASC	RURAMBA	475331192610198	BPR	0782840507	
44.	TABARO Cyprien	Coordinateur ASC	RURAMBA	475331926 10198	BPR	0783774173	
45.	TWAGIRUMUKIZA Bernard	Coordinateur ASC	MATA	475 478 7464 10 147	B.P.R.	0789838717	
46.	NIRAGIRE Marie	Cordinateur ASC	MATA	Association TUREMERUBUZIMA 475331735710185	B.P.R.	0782200347	
47.	Muraragira Pierre	Titulaire	Gakindo	475332198610 167	BPR	0788990340	
48.	Ndayisenga Eugène	Titulaire	Ngeruka	6605600579263 32	BK	0785897386	
49.	SEBAGENZI Christophe	Coordinateur	MUGANZA	475332383410158	DUKOMEREKUBUZIMA MUGANZA BPR	0781810843	
50.	Ntawukiriyayo Valens	Coordinateur	Muganza	475332383410158	Dukomere Kubuzima Muganza BPR	0788935603	
51.	BAKORIMANA Valence	Claude Marcel	Muniini	1000892241838	BK	0786122149	
52.	MUKAGASIBUBI Anastasie	Coordinateur ASC	Muniini	TUHARANIRUBUZIMA MUNINI 475331932 610157	BPR	0784648645	
53.	Uwisabyimana Perpetue	Cell Coordinator	Muniini	TUHARANIRUBUZIMA MUNINI 475331932 610157	BPR	0776081532	
54.	NIYITEGEKA Vestine	Titulaire Adjointe	MUGANZA HC	41737587881011	BPR	0784135067	

Claude DHt

55.	DWASEKURU Emmanuel [illegible]	Titulaire	Gko HC	00050061190141	BK	0782578685	
56.	DUSENGE Jean Pierre	SEO	Kivu sector	9000 89377-00	UMWALIMU SACCO	0783020594	
57.	[illegible] Nutoinette	ASC	COKO	4753329086[illegible]10 179	BRR	0782200090	
58.	Agnes Mukabagorora	ASC	KABIRIZI	4753326090 116 [illegible]	KABIRIZI BRR	078937569	
59.	Umutesi [illegible]	ASC	Cyahinda	47533[illegible]	BPR	0782200099	
60.	Ndindyaho [illegible]	Titulaire	Ruheru	48533106951[illegible]	123 BPR	0782678420	
61.	Uwitonze Pasifique	ASC	cyahinda	475331243210 144	CYAHINDA BPR	0787835 215	
62.	KANYAMAGORE Leonard	EHO	Munini DH	4400541371	KCB	0788446065	
63.	Umwali Alice	A.S.C	Cyahinda	47533124327[illegible] 144	CYAHINDA BPR	0782200[illegible]	
64.	Hakizimana Jean [illegible]	ASC	Cyahinda	47533124320 144	CYAHINDA BPR	0780110965	
65.	TWAGIRAYEZU Albert	Titulaire	Kabilizi HC	~~0330891004~~	I&M Bank	0788750225	
66.				20330891001			
67.	MUKAKAYANGE Faina	Cell Coordinator	Kibeho HC	47533162721018[illegible]	BPR KIBEHO	0788033416	
68.	RUTINYWA Jean de Dieu	Cell Coordinator	Kibeho HC	4753316273101[illegible]	BPR KIBEHO	0784428707	
69.	[illegible] Euphrem	Cell Coordinato	Kibeho HC	47533162770.13[illegible]	BPR Kibeho	0780245745	
70.	Saiva TUYISENGE	Titulaire	Mpoma HC	4009211606269	Equity Bank	078 8217743	

5

Claude Dtn

71.	SENEZA Jean Damascene	Cell Coordinator	NYARAMATA	47533171126 10116 BPR	TURWANEKU BUZIMA NYABIMATA	0783744982	
72.	NGAYABERURA Innocent	Cell Coordinator	NYABIMATA	475331712[illegible]	BUZIMA NYABIMATA BPR	0782238486	
73.	Nkurikiyimana [illegible] Jimy	Coordinator	Nyabimata	47533171[illegible] 116 BPR	[illegible]	0785[illegible]	
74.	NDAYISHIMIYE Innocent	Coordinateur	Nyabimata	47533171[illegible] 6 BPR	Twiyubake [illegible]	0782200[illegible]	
75.	Ndahayo Tenoyne	Coordinateur	Nyabimata	475331712[illegible] 116 BPR	TURWANE KUBUZIMA	0788946831	
76.	Nsabiyaremye Justin	Coordinateur	Muganza	475332 3834 10158 BPR	DUKOMERE KU BUZIMA MUGANZA	0782[illegible]	
77.	Uwimana Cyrille	Coordinateur	Muganza	475332 3834 10158 BPR	DUKOMERE KU BUZIMA MUGANZA	07822[illegible] 385	
78.	NDIKUMANA JEAN DAMASCENE	Coordinateur	MUNINI	475331932[illegible] BPR	DUHARANIRE UBUZIMA MUNINI	0782158629	
79.	HABIMANA Vedaste	SES	RURAMBA	47533 2[illegible] 10187 BPR	BPR	0788568014	
80.	Karemera Athanase	HPDCO	District	4611112030 10131	BPR	07886413485	
81.	KAMPOGO Dative	Head of HC	Nyarugunda HC	4753315735 10168	BPR	0788757518	
82.	BIZIMANA [illegible]	SES	Ngoma	4784233042 10177	BPR	0785351176	
83.	NIYIGIRIMANA Jean Claude	Director of Health	District	4753316266 10154	BPR	0788648357	
84.	[illegible] NTAKIRUTIMANA	Coordinator	MATA	47533173 56770 185	BPR	0785458890	
85.	Gaspard SIBOMANA	Coordinator	MATA	475331735[illegible]	BPR	0784983101	
86.	J'pater BYIRINGIRO	Coordinator	MATA	475331735[illegible]	B.P.R	0782[illegible]	

6

87.	TUYISHIME Apicetus	SES	MUGANZA	000900378481 37	BK	0788418341	
88.	NIYIRAMIYA Fidele	SES	Busanze	[illegible]	BPR	0788535127	
89.	NIYIRAKANYANA	Head of HC	NYABIMATA HC	4753322641089	BPR	0783377580	
90.	Vestine Uwimana	S/Coordinatrice	KABIRIZI HC	4753326090	KABIRIZI BPR	0786912376	
91.	Generose Nyirahabimana	S/Coordinator	Kabirizi	475332609	BPR Kabirizi	0781861318 86	
92.	Kanyabe Nyiracaliei	S/Coordinator	Ngera	0130-131-11024 85-08	Ngera	0781466137	
93.	Mukaruziga Umuraciato	S/Coordinator	Ngera	0130-131-1102485-08 P.BFC	Ngera	0780814013	
94.	NTAZINDA Narcisse	S/Coordinateur	KABILIZI	4753326090 IMBANGUBUGIZIRA	BPR	0788348904	
95.	Hakizimana Odiline	S/Coord.	Nfera	KABILIZI 0130-131-11024	Bogeb.	0784759091	
96.	Usabyimana Vincent	C/Coordinateur	Ngera	0130-131-110 2485-08 PBFC	Cogebank	0787657016	
97.	Mukashema Therese	Titulaire	Mwalo	475332872010 163	BPR	0786137043	
98.	NIKUZWIMANA Alphonsine	SES	Kibeho	00285-006593 92-46	BK	0788830036	
99.	Dusabe Josee	Titulaire	Nyantanga	485330582310165	BPR	0782853600	
100.	Uwizeyimana Albertine	CHW Supervisor	Munini DH	00054002957 6441	BK	0783121147	
101.	MUGISHA - Ukurl	Head of HC	Rukoko	000600032449169	BK	0788703165	
102.	NDIKUMANA Pierre	SES	NGERA	440143074 3	KCB	0788582472	

Claude Athu

103.	NSABIMANA Jean Claude	BDE/TATA	TATA	4009100637067	Equity	0785211160	
104.	Florence Bebeter	ES	Cyahinda	44010860 82	KCB	0788434031	
105.	MUHIRWA Speciose	SES	Nyagisozi	00040003 10 605-44	Bank of Kigali	0788540122	
106.	UMUHOZA Josephine	SES	Rusenge	00044003 4853560	BK	0788487252	
107.	Nyirasaba Dorothee	Head of HC	Kibeho	4023752 55010115	BPR	0788571509	
108.	NSENGIMANA Callixte	C/S Coordinator	Ngoma	4753321600 10166	BPR	0786756663	
109.	Kamarita Marie Louise	CHW	Ngoma	4753321600 10166	BPR	0785757003	
110.	MUKAMFURA Martine	DHSO	KIBEHO	00285-065846 3917	BK	0788699471	
111	NSABUMUREMYI Javier	ECD/Focal Point	District	00331 5200253	I&M Bank	0781563168	