United Nations Children's Fund (UNICEF)
&
World Food Programme (WFP)

Second Additional Financing for the Health Emergency Response Project Afghanistan

Stakeholder Engagement Plan

October 2024

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Acronyms & Abbreviations:

ADB	Asian Development Bank
AAP	Accountability to Affected Population
DoPH	Directorate of Public Health
ESF	Environmental and Social Framework of the World Bank
ESHS	Environment, Social, Health, and Safety
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
ESS	Environmental and Social Standard(s)
FMFA	Financial Management Framework Agreement
GBV	Gender Based Violence
GM	Grievance Mechanism
IDPs	Internally Displaced Persons
IE&LFS	Income, Expenditure and Labor Force Survey
IP	Implementing Partner
IPCP	Infection Prevention and Control Plan
HCWMP	Health Care Waste Management Plan
MoPH	Ministry of Public Health
NEPA	National Environment Protection Agency
NGO	Non-Governmental Organization
OHS	Occupational Health Safety
PBW	Pregnant and Breastfeeding Women
PLW	Pregnant and Lactating Women
SEA	Sexual Exploitation and Abuse
SEP	Stakeholder Engagement Plan
SH	Sexual Harassment
SMF	Security Management Framework
TPM	Third Party Monitoring
TPMA	Third Part Monitoring Agency
UN	United Nations
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organization

Stakeholder Engagement Plan (SEP)

1 Introduction/Project Description

1.1 Introduction

This Stakeholder Engagement Plan (SEP) builds on the stakeholder engagement plan which was developed under the parent project (Health Emergency Response Project (HER) (P178775). The SEP prepared under the HER project, which was later updated for another 15 months under Additional Financing (HER AF) (P181378), was revised and updated jointly by the United Nations Children's Fund (UNICEF) and the United Nations World Food Programme (WFP) for the Afghanistan Health Emergency Response Second Additional Financing (HER AF2) Project in accordance with the World Bank Environmental and Social Standard on Stakeholder Engagement and Information Disclosure (ESS10). This plan defines a program for stakeholder engagement, including public information disclosure and consultation throughout the entire project cycle, outlines the ways in which the project team will communicate with stakeholders, and includes a mechanism by which people can raise concerns, provide feedback, or make complaints about the project and any activities related to it.

The involvement of the local population is essential to the success of the project to ensure smooth collaboration between project staff and local communities and to minimize and mitigate environmental and social risks related to the proposed project activities. The project stakeholder engagement is key to communicating the information of project services and scope to all stakeholders and reaching out to disadvantaged and vulnerable groups.

The SEP will be periodically updated, as necessary, during the project implementation to ensure that the information presented herein is consistent and up to date, and that the identified methods of engagement remain appropriate and effective in relation to the project context. Any major changes to the project-related activities and/or schedule will be duly reflected in the SEP.

1.2 Project Description

The Second Additional Financing to the Afghanistan Health Emergency Response (HER) project is financed by the International Development Association (IDA), the Afghanistan Resilience Trust Fund (ARTF), and the Global Financing Facility (GFF) and will be implemented by UNICEF (components 1 and 2) and WFP (component 3), and their implementing partners/contractors to provide essential health services to the population of Afghanistan. The project geographic scope funded under the Second AF will be for 24 provinces. The remaining 10 provinces are currently financed by the ADB, using a similar contract design as those provinces financed through the ARTF. The project development objective (PDO) for the Second Additional Financing is to increase the utilization and quality of essential health and nutrition services in Afghanistan. The second additional financing for the HER project will consist of the following three components:

Component 1: Urgent provision of essential primary and secondary health services (UNICEF)

Under component 1, the Second AF will continue to deliver a package of primary and secondary-level health services free of charge to all Afghans through Service Providers supporting a network of health facilities across 24 provinces. Service providers work under performance-based contracts administered by UNICEF. Additional support is provided for nutrition services and for the detection of and response to

infectious disease outbreaks (supported by the World Health Organization). Component 1 includes the following subcomponents:

- **Sub-component 1.1: Enhancing utilization and quality of the Basic Package of Health Services and Essential Package of Hospital Services.**

UNICEF manages the contracting of national and international Service Providers (SPs) to deliver health services under the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) across various levels of healthcare facilities. Using a pay-for-performance (P4P) model, the project funded by the World Bank in 24 provinces and by the Asian Development Bank in 10 provinces ensures performance-based payments for maternal, child, and nutrition services. BPHS focuses on primary healthcare, including maternal and newborn care, immunization, and communicable disease control, while EPHS offers specialized hospital services such as gynecology, surgery, and gender-based violence support.

- **Sub-component 1.2 Enhancing community and facility-level nutrition services.**

The BPHS and EPHS nutrition interventions will be strengthened through additional support in key areas, focusing on expanding the role of female nutrition counselors (NCs). Over 2,000 NCs will be maintained and trained to deliver maternal and child nutrition services at both the health facility and community levels. Their community outreach will include working with community health workers (CHWs) to mobilize pregnant and lactating women and children under two for nutrition services, growth monitoring, and promoting optimal feeding practices. Behavior change communication (BCC) materials will be developed to promote key nutrition messages through all contact opportunities. The approach will shift focus toward community-level messaging and climate-sensitive feeding practices, while coordinating with social and behavioral change communication (SBCC) efforts to complement ongoing project activities.

- **Sub-component 1.3: Preserving the health system's capacity to prevent major infectious disease outbreaks.**

Under this component, UNICEF will work with the World Health Organization (WHO) and other partners to ensure full COVID-19 surveillance integration with Disease Early Warning System (DEWS). In addition, the capacity of the health system to prevent, diagnose and treat infectious disease outbreaks (including climate exacerbated vector-borne and waterborne diseases) will be further strengthened through activities to support the SPs with (i) infection prevention and control; (ii) improving diagnostic and reporting capacity; (iii) improving treatment capacity; and (iv) risk communication and community engagement to protect people and increase demand for vaccination. These activities are implemented by the WHO through an UN-to-UN agreement with UNICEF.

Component 2: Strengthening service delivery (UNICEF)

Under Component 2, financing is provided to promote quality of care through training and mentorship and procurement of drugs and essential equipment. Component 2 includes the following subcomponents:

- **Sub-component 2.1 Promoting quality of care and strengthening healthcare worker capacity.**

This sub-component focuses on improving quality of care by (a) linking the Quantified Quality Metric (QQM) to financial incentives for SPs; and (b) undertaking analysis of SP performance data combined with SPs' qualitative feedback to ensure strong implementation of best practices. Training and mentorship activities that were financed under the parent project have been dropped.

- **Sub-component 2.2 Enhancing quality health product and equipment supply chains.**

The project will implement a hybrid procurement model for medicines and medical supplies, combining UNICEF's pooled procurement through its Copenhagen supply division with local procurement by Service Providers (SPs). SPs can locally source items from an approved list that meet quality standards, while UNICEF handles the remaining procurements. This subcomponent will assist SPs with forecasting, procurement, and capacity building, while also supporting the development of platforms for coordinated procurement and market-shaping strategies for high-quality health products and essential equipment.

- **Sub-component 2.3 Third-Party Monitoring and Management Accompaniment for UNICEF.**

To ensure that the design elements of Components 1 and 2 lead to better performance by Service Providers (SPs), service delivery and quality data will be verified. A Third-party Monitoring (TPM) agent, specializing in large-scale health surveys, will validate routine reporting data. Additionally, this subcomponent offers technical assistance to enhance SPs' performance and management, including third-party management accompaniment.

- **Sub-component 2.4 UNICEF Project Implementation Cost.**

This subcomponent will cover UNICEF's direct and indirect costs, with direct costs focusing on project implementation, coordination, and monitoring and evaluation (M&E). It will ensure oversight of institutional, strategic, operational, and contextual risks across the program, supported by key functions such as financial management, human resources, logistics, partnerships, and information security.

- **Sub-component 2.5: Survey**

A new sub-component was added to reflect the financing added for the implementation of the Afghanistan Income, Expenditure, and Labour Force Survey (IE-LFS). The latter will yield pertinent data to inform HER project implementation and address knowledge gaps on welfare and health policy issues in Afghanistan.

Component 3: Strengthening Demand and Access to Enhance Nutritional Outcomes Among the Most Vulnerable – the Maternal and Child Benefit Program (WFP)

The MCBP complements the provision of health and nutrition services (Components 1.1 and 1.2) to improve the nutritional status of pregnant and breastfeeding women (PBW) and children under two years of age in selected districts with high child malnutrition (the target population). MCBP will provide two benefits on a quarterly basis over a total of 18 months: cash transfers (subcomponent 3.1); and social and behavioral change communication (SBCC) sessions (subcomponent 3.2). The main recipient of these benefits will be women who are pregnant and/or have a child under 2 years of age. The component activities aim to improve the nutritional status of the target population by promoting increased utilization of maternal and child health and nutrition services, improving related behaviors (e.g., feeding practices), and increasing access to nutritious foods. Globally, cash transfers targeted to households with young children have been found to improve child nutritional outcomes, particularly when combined with SBCC.[1] The component will be implemented by WFP with the assistance of payment providers and cooperating partners (CPs).

- **Sub-component 3.1: Cash transfers**

This subcomponent will finance quarterly cash transfers of US$60 over 18 months to beneficiary women, aiming at incentivizing the utilization of health and nutrition services and increasing access to nutritious

[1] Manley et al. (2020) (https://pubmed.ncbi.nlm.nih.gov/33355262/); Akhter et al. (2019) (https://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/133420/filename/133631.pdf).

foods.[2]- Payments will be delivered at designated cash distribution points, which beneficiaries will be informed about along with assigned payment days. Beneficiaries and alternates, where applicable, will be informed to attend the SBCC sessions before collecting cash benefits, but session attendance will not be used as a condition to receive cash benefits.

- **Sub-component 3.2: Social and behavioral change communication (SBCC)**

This subcomponent will finance implementation of the SBCC sessions, including direct costs (e.g., payments to sessions facilitators and supervisors, and materials). SBCC sessions will be delivered quarterly through structured sessions to beneficiary women and those who accompany them (or their alternates) at the designated cash distribution points and prior to collecting cash benefits. Beneficiaries will be encouraged to bring children under 2 to the sessions and parallel sessions for male companions will also be organized. Sessions will aim at encouraging good health and nutrition practices and the utilization of relevant health and nutrition services. Health and nutrition messages will be delivered utilizing videos, charts/banners, handouts, registration cards, etc. Where possible, and available, Nutrition Counselors (NCs) and Community Health Workers (CHW) may be invited to engage, through coordination with UNICEF and with field level implementers of the BPHS/EPHS, around the sessions for linkages to the health system. In-person SBCC sessions will be complemented by remote targeted messages delivered via SMS, according to beneficiary women life stage. Remote messaging will be delivered on a more frequent basis (e.g., weekly).

- **Sub-component 3.3: TPM arrangements with WFP**
- **Sub-component 3.4: WFP implementation costs**

- **Sub-component 3.5: Productive Inclusion for Vulnerable Youth Pilot (New Sub-component)**

This new sub-component will contribute to the sustaining of health and nutrition outcomes by building more diversified livelihoods of selected vulnerable MCBP households and testing the MCBP as a safety net delivery platform. The pilot will target vulnerable youth aged 18-35 from MCBP households who are un- or underemployed in the informal sector and interested in receiving skilling and capital support to start or expand nutrition-sensitive income generating activities (IGAs). The pilot will aim at targeting a subset of MCBP households, while ensuring that 50 percent of these beneficiaries are female. The activities will complement MCBP cash and SBCC benefits. Beneficiaries will receive business and life skills training and at the end of the training, will be encouraged to identify a nutrition-sensitive IGA. Beneficiaries will receive a one-time productive grant to implement their IGA. This sub-component will finance (a) beneficiary profiling and market assessment, (b) the development and delivery of a training program, (c) support IGA beneficiaries to develop a business plan, (d) a one-time productive grant, and (e) coaching of IGA beneficiaries.

2 Objective/Description of SEP

The overall objective of this SEP is to define a program for stakeholder engagement, including public information disclosure and consultation throughout the entire project cycle. The SEP outlines the ways in which UNICEF and WFP will communicate with stakeholders and includes a mechanism by which people can raise concerns, provide feedback, or make complaints about the project and any activities related to the project. The SEP specifically emphasizes methods to engage groups considered most vulnerable and that are at risk of being left out of project benefits.

[2] One payment per beneficiary per quarter. However, there can be multiple eligible beneficiaries per household.

3 Stakeholder identification and analysis per project component

3.1 Methodology

For the HER AF2, the following stakeholders have been identified and analyzed per project component. These stakeholders include affected parties (as defined in section 3.2.1 and 3.3.1), other interested parties (as defined in section 3.2.2 and 3.3.2) and disadvantaged/vulnerable individuals or groups (as defined in section 3.2.3 and 3.3.3).

3.2 Components 1 & 2 (UNICEF)

3.2.1 Affected Parties

Affected Parties include local communities, community members and other parties that may be subject to direct impact from the Project. The largest component of the project (Component 1) will provide broad support to the BPHS and EPHS in Afghanistan, supporting over 1660 primary care facilities and hospitals to provide basic and essential health services to the population. It will also support community- based nutrition services and prevention and response to major infectious disease outbreaks. For this component of the project, Affected Parties include local communities, health and nutrition service receivers and providers, health care institutions and other parties that may be subject to direct impacts from Project activities. For the Second HER AF project in Afghanistan, these include the following groups or individuals:

- Health workers including Health Facility and Community Health Workers at national, provincial, district and local levels;
- Health and Nutrition service receivers;
- Communities in the vicinity of planned Project activities with particular focus on most vulnerable;
- Community-based groups and non-governmental organizations (NGOs) that represent residents and other local interest groups, and act on their behalf;
- NGO Implementing Agencies;
- Health cluster partners and other implementation partners in the health sector; and
- Business owners and providers of services, goods and materials within the project area will be involved in the project's wider supply chain or may be considered for the role of project's suppliers in the future.
- Staff working in laboratories, quarantine centers, and screening posts outside of health facilities, along with neighboring communities and workers at these sites
- Public health workers;
- Medical waste collection and disposal workers; and
- Workers of large public places, including public markets, supermarkets etc.;

3.2.2 Other Interested Parties

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

- Community members and decision-makers;
    - Family Health Action Groups (FHAGs);
    - Health Management Shuras (HMS);
- Other local authorities
    - District and provincial governors;

- Residents of the other area local communities within the project area, who can benefit from employment and training opportunities stemming from the Project;
- Contractors for construction/rehabilitation works;
- Other humanitarian and development agencies and partners that are engaged in Health and Nutrition activities in target area;
- Traditional media;
- Participants/influencers of social media.

3.2.3 Disadvantaged/vulnerable individuals or groups

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

- Families living in remote locations / White Areas
- Women and girls
- Persons with disabilities
- Families and communities experiencing poverty, especially extreme poverty
- IDPs
- Returnees
- Pastoral nomads (Kuchis)
- Elderly people, including those who live in remote areas
- Women-headed households
- The unemployed
- Youth (Adolescents)
- Homeless people and those living in informal settlements
- Disadvantaged groups including ethnic minorities Refugees, asylum seekers, populations in conflict setting or those affected by humanitarian emergencies, vulnerable migrants in irregular situations
- Social groups unable to physically distance (examples: geographically remote clustered populations, detention facilities, dormitories, military personnel living in tight quarters, refugee camps)
- Groups living in dense urban neighborhoods.
- Groups living in multigenerational households

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

3.3 Component 3 (WFP)

3.3.1 Affected Parties

Affected parties for all of Component 3 activities are identified as follows:

- Pregnant and Breastfeeding Women (PBW) and children under two;
- Community Midwives;
- Health workers and nutrition counselors including health facility and community health workers at local level;
- Other children and women at household level;

- NGOs cooperating partners;
- Commercial banks, mobile telephone companies, and money service providers who will be involved in cash transfer;
- Eligible youths (18-35 years old) within MCBP-targeted HHs
- Community-based groups and Civil Society Organizations that represent residents and other local interest groups, including organizations and companies specialized in youth programming and business development;
- Organizations of persons with disabilities (OPDs); and
- Communities in the vicinity of planned Project activities with particular focus on most vulnerable.

3.3.2 Other interested parties

Other interested parties are identified as follows:

- National and subnational level authorities (De Facto Authorities)
- Main counterpart ministries, both at technical and leadership level (e.g., Ministry of Public Health – MoPH, Ministry of Economy – MoE, Ministry of Labor and Social Affairs - MoLSA)
- Potential other ministries for coordination both at technical and leadership level (e.g., Ministry of Rural Rehabilitation and Development – MRRD)
- Provincial Governor Offices, District Governor offices, line departments of relevant ministries at provincial and district level (if exist at district level).
- Community members and decision-makers
- Community Development Councils (CDCs)
- Community Food Assessment Consultations (CFAC)
- Religious and ethnic Shuras
- Health Shuras
- Women's Led Organizations/Women led CSOs.
- Organization of Persons with Disabilities (OPDs)
- Family Health Action Groups (FHAGs) Respected senior women within the communities.
- Youth-led Organizations/Youth-led CSOs
- Local business owners
- Other humanitarian and development agencies and partners that are engaged in Health, Nutrition, Livelihood and Food Security activities in target areas;
- Residents of the other area local communities within the project area, who can benefit from employment and training opportunities stemming from the Project;
- Traditional media (e.g., radio, TV, etc.) and,
- Participants/influencers of social media

3.3.3 Disadvantaged / vulnerable individuals or groups

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

Disadvantaged vulnerable individuals or groups are defined as groups and persons that may be disproportionately impacted or further disadvantaged by, or marginalized from, Project activities, and

thus may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with Project activities.

Within the Afghanistan context the vulnerability may stem from the person's origin, ethnicity, gender, age, disability, health condition, economic deficiency and financial insecurity, disadvantaged status in the community, such as marginalized groups, returnees, or Internally Displaced Persons (IDPs), or dependence on other individuals. Engagement with the vulnerable groups and individuals will be carried out through gender/age/disability-sensitive citizen engagements to facilitate their participation in Project-related decision making, to ensure that their understanding of and input into the overall process are commensurate to those of the other stakeholders.

Vulnerable groups include:

- Families living in remote locations/ White Areas;
- Women and girls;
- Persons with disabilities;
- Families and communities experiencing poverty, especially extreme poverty;
- IDPs;
- Returnees;
- Religious and ethnic minority groups
- Pastoral nomads (Kuchis);
- Elderly people;
- Women-headed households;
- Unemployed individuals;
- Socio-economically marginalized Youth, especially those who are out of education and employment;;
- Homeless people and those living in informal settlements or urban slums;
- Disadvantaged groups, including ethnic minorities;
- Low-income migrant workers;
- Refugees, asylum seekers, populations in conflict setting or those affected by humanitarian emergencies, vulnerable migrants in irregular situations;
- Hard to reach population groups;
- Older adults defined by age-based risk; and
- Groups living in multigenerational households.

4 Stakeholder Engagement Program

4.1 Components 1 & 2 (UNICEF)

4.1.1 Summary of stakeholder engagement done during project preparation

UNICEF regularly coordinates with relevant stakeholders at both central, provincial and local levels on coordination and issues related to health and nutrition services. Through these consultations, UNICEF is ensuring that the monitoring framework designed under the HER AF project continues to be open, transparent, and maintains buy-in from key stakeholders.

UNICEF is the lead for the Nutrition Cluster in Afghanistan and coordinates and organizes monthly meetings with key stakeholders at national, provincial, district and local levels. More specifically, through this forum, Nutrition Cluster members including UN Agencies such as WFP, WHO and international and national NGOs (INGOs and NNGOs), regularly provide UNICEF with information regarding needs and priorities in the nutrition sector. In addition, UNICEF is an active participant in the Health Cluster at national and provincial levels, through which it regularly engages with similar stakeholders to understand the needs and plans in these programming areas. These platforms were used to ensure key beneficiaries were engaged throughout the implementation of the parent project.

UNICEF has three (Central, North, and East) field offices and four (Bamyan, Nili, Gardez, and Faizabad) outpost offices which played an instrumental role in stakeholder engagement at various levels during the HER-AF project implementation. The chiefs of these offices and the respective health and nutrition teams coordinate and meet regularly with actors at provincial level, including the governor, security authority, and provincial public health offices, local offices of implementing partner NGOs, provincial sub-cluster members to discuss planned health and nutrition activities. As part of the AAP mechanism to inform the community about the program objectives and collect their feedback and complaints, field monitoring visits and regular local stakeholder coordination plans, UNICEF staff meet regularly with health facility staff, clients in health facilities, CHWs, nutrition counsellors, Family Health Action Groups (FHAGs), social mobilizers, Health Management Shuras (HMSs), community elders, faith / religious leaders, medical associations, women's groups, etc. Through these conversations, staff solicit feedback on their satisfaction with health and nutrition services, and suggestions for how to improve service planning, delivery, and quality. Field office staff channel these insights into UNICEF's programs by sharing field visit reports with relevant sections, providing feedback during regular internal coordination meetings, and during planning processes (when developing and reviewing annual work plans) and through mid-year and annual review processes.

By leveraging the lessons learned from the HER and HER-AF projects, the implementation of the HER Second AF SEP activities will integrate and enhance stakeholder engagement initiatives. As the planning for the Second HER-AF project continues, UNICEF will build on the ongoing programme consultation and schedule dedicated stakeholder consultations in local languages with various stakeholders using the existing platforms which will include the relevant clusters, potential implementing partners, community leaders, and representatives of vulnerable groups to seek feedback and recommendations. These consultations will be documented and reported as part of the project progress report.

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

The Stakeholder Engagement Plan for Components 1 & 2 below outlines the engagement process, methods, including sequencing, topics of consultations and target stakeholders. Table 1: SEP Summary Table

Project Stage	Types of information to be disclosed	Timetable: Locations, Dates	Methods Proposed	Target Stakeholders	Targeted Reach	Responsible
Project (Second AF) Start, Mid-Term and at End of Project Reviews	Overall Project: Activities, Timeline, Targets	Within 3 months of effectiveness	**Official Meetings** and workshops at national and provincial levels: Participatory workshops where participants will be informed about the project scope, parameters and asked to support the conduct of the project components and communication to relevant beneficiaries. **Official Letter:** Correspondence to share information on new project components and request support and access to location sites	Relevant Line Ministries, Provincial and District level officials. Local authority, provincial and district level (Provincial Governors)	At least 1 meeting with MoPH at national and provincial level Provinces (Governor and PPHD) through official letter informing them about additional financing of the project and request support for implementation	UNICEF, through its implementing partners
			Community Meetings: In person involving local actors, influencers and beneficiaries representing different communities. May be joined with regular Health Management Shura meetings.	Beneficiaries, individuals, and groups (including vulnerable groups) community leaders, NGOs and CSOs, Health Management Shuras, Mobile Health Team, through nutrition counsellors and health extenders	At least 1 community within each province	UNICEF, through its implementing partners

Project Stage	Types of information to be disclosed	Timetable: Locations, Dates	Methods Proposed	Target Stakeholders	Targeted Reach	Responsible
			Social Media (Facebook, WhatsApp): Visual, written, and audio-visual content sent to a network of local actors, female only networks, and all stakeholders. UNICEF, existing channels such as UNICEF country office website and social media platform (Facebook, Instagram and twitter), Sit-Rep	Different social media platforms can be leveraged to access various stakeholder groups. Facebook may be more appropriate for communities whereas WhatsApp groups are effective in communicating with provincial, district, and facility / site-level staff and community groups (such as community volunteer networks). Targeted WhatsApp communications with specific groups	Facebook, Instagram and Twitter post announcing additional financing of project Additional Facebook posts informing the public of key project moments (start, revision, end, etc.), and results (quantity / frequency to be determined based on project communications plan) Targeted WhatsApp communications ad hoc as needed	UNICEF, through its implementing partners

			Print outs including banners, cards, posters, leaflets	Health institution managers and staff and communities	One time at beginning of project; updated ad hoc as needed if any changes made to the project	UNICEF
			Updates at Health cluster, and Nutrition cluster at national and provincial levels	Health and Nutrition Clusters (implementers)	At least one update to each relevant cluster at project start, mid-term, and end	UNICEF at national level UNICEF, through its implementing partners at Provincial clusters
			Updates at Health- STWG	Donors	At least one update to Health Development Partners at project start and end	UNICEF
			Update at HER-Coordination Committee meetings	WHO, USAID, WBG-ARTF Donors, UNDP, ADB and others	Monthly	UNICEF
Implementation	Introduction of implementing partners and request facilitation of project implementation	Once at the beginning of the additional financing of the project	**Official Letters:** Providing information about the project, partners and site**s**	MoPH	Submitted at national level to national MoPH; MoPH to inform each DoPH (once at beginning of project), MoPH to inform Provincial Governors	UNICEF
	Assessments, Monitoring, including TPM, Verification	Throughout the project implementation	In person meetings, emails and official letters	MoPH	Submitted at national level to national MoPH; MoPH to inform each DoPH (once at	UNICEF

					beginning of project), MoPH to inform Provincial Governors	
	E&S Instruments (ESCP, SEP, and ESMF)	Throughout the project implementation	**Posters, Flyers, Banners Publish documents on website / social media**	Communities in the project targeted areas; Community Health services providers; Project labor	Project staff (UNICEF, WHO, implementing partners, Service providers), health workers and communities.	UNICEF

4.1.3 Proposed strategy to incorporate the views of vulnerable groups

UNICEF will seek the views of vulnerable or disadvantaged groups identified through the following methods and measures will be taken to remove obstacles to full and enabling participation / access to information:

Table 2: Proposed Strategy to incorporate the views of vulnerable groups

Stakeholder Group	Limitations to Engagement	Measures/Resources to Facilitate Engagement
Families living in remote locations. / White Areas	• Challenges associated with transportation to engagement events / Focus Group Discussions (FGDs) / face-to-face meetings. • Limited phone and internet networks • Limited movement due to security protocols and cost associated with travel.	• Transportation costs provided to participants, where feasible • Workshops / FGDs / Key Informant Interviews (KIIs) conducted in district hubs or health facilities when possible; • Inter-agency call center, Awaaz and UNICEF hotline which is functional 6 days per week and is toll-free; and • Engagement events conducted online (where network is available) •
Women and Girls	• May feel uncomfortable sharing opinions or raising concerns in the presence of men. • Childcare / family responsibilities, social and gender norms, need for spousal permission may make it difficult to	• Create safe spaces: Provide separate forums or sessions where women and girls can freely express their opinions and concerns without the presence of men. This can foster a more inclusive and supportive environment for their active participation.

	participate in events that are far from their health facilities / homes or that are scheduled at certain times. • Many women do not have a mobile phone. • High rate of illiteracy / low education levels • Restriction on women's movement and requirement of Maharam • Morality laws restricting movement and voice	• Female facilitators conduct workshops / KIIs / FGDs, and female data collectors conduct TPM / beneficiary interviews. • Flexibility in event planning: Organize events at convenient times and locations, considering childcare and family responsibilities. Provide options such as on-site childcare facilities or virtual participation to accommodate those unable to travel far from their health facilities or homes. Locations of public consultation are close to the homes of those whose engagement is sought. • Hold small, gender-disaggregated meetings where female health workers / clients / caregivers are more comfortable asking questions or raising concerns. • Diverse communication channels: Recognize that not all women have access to mobile phones. Utilize alternative modes of communication such as community gatherings, local radio programs, or partnering with trusted community leaders to ensure information reaches a wider audience. Ensure dissemination of project information through multiple channels including radio, social media, banners, word of mouth through peer groups, female CSOs, community and religious leaders, including audio-visual materials for illiterate people / picture-based materials • Tailored information and capacity-building: Develop user-friendly educational materials, employing visual aids and simplified language to address the high illiteracy/low education levels. Conduct training sessions or workshops specifically designed to enhance literacy and empower women with necessary skills for engagement. • Advocate for women's rights: Collaborate with local authorities and community leaders to challenge and mitigate restrictions on women's movement. Raise awareness about the importance of women's participation and their right to engage in decision-making processes
Beneficiaries living with disabilities	• Challenges related to accessibility of venues, transportation, workplace, and public spaces. • Discrimination, stigma, wrong believes, using offensive language, and stereotype.	• Ensure facilities for consultations / engagement events are accessible. • Materials are produced in accessible formats Use a variety of audio-visual approaches (print, radio, television, social media, word of mouth, community, and religious leaders, etc.)

	• Inaccessible feedback mechanism • Unavailability of disability disaggregated data • Inadequate disability inclusive funding/budget • Inadequate inclusive policies, strategies, and workplans • Challenges related to meaningful participation of persons with disabilities. • Challenges related to the unavailability of some disability specific services e.g., physiotherapy services, prosthetic and orthotic services. • Format of materials and information	• Ensure call center has multiple channels of communication to allow for different communication needs
Families and communities experiencing poverty	• Cannot pay for transportation to reach engagement events. • Health is not a priority; competing agenda for limited budget, time, and attention (food and livelihood concerns are more pressing)	• Transportation costs provided to participants. • Workshops / FGDs / Key Informant Interviews (KIIs) conducted in district hubs or health facilities when possible (as close to the targeted engagement group as possible) Call center that is functional 6 days per week and is toll-free
IDPs, Returnees	• May feel unwelcome to attend events (fear of discrimination) • May not be informed about public events because they do not access host community communication channels. • May speak a different language.	• Community and religious leaders usually have a good understanding of the people living in their community and can be engaged to facilitate participation in stakeholder engagement activities. • Targeted communications aimed at IDP and returnee communities to inform them of public consultations; and • Organize separate engagement events specifically for IDP communities to ensure their needs are considered

Pastoral nomads (Kuchis)	• Mobile populations may not be informed about public events if not integrated into fixed communities	• Movement patterns are considered in planning engagement event locations; and, • Engagement with communities locally to understand the presence of these communities and the best way of reaching them.
Elderly people/those with chronic illness	• Challenges related to accessibility of venues and public spaces due to health conditions associated with ageing • Lack of understanding of the needs or challenges of the elderly	• Workshops / FGDs /KIIs conducted in district hubs or health facilities when possible (as close to the targeted engagement group as possible); • Materials produced in an accessible format for all audiences and using a variety of audio-visual approaches (print, radio, television, word of mouth, community, and religious leaders, etc.).
Women-headed households	• Economic challenges • Childcare / family responsibilities, social and gender norms • Many women do not have a mobile phone. • High rate of illiteracy / low education levels • Health is not a priority; competing agenda for limited budget, time, and attention (food, livelihood, childcare concerns are more pressing) • Restriction on their movements, because not having male relatives	• Ensure female facilitators conduct workshops / KIIs / FGDs, and female data collectors conduct TPM / beneficiary interviews; • Locations of public consultation are close to the homes of those whose engagement is sought whenever possible; • The timings of consultations do not interfere with household / family commitments / obligations; • Small, gender-disaggregated meetings are held where female health workers / clients / caregivers are more comfortable asking questions or raising concerns; • Project information is disseminated through multiple channels including radio, social media, banners, word of mouth through peer groups, female CSOs, community and religious leaders, including audio-visual materials for illiterate people; • Inter-agency call center, Awaaz, and the UNICEF hotline, which is functional 6 days per week and is toll-free: and, • Support from male household members is sought to facilitate women's movement and access to services.

The unemployed	• Cannot pay for transportation to reach engagement events. • Health is not a priority; competing agenda for limited budget, time, and attention (food and livelihood concerns are more pressing)	• Transportation costs provided to participants. • Workshops / FGDs / Key Informant Interviews (KIIs) conducted in district hubs or health facilities when possible (as close to the targeted engagement group as possible) • Call center that is functional 6 days per week and is toll-free
Youth (Adolescents)	• Health facilities are generally not adolescent- friendly; adolescents are not usually engaged as a key target group or stakeholder for health services	• Social media • U-Report • Engagement with youth within the communities • Create youth health champions

4.2 Component 3 (WFP)

4.2.1 Summary of stakeholder engagement done during project preparation

Safe, inclusive and accountable programming is at the core of WFP's intervention, ensuring integration of protection and accountability across the programme cycle with strong focus on inclusive community engagement and risk mitigation.

WFP engages with key stakeholders at the central, provincial and community level, as well as with other UN agencies, local and international NGOs, to ensure that those in need receive the right assistance at the right time in the right way. WFP co-chairs the Cash and Voucher Working Group, sits on the Strategic Advisory Groups of the PSEA Network and Gender in Humanitarian Action Group, and participates in the Nutrition Cluster, Protection Cluster and Accountability to Affected Population (AAP) Working Groups, Disability Inclusion Working Group (DIWG), Child Protection Area of Responsibility (CPAOR). Central to this engagement is supporting bi-directional dividends, including contribution to strategic planning, evidence generation, access engagement, and referrals of relevant cases, among others.

To effectively engage with communities and implement its programmes, WFP Afghanistan has six field offices and five satellite offices. WFP has an access team at country level and staff to support access negotiation teams in each Area Office that are proactively engaging and negotiating with local authorities and engaging with local communities to ensure WFP delivers food and cash-based assistance in a principled manner. WFP also engages with authorities as necessary and wherever possible to ensure the safety and security of women beneficiaries and female staff.

Communities are a central element of WFP's interventions across the programme cycle; WFP adopts a People Centered Approach and particular emphasis is dedicated to inclusive community-based targeting because of its effectiveness and efficiency, as well as contribution to transparency and sustainability. Community leaders (elders, religious leaders, women leaders, persons with disability, IDPs, minority groups, community development councils, shuras, and other relevant community bodies) in particular, are critical to the success of all of WFP's projects in Afghanistan.

The Community Food Assistance Consultations (CFAC) process is designed to empower communities and promote transparency and accuracy of process at the local level. The participants to the CFAC, trained and supported by WFP cooperating partners, represent all segments to help identify the most vulnerable households in the community as per WFP's targeting criteria. During implementation of Component 3, WFP has worked with partners and communities to facilitate women's participation in CFACs and use existing data from the nutrition cluster, national nutrition surveys and its programme monitoring data to target vulnerable pregnant and breastfeeding women and women with children under two. In-built through the verification process are additional layers of spot-checking with WFP partners and monitors where follow-up visits to assure inclusion/exclusion errors of vulnerable households are identified. Continuous efforts are made to strengthen the level of accountability and inclusiveness of these crucial community-based entities, including through the development of procedures aimed at ensuring representation of groups who are at heightened risk of marginalization, including women and persons with disabilities such as a Code of Conduct aimed at mitigating risks associated to possible misconduct with regards to community actors involved in decision making on targeting of humanitarian assistance; and increasing investments in sensitization and monitoring.

Protection and Accountability to Affected Population (AAP) is at the core to WFP's operations. In accordance with the "Do No Harm" principle and the WFP Protection and AAP Policy, protection and accountability are hinged on maintaining in-depth contextual awareness and adopting risk mitigation

approaches, establishing effective community feedback mechanisms (CFM, or WFP's GM), engaging with communities and their representative bodies (e.g. CFACs) to ensure they are aware of assistance entitlements (including duration, eligibility criteria, appeal mechanisms, redemption modalities, etc.). This allows WFP to identify risks, incorporate feedback, and address problems in a timely manner. In accordance with the WFP Protection and Accountability Policy (2020), WFP undertakes regular protection-oriented analyses of the operational context and projects to ensure they do not exacerbate potential harm to the people and communities where WFP operates and to the extent possible, contribute to their safety, dignity, and integrity. WFP also provides Protection and AAP trainings to partners and TPMs to ensure staff are providing affected populations with the safety, dignity, and integrity entitled to them at all phases of programs. For Component 3, protection risks have been analyzed at field level, both prior to the start of the project and throughout implementation, to inform further mitigation measures and adjustments to enable as much female direct access as possible and adopt mitigation measures.

A one-size-fits-all approach in community engagement would not work as communities are different from each other and different factors need to be considered to effectively and safely engage different Age, Gender and Diversity groups within targeted communities.

During project preparation and implementation of Component 3, WFP worked closely with its CPs to identify strategic entry points/allies across targeted communities to prioritize directly or indirectly reaching women as key target audience (e.g. education shuras, healthcare personnel). Relevant stakeholders were mapped to inform presence of existing structures and people and ensure as much direct outreach to women in the targeted communities as possible.

Relevant information about the project (e.g. eligibility criteria, nature of entitlements, implementation timeframe, appropriate nutrition practices, availability of CFMs, etc.) is shared across targeted communities through diversified and accessible communication channels, combining in-person (e.g. messages passed to communities through community-based representative structures, direct interaction between communities and project field staff) and remote engagement (e.g. use of radio broadcasting, WFP hotline), using written, visual and verbal communication approaches, which contributes to meet the communication needs and preferences of different Age, Gender and Diversity groups.

For the implementation of Component 3 under the first AF, brochures and posters were designed and translated into local languages (Pashto and Dari) to provide essential information about the MCBP and convey key messages to target groups. These materials are designed with culturally sensitive messaging and user-friendly illustrations to ensure easy understanding and high engagement. Posters are strategically displayed in verification, registration, and distribution sites; brochures displaying eye-catching graphics and concise text are distributed to all beneficiaries.

Community messages, translated into local languages (Dari and Pashto), were and continue to be disseminated to trained CPs, TPMs, and CFACs to facilitate direct engagement with community members, raise awareness, address concerns, and provide support to program beneficiaries. In a context where communities trust and rely mostly on word-of-mouth, passing critical information through in-person engagement with trusted community-based stakeholders enhances outreach to the intended beneficiaries.

Based on feedback received by targeted communities, community members, and CFACs expressed satisfaction about community engagement approaches adopted during Component 3, with particular emphasis on the effectiveness of communication with local authorities and CFAC members before and during the targeting process and the direct support CFAC members and other community-level bodies

were able to provide during targeting and implementation. Consultations with communities in selected districts, who requested to have distribution sites located closer to where beneficiaries lived, led to additional sites set-up to facilitate women's access.

While inclusive community engagement, AAP, and risk mitigation proved to have been operationalized successfully during Component 3, some challenges arose. Despite the described comprehensive communication with communities' efforts, awareness about WFP's CFM needs to be further strengthened across targeted communities as some beneficiaries were found not to be aware of existing channels to reach out to WFP. Moreover, broadcasting the MCBP radio drama in Warduj, Gyan and Kamdesh districts has not been possible due to the absence of radio coverage in the mentioned districts.

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

The Stakeholder Engagement Plan below outlines the engagement process, methods, including sequencing, topics of consultations and target stakeholders. The World Bank and the Borrower do not tolerate reprisals and retaliation against project stakeholders who share their views about Bank-financed projects

Table 3: Summary of the project stakeholders needs and methods, tool, and techniques for stakeholder engagement.

Project stage	Target stakeholders	Topic of consultation / message	Method used	Responsibilities	Frequency / Timeline
Preparation & Implementation Stage	National, Provincial & District level National Ministries of Public Health, Economy, Labour & Social Affairs and Deputy minister of Youth affairs, TVET Authority. Relevant or influential community and civil society such as CFAC.	Sharing information on the project scope, parameters and identify support co-planning of interventions for project sub-components and intended communication to relevant beneficiaries. Details of the project activities, targeting, locations, timelines. Roles and Responsibility clarification and assignments for local level authority. Feedback to WFP	Coordination workshops/meetings with partners including UNICEF Orientation meetings, with follow-ups and updates as necessary, for targeted provincial level influencers. Official letter Request for directive letters to targeted provinces through applicable National Ministries	WFP	Within 3 months of effectiveness
Preparation & Implementation Stage	Communities representing targeted locations:	Inform and discuss with them essential project details and locations.	Coordination Meeting	WFP	Within 3 months of effectiveness

	elders, religious leaders, local actors and influencers, beneficiaries, women leaders, persons with disability, IDPs, minority groups, community development councils, Health shuras, and other relevant community bodies.	Roles and Responsibility clarification and assignments for local level authority engagements. Explaining targeting criteria and beneficiary verification exercises. Feedback to WFP	Community Meetings (2 per province) Official letters	Implementing partners/ Cooperating Partners	
Implementation Stage	CPs Community members/ Affected people Vulnerable groups	Capacity building on Protection and AAP. Additional stakeholder identification/mapping where applicable with direct/indirect link to reaching women as key target audience (e.g. education shuras, healthcare personnel). Ensure identification and participation by key target audience. Assessments, Monitoring and TPMs verifications. Feedback to WFP	Consultation meetings Posters/banners Printouts or print media/ Flyers. Approved visual, written, and audio-visual content. Community meetings in person or over the phone TPM	WFP & Cooperating partners	One time at beginning of site activities; updated as needed, in cases of major changes made to the project Regularly

		Sharing information Increasing community support for Project activities Soliciting feedback on project performance and satisfaction Obtaining actionable information to improve programmes and operations. Community level outreach (announcements of distribution dates) Community level outreach, though partners, radios, and other broadcast and paper-based messaging to provide program updates and key messages. To ensure their participation in consultations through community level engagement and trust building To increase awareness, provide consultations and collect feedback To regularly assess and better understand ongoing and emerging needs and priorities. To prevent sexual exploitation and abuse To prevent misinformation and rumors	Inter-agency call center, Awaaz, and the WFP CFM, which is functional 6 days per week and is toll-free		

		To allow for a direct communication channel with WFP			
Implementation Stage	National and provincial Health, Livelihoods and Nutrition clusters Humanitarian development actors	Coordination of efforts to improve efficiency and avoid duplications from cluster actors. Obtain access to implementation sites. Empower communities and promote transparency and accuracy of process. Feedback to WFP Obtain information on direct impact on the ground Obtain inputs from technical specialists.	Cluster meetings (virtual or agency premises) Flyers, fact sheets, dashboards, briefing documents, sitreps, etc. Emails	WFP	Regularly as per each cluster TORs
Implementation Stage	National Ministries of PH, EC, LSA and Deputy minister of Youth affairs, TVET Authority.	Introduction of implementing partners/CPs Assessments, Monitoring and TPMs verifications Feedback to WFP	Meetings National information sharing meetings. Communication to request support and further advocacy for the project.	WFP	Once at the beginning of the project. As required throughout the project
Implementation Stage	Health Staff (Facility Managers, Health Workers)	Sharing information on project objectives and details of support to be provided	Fliers, posters, information sheets Workshops	UNICEF & WFP through cooperating partners	Before each quarterly distribution

		Soliciting feedback	GM hotlines U-Report Satisfaction surveys Extenders TPM		
Implementation Stage	Humanitarian and Development actors supporting work in the targeted areas	Information sharing Obtain feedback to WFP. Feedback collection through meetings and touch- bases with WFP and UNICEF partners on the ground, as well as other humanitarian and development actors	Virtual meetings, meetings at agency premises Partner meetings and calls Flyers, fact sheets, dashboards, briefing documents, sitreps	WFP & Cooperating Partners	As required throughout the project

4.2.3 Proposed strategy to incorporate the views of vulnerable groups

The project will seek the views of *vulnerable or disadvantaged groups identified* through the following methods. The following measures will be taken in order to remove obstacles to full and enabling participation / access to information:

WFP is committed on accountability to affected people and processes to incorporate the views of people and communities where we operate, and assist are established throughout programmes. WFP will always ensure that vulnerable individuals, groups, or communities are identified, purposefully consulted, and adequately represented by engaging directly, through cooperating partners, local representatives and having mechanisms in place for vulnerable groups to reach WFP, like community consultations to inform the design, as well as the Community Feedback Mechanism (CFM). In addition to a team in the WFP Country Office that works on Protection, Disability Inclusion, Community Engagement and the CFM, WFP also has a system of Protection, AAP, and Gender (PGAAP) dedicated staff from each Area Office to support the implementation of our community engagement efforts, which encompasses information provision to beneficiaries, beneficiary engagement and participation, and feedback and complaints.

WFP and its cooperating partners will share project information and receive feedback on the content of the project as well as the related processes to targeted stakeholder audiences, including vulnerable groups, as defined throughout this document.

Information sharing could use a combination of different channels as found suitable for each specific project component and stakeholder. These can include face-to-face meetings where applicable and accompanied by information shared via radio or other relevant broadcast-based media, posters, brochures, banners, leaflets, audio messages, on-site helpdesks and keeping in mind the variations of languages spoken by the communities where we operate.

WFP has a well-established grievance mechanism (GM), and collaborate closely with Awaaz, the inter-agency call center. This allows beneficiaries to raise any feedback or concern on the project to the implementers. This will also provide a channel for vulnerable groups to raise any concerns in a confidential manner and ensure they are addressed.

Table 4: Tailored Stakeholder Engagement Measures (Disadvantaged/Vulnerable Individuals or Groups) for Component 3 activities.

Stakeholder Group	**Limitations to Engagement**	**Measures/Resources to Facilitate Engagement**
Families living in remote locations. / White Areas	• Challenges associated with transportation to engagement events / Focus Group Discussions (FGDs) / face-to-face meetings. • Limited phone and internet networks • Limited movement due to security protocols	• Workshops / FGDs / Key Informant Interviews (KIIs) conducted in district hubs or health facilities when possible; • Inter-agency call center, Awaaz, and the WFP CFM, which is functional 6 days per week and is toll-free; and • Community level outreach, though partners, radios and other broadcast and paper-based messaging to provide program updates and key messages.
Women and Girls	• May feel uncomfortable sharing opinions or raising concerns in the presence of men. • Childcare / family responsibilities, social and gender norms, need for spousal permission may make it difficult to participate in events that are far from their health facilities / homes or that are scheduled at certain times. • Many women do not have a mobile phone.	• Engagement with authorities as necessary and where possible to safely secure female facilitators to conduct workshops / KIIs / FGDs and female data collectors conduct TPM / beneficiary interviews; • Locations of public consultation are close to the homes of those whose engagement is sought; • Timings of consultations do not interfere with household / family commitments / obligations; • Small, gender-disaggregated meetings are held where female health workers / clients / caregivers are more comfortable asking questions or raising concerns, e.g., homes of women leaders or respected senior women in communities;

	• High rate of illiteracy / low education levels • Restriction on women's movement	• Project information disseminated through multiple channels including radio, social media, banners, word of mouth through peer groups, CFACs, female CSOs, community and religious leaders, including audio-visual materials for illiterate people/ picture-based materials and in local languages; and, • Material produced is informed by the needs of women and children benefitting from the program.
Persons with Disabilities and organizations of persons with disabilities	• Challenges related to accessibility of venues, transportation, workplace, and public spaces. • Discrimination, stigma, wrong beliefs, using offensive language, and stereotype. • Inaccessible feedback mechanism • Unavailability of disability disaggregated data • Inadequate disability inclusive funding/budget • Inadequate inclusive policies, strategies, and workplans • Challenges related to meaningful participation of persons with disabilities. • Challenges related to unavailability of some disability specific services e.g., physiotherapy services, prosthetic and orthotic services. • Format of materials and information	• Engagement with persons with disabilities and representative organizations (OPDs) to ensure inclusiveness and outreach of the programs. • Ensure Disability Inclusion is an integral part of the capacity building trainings and awareness raising campaigns; • Materials and information are produced in accessible formats using at least audio and video formats; • CFM channels are accessible for persons with differing disabilities; • Regular collection and reporting of data based on Sex, Age, Disability; • Policies, strategies, and workplans are disability inclusive, aligned with WFP and relevant international policies and strategies; • Use of a variety of audio-visual approaches (print, radio, television, social media, word of mouth, community, and religious leaders, etc.)
Families and communities experiencing poverty	• Cannot pay for transportation to reach engagement events. • Health is not a priority; competing agenda for limited budget, time, and	• Workshops / FGDs / KIIs conducted in district hubs or health facilities when possible (as close to the targeted engagement group as possible); • Inter-agency call center, Awaaz, and the WFP CFM, which is functional 6 days per week and is toll-free;

	attention (food and livelihood concerns are more pressing)	• Cooperating Partners helpdesks at distribution sites are available to provide information and receive community feedback; • CFAC members support in circulating key messages to community people; and, • Community level outreach, though partners, radios and other broadcast and paper-based messaging to provide program updates and key messages.
IDPs, Returnees, religious and ethnic minorities	• May feel unwelcome to attend events (fear of discrimination) • May not be informed about public events because they do not access host community communication channels. • May speak a different language.	• Community, religious leaders, and CFACs' participants to be engaged leveraging their good understanding of the people living in their community to facilitate participation in stakeholder engagement activities; • Targeted communications aimed at IDP and returnee communities to inform them of public consultations; and, • Targeted communications and outreach to minority communities to inform them of public consultations.
Pastoral nomads (Kuchis)	• Mobile populations may not be informed about public events if not integrated into fixed communities	• Movement patterns are considered in planning engagement event locations; and, • Engagement with communities and authorities locally to understand the presence of these communities and the best way of reaching them.
Elderly people/those with chronic illness	• Challenges related to accessibility of venues and public spaces due to health conditions associated with ageing	• Workshops / FGDs /KIIs conducted in district hubs or health facilities when possible (as close to the targeted engagement group as possible); • Materials produced in an accessible format for all audiences and using a variety of audio-visual approaches (print, radio, television, word of mouth, community, and religious leaders, etc.).

Women-headed households	• Economic challenges • Childcare / family responsibilities, social and gender norms • Many women do not have a mobile phone. • High rate of illiteracy / low education levels • Health is not a priority; competing agenda for limited budget, time, and attention (food, livelihood, childcare concerns are more pressing) • Restriction on their movements, because not having male relatives	• Engagement with authorities as necessary and where possible to safely secure female facilitators conduct workshops / KIIs / FGDs, and female data collectors conduct TPM / beneficiary interviews; • Locations of public consultation are close to the homes of those whose engagement is sought whenever possible; • Timings of consultations do not interfere with household / family commitments / obligations; • Small, gender-disaggregated meetings are held where female health workers / clients / caregivers are more comfortable asking questions or raising concerns; • Project information is disseminated through multiple channels including radio, social media, banners, word of mouth through peer groups, female CSOs, community and religious leaders, including audio-visual materials for illiterate people/ picture-based materials; • Inter-agency call center, Awaaz, and the WFP CFM, which is functional 6 days per week and is toll-free: and, • Support from male household members is sought to facilitate women's access to services.
The unemployed	• Cannot pay for transportation to reach engagement events. • Health is not a priority; competing agenda for limited budget, time, and attention (food and livelihood concerns are more pressing)	• Workshops / FGDs / KIIs conducted in district hubs or health facilities when possible (as close to the targeted engagement group as possible); • Inter-agency call center, Awaaz, and the WFP CFM, which is functional 6 days per week and is toll-free: and, • Community level outreach, though partners, radios, and other broadcast and paper-based messaging to provide program updates and key messages.

Socio-economically marginalized Youth, especially those who are out of education and employment	• Low literacy due to limited education opportunities • Lack of expertise and financial resources to launch and maintain income generating activities • Social challenges due to idleness, social pressure, frustration, with heightened risks of adoption of antisocial behaviors (e.g. substances abuse, family violence, criminal activities, etc.) and other negative coping mechanisms (e.g. irregular migration).	• Develop solid targeting criteria and effective communication with communities approaches about the Youth component to mitigate risks related to possible intra-HH and inter-HH/community tensions. • Ground selection of training opportunities and related income generation activities on solid market assessments. • Engage representatives of women and persons with disabilities (e.g. OPDs) in the selection of training and income generating opportunities to ensure safety and accessibility. • Account for context-specific socio-cultural norms and restrictive normative framework to identify activities that can be attended by female youth, for which restrictions might be perceived as particularly stringent. • Leverage youth's familiarity with social media and technologies to pass information about the project, receive feedback and complaints, facilitate learning and income generation opportunities.
Youth (Adolescents)	• Health facilities are generally not adolescent- friendly; adolescents are not usually engaged as a key target group or stakeholder for health services	• Social media; • Engagement with youth within the communities; • Engage/add youth to CFACs; • Inter-agency call center, Awaaz, and the WFP CFM, which is functional 6 days per week and is toll-free; and • Community level outreach, though partners, radios and other broadcast and paper-based messaging to provide program updates and key messages.

5 Resources and Responsibilities for implementing stakeholder engagement

5.1 Implementation Arrangements and Resources

UNICEF and WFP will implement activities assigned to each in the Project Paper either directly or through partnership agreements with NGO implementing partners/Cooperating partners, as per their respective Grant Agreements. Each Agency will define its own management structure to implement the Project that will oversee the Project activities.

UNICEF and WFP will prepare and submit to the World Bank progress reports as specified in their respective Grant agreement, which will contain updates on the SEP as relevant.

UNICEF and WFP will be responsible for carrying out their respective stakeholder engagement activities for the project, and for ensuring their respective NGO implementing partners/Cooperating partners carry out stakeholder engagement activities at relevant levels (provincial and community). The stakeholder engagement activities will be documented as part of each agency's project progress reporting requirements, and as indicated in the Environmental and Social Commitment Plan (ESCP).

The budget for the SEP is an integral part of the project and the WFP Afghanistan wider activities as supported by other partners. The budget for stakeholder engagement activities is not a stand-alone budget line but is integrated into the budgets provided to the Cooperating Partners, who will be conducting the engagement activities throughout the implementation of the project, supported by relevant technical experts.

6 Grievance Mechanism

A Grievance Mechanism is a system that allows not only grievances, but also queries, suggestions, positive feedback, and concerns of project-affected parties related to the environmental and social performance of a project to be submitted and responded to in a timely manner.

6.1 Description of UNICEF Grievance Mechanism (GM)

Promotion of accountability, community engagement and participatory communication (two-way) between the affected population and Service Providers involved in the project, will be part of the integrated services delivery. It will support accessible, and inclusive AAP approaches, processes, mechanisms, and systems by strengthening the community feedback and empowering communities expressing their views of their experiences of the implementation of the project. This component will be integral for all the above components to ensure that implementors involved remain accountable to the people they serve.

In the context of the country, empowering communities as active beneficiaries and recipients of the aid and services provided by the project will reinforce their social accountability and generate demand for quality services.

The parent project has established comprehensive GM mechanisms implemented under the project through, and this will continue will cover the HER AF2 components.

The parent project GM has a two-tiered structure:

Partner (Service Provider) Decentralized GM

Service Providers manage grievance mechanisms at the local level to ensure contextual appropriateness and community engagement. Service Providers are required to have GM SOPs, site level registers and focal points, uptake channels, site level registers and visibility materials posted at the facility level. Service providers are required to train staff on GM SOPs, ensure stakeholders are aware of the GM and how to submit grievances.

UNICEF Centralized GM

UNICEF has established a central mechanism. The use of a toll-free call center and an information management system (MIS) provides a strong backbone for real-time grievance logging and tracking. This approach is critical for national coverage and allows for centralized independent oversight on grievance trends and sensitive cases, like SEA (Sexual Exploitation and Abuse) and fraud.

The presence of a Risk Management Committee (RMC) in UNICEF Afghanistan and escalation procedures to UNICEF's Office of Internal Audit and Investigation (OIAI) ensures that sensitive issues are handled with due diligence. Technical support to Service Providers for GM system strengthening is crucial to maintain alignment across both levels of the mechanism.

Table 5: Illustrative Table on the GM Steps-Component 1 and 2

Step	Description of process (e.g.)	Timeframe	Responsibility
Grievance uptake	Centralized: • Toll-free telephone hotline: [*455*] operated by UNICEF call centre 7 days / week. 7am-7pm. 50% female agents. • Sensitive grievances: AFG-RMC-Secretariat@unicef.org (UNICEF Afghanistan Risk Management Committee) afgpsea@unicef.org (UNICEF Afghanistan SEA) integrity1@unicef.org (UNICEF HQ) • In-person reporting to UNICEF staff (zonal offices, monitoring visits) Decentralized: • Service providers are required to operate a minimum of 2 culturally and contextually appropriate grievance uptake channels at the facility level. • Examples include in-person grievance desks, hotlines, suggestion boxes, emails and social media.	Upon Receipt of grievance	Centralized: UNICEF Decentralized: Service provider site focal points

Step	Description of process (e.g.)	Timeframe	Responsibility
Sorting, processing	Centralized: Complaints are logged in the GM MIS according to project categories (Social Safeguarding, Environmental Safeguarding, Procurement, Potentially Sensitive, Service Provision) where they are immediately route grievances to subject matter experts for review based on the nature of the complaint. Decentralized: Any complaint received is forwarded to Service Provider focal person; categorized and logged in the GM register using the above-mentioned categories.	Upon receipt of grievance	Centralized: UNICEF Decentralized: Service Provider site grievance focal points
Acknowledgment and follow-up	Centralized: Receipt of the grievance is acknowledged to the complainant by the UNICEF Call centre and/or UNICEF reviewer. Decentralized: Receipt of the grievance is acknowledged to the complainant by the Service Provider GM focal person where the complaint is reviewed.	Immediately upon receipt or within 7 days depending on the uptake channel	Centralized: UNICEF Decentralized: Service Providers site grievance focal points
Verification and action	Centralized: Verification and action on complaints is carried out by UNICEF subject matter experts. UNICEF reviews and verifies all sensitive cases (SEA, Fraud, Corruption etc). Escalation to OIAI is carried out according to UNICEF policy and procedure. Non-sensitive cases are reviewed, verified, and approved by relevant UNICEF staff. Decentralized: All sensitive grievances are escalated to UNICEF within 24 hours. Verification and resolution of non-sensitive grievances takes place at the facility level. Where this is not possible, grievances are escalated internally to the Service Provider grievance committees.	Varies based on the nature and complexity of the grievance. Non sensitive complaints: Review within 10 working days. Verification varies based on nature and complexity of the grievance.	Centralized: UNICEF Decentralized: Service Providers site focal points and/or National / Provincial Grievance Committees
Monitoring and evaluation	Centralized:	Real time	Centralized: UNICEF

Step	Description of process (e.g.)	Timeframe	Responsibility
	Data on complaints are collected in the GM MIS. Monitoring is real time and conducted using a dashboard and reports used internally and externally for donors progress reports. Decentralized: GM reporting is submitted to UNICEF monthly. Service provider GM performance is monitored through the reporting dashboard for use in performance reviews, coordination forums and donor progress reporting.	Monthly	Decentralized: Service Providers
Provision of feedback	Feedback from complainants regarding their satisfaction with complaint resolution is collected through the call centre.	After resolution on a case-by-case basis	
Training and community engagement	Centralized: Training is provided to the UNICEF staff, UNICEF call centre, and service provider management and SP focal points. Decentralized: The Service Provider staff are responsible for cascading GM training to field-level staff on the GM SOPs, GM registers, escalation process and reporting framework. SPs are responsible for informing the community of the GM and call centre.	Throughout implementation	Centralized: UNICEF Decentralized: Service providers
Appeals process	Centralized: Non sensitive grievances can be forwarded to the call center for feedback. If the complainant is not satisfied with the resolution, the call center will reopen the case, noting the cause of dissatisfaction. The al process will be initiated again, and a fair resolution acceptable to the complainant will be provided. Decentralized: Service provider grievance al committee addresses the grievance, and the GM focal points provide feedback to the complainant. If the complainant is not satisfied with the resolution, the GM focal person reopens the case with the reason and comments from the complainant regarding their dissatisfaction, and the case goes through the al process again to provide a fair response to the complainant.	As Applicable	Centralized: UNICEF Decentralized: Service providers

The Grievance Mechanism is accessible to communities, beneficiaries, and project workers to voice their concerns. Project workers may seek resolution related to labor practices, working conditions, and any grievances they may encounter during their employment. It is designed to be accessible, confidential, and responsive, ensuring that all complaints are handled fairly and promptly.

The GM is sensitive to handling SEA/SH complaints, including the option of reporting anonymously, a response and accountability protocol including referral pathways to connect survivors with needed SEA services. These grievances are categorized in a dedicated grievance category accessible only to the SEA Specialist and SEA Focal Points.

The management of these grievances follow the procedures established by UNICEF at the global level.

Overview of Grievance Mechanism under HER Additional Financing

The primary issue raised (71%) during the project revolved around salaries and labor contracts. Insufficient salary amounts, driven by exchange rate fluctuations, led to lower-than-expected compensation in 2023. In response, UNICEF worked with service providers to realign budgets where feasible and recommended utilizing Quality of Care (QoC) resources to cover any salary shortfalls.

UNICEF also received complaints (7%) regarding the lack of essential medical equipment and supplies. In response, UNICEF has developed a guidance note on the hybrid procurement model to clarify procurement responsibilities of UNICEF and SPs. In addition, UNICEF is developing a system to distribute medicines to SPs every quarter based on the SPs consumption data.

Lessons Learned

Establishing a robust Grievance Mechanism (GM) requires considerable investment, particularly in human resources. Beyond system setup, ongoing support, training, and stakeholder engagement are essential. Ensuring that the right team is in place is critical to maintaining smooth GM operations and effectively addressing stakeholder needs. In addition, service providers require adequate budget allocations to ensure the effective implementation of the mechanism at the community level.

While UNICEF has successfully trained partner staff and significantly increased awareness of the Grievance Mechanism (GM) at provincial, district, and health facility levels, challenges remain in extending this awareness to the community level. Ensuring that GM minimum requirements are fully implemented at health facilities—such as displaying visibility materials and conducting awareness sessions within communities—requires further attention. UNICEF will continue to improve the cascading of training through service providers to enhance GM visibility and engagement at the grassroots level.

Implementing bi-weekly clinics for programme staff has been an effective strategy for maintaining consistency in grievance resolution. These sessions provide opportunities for continuous learning, sharing of best practices, and collaborative problem-solving, helping to ensure that the GM remains responsive and effective.

Description of WFP Grievance Mechanism (GM)

For WFP, AAP one of the key principles in protection mainstreaming and is a practical way to contribute to protection outcomes. AAP is defined by WFP as ‘an active commitment to give account to, take account

of, and be held to account' by people negatively affected by food and nutrition insecurity, or who face barriers to participation or access in food security interventions. WFP Afghanistan has an active approach to AAP implemented through community feedback mechanisms (hotline, email, helpdesks, and M&E), inclusion (through engaging with diverse populations throughout WFP activities), and information and knowledge management (through presentation of feedback data via dashboards and with interagency systems).

WFP's Grievance Mechanism, called Community Feedback Mechanism (CFM) is currently comprised of a toll-free hotline that can be reached via phone a dedicated email address, and helpdesks at project sites. This enables beneficiaries, regardless of literacy levels, to raise concerns or offer feedback on the operation, targeting, and entitlements with an element of anonymity. The hotline is operated by both female and male staff in line with Afghan cultural protocols, who speak both national languages (Pashto and Dari). Beneficiaries, partners, and others can confidentially call the direct line to provide feedback, comments, or report a concern about any WFP supported operation. The CFM has an established structured and SOP to systematically and consistently in-take, handle, escalate and resolve cases. In addition, the mechanism also has an information management and reporting system that enables case tracking, reporting and ad-hoc analysis, e.g., to look at specific issues in a specific location, assess rumors, undertake perceptions surveys. All operators are trained to handle sensitive cases and be survivor-centered, particularly when receiving and escalating GBV, SEA and other cases of misconducts.

WFP also encourages communities to utilise **Awaaz Afghanistan's inter-agency toll-free hotline**, which regularly refers to and receives relevant cases from WFP for follow-up.

Wherever possible, helpdesks managed by WFP's cooperating partners are also available at registration and distribution sites to provide information and collect feedback. In efforts to standardize and systematize helpdesk management practices across distribution points, WFP developed a new helpdesk management toolkit for CPs in 2024, which includes a technical guidance, case in-take forms and procedures, FAQs, visibility products and a training package. The helpdesk process is electronically linked to site-based data collection platform, enabling real time registration and resolution of questions raised through helpdesks. WFP completed CP capacity strengthening efforts across all area offices with the aim of equipping CPs' field staff across implementation areas with the required knowledge and tools to implement safe and inclusive programming and effective helpdesk management.

The majority of the cases WFP receives through the CFM are requests for information – such as targeting, distribution dates, distribution locations, amount, and other questions that people or communities have about our projects. These are immediately answered by the operators.

Request for information comprise between 95 to 99% of the calls each month and operators have with them the programmatic information to answer these questions. The WFP operators are also trained on the various modalities through which WFP provides assistance and can guide beneficiaries over questions they may have, including on receiving cash transfers from financial Service Providers. Operators have full information on the MCBP to be able to address any specific question. In case the CFM operator is unable to answer the questions a beneficiary asks, or the issue requires further enquiry, then the issue is escalated to the relevant department, which could be in the WFP Country Office or also in an Area Office of WFP across the country. Depending on the type of issue, cases are prioritized in terms of escalation:

- High Priority (to be responded in 24 hours): e.g. PSEA, GBV, Fraud, Diversion
- Medium Priority (to be responded within 3 days): e.g., Distribution Site Issues, Inclusion Requests, HH coming with Distribution Point but are not on the Distribution List
- Normal Priority (to be responded within 7 days): e.g., Request for information to which operators don't have an answer (e.g., distribution round, targeting), suggestions to WFP (e.g., about location of Distribution Point.

Labour Grievance Mechanism

The CFM covers all programmatic areas of WFP in Afghanistan, including Component 3. WFP does not have project-based CFMs but rather ensures that the system in place leverages a programme-based one that covers all areas of work and is **accessible to all project stakeholders, from community members to beneficiaries and project staff**.

Grievance Mechanism for SEA Grievances

In line with WFP Executive Director's Circular 30 May 2023 OED2023/011 ('ED Circular'), all staff, contractors, and partners of WFP are obliged to abide by a 'Zero Tolerance for Inaction' approach to SEA, meaning they must not commit SEA and must escalate any suspicion, rumor, or report of SEA to WFP's Office of the Inspector General – Investigations (OIGI) immediately for further investigation.

WFP Afghanistan's CFM, which is toll-free, contains safe and accessible channels for communities and victims/survivors to report SEA allegations and GBV. All CFM hotline operators and staff are trained in SEA and GBV case intake and escalation. WFP sets no limitations on who can make a SEA or GBV report to the CFM (whether a victim/survivor, community member, contractor, partner, WFP staff, or other person). Regardless of their identity, the personal details of complainants may only be stored and shared by the CFM with the complainant's informed consent. Personal details are then only ever shared on a need-to-know basis; for escalation to OIGI (in the case of SEA) and for securing survivor support services where requested.

WFP CFM operators, as well as staff and partners who receive disclosures in the field, are required to ask at the point of complaint whether survivor support services are requested, and complainants may additionally request these services at any point after the point of disclosure. Complainants (whether a victim/survivor or third party), have the option of either being put in touch with service providers directly by WFP or being provided with a service provider contact number. Service requests are escalated to WFP Afghanistan's Lead PSEA Focal Point and their Alternate in the WFP Afghanistan Country Office, for identification of available services through liaison with the Interagency GBV Sub Cluster.

WFP has a team of focal points for protection from sexual exploitation and abuse (PSEA) in each area office, as well as the country office, and a Standard Operating Procedure on PSEA which includes risk analysis, awareness raising for staff, partners, contractors and beneficiaries, participation in interagency meetings on PSEA, complaints handling and survivor assistance. WFP has mandatory online training in PSEA and provides annual staff refresher sessions and training of focal points.

All investigations into SEA, including follow-up action, are managed by WFP's OIGI. WFP staff (including CFM operators and staff), partners and contractors are strictly prohibited from initiating any investigation themselves.

In addition, WFP also works closely with Awaaz, the inter-agency call-center, to, following appropriate consent and safe escalation processes, refer and receive any SEA and GBV case.

Implementation of WFP GM for HER-AF

WFP maintained a robust Community Feedback Mechanism (CFM, or GM) throughout the implementation of the first additional financing, comprising multiple communication channels for affected populations, including both beneficiaries and non-beneficiaries, to safely provide feedback, raise complaints, or seek answers to their queries. CFM/GM channels include WFP's toll-free hotline, which can be reached via phone, short message service (SMS), or a dedicated email address; CP helpdesks available at distribution sites to provide information and respond directly to queries from community members; and in-person with WFP or CP staff.

Most cases received through WFP's hotline between January and August 2024 related to requests for information and assistance (e.g. information requests around targeting criteria and types of support, how to enrol for assistance, etc.). These types of cases are usually solved on the spot ("First Case Resolution") by CFM operators. A much smaller portion of CFM cases - such as complaints about exclusion from assistance, allegations of misconduct, etc. - require follow-up actions. These cases are referred to pre-identified focal points, individually verified, and resolved. Established case handling procedures, analysis and reporting enable high levels of answerability, effective case handling, and evidence-based analysis contributing to informing decision-making on required operational adjustments.

Overall, UNICEF and WFP established specific protocols to refer cases and, following data protection procedures, share feedback and complaints-related data for seamless support for both components. Primarily, this is undertaken through Awaaz, the interagency call-center in Afghanistan, which has referrals and data sharing protocols with all relevant agencies in Afghanistan. Cases that WFP receives about UNICEF's project activities are, through the consent of the case lodger, referred to Awaaz for further referring to UNICEF, and vice versa for cases that UNICEF receives about WFP's project activities.

Table 6: Illustrative Table on the GM Steps-Component 3

Step	Description of process (e.g.)	Timeframe	Responsibility
GM implementation structure	WFP Afghanistan CFM is a two-way communication mechanism established and managed centrally at the CO. The CFM has a dedicated team of 26 operators, one Information Management Officer, and one CFM Manager. Helpdesks are established across distribution points and are operated by WFP's Cooperating Partners. CFM focal points responsible for case verification and follow-up are established across WFP's Area Offices. The CFM, as part of WFP's AAP and Community Engagement commitments, falls under the Protection and AAP Unit	Daily	WFP and CPs

Step	Description of process (e.g.)	Timeframe	Responsibility
	headed by the Head of Protection and AAP.		
Grievance uptake	Grievances can be submitted via the following channels: Toll-free telephone hotline: 0790 55 55 44 (toll-free, from Sunday to Thursday, from 8am to 4pm) operated by Afghanistan CFM Short Message Service (SMS) to 0790 55 55 44 E-mail to wfp.afg@wfp.org In-person Helpdesks placed at the distribution sites All CFM cases are registered by CFM operators based on a standard case in-take form that captures all required details related to the CFM user, the case categories, the case description, etc.	Daily	CFM operators
Sorting, processing	Feedback and complaints coming through various CFM channels are logged in to SugarCRM (corporate tool), categorized based on the WFP CFM global standard categories and Afghanistan-specific sub-categories, and, whenever follow up and verification are needed, are internally escalated to respective activity managers/focal points at the Area Offices. Main category types are: Requests for information; Requests for assistance; Requests for non-WFP services; Complaints; Data requests; Access, safety and security threats; Allegations of misconduct; Observations and suggestions; Interaction issues. Priority levels are assigned to all received cases and related escalation logics reflect assigned categorization and prioritization criteria. Relevant focal points for case follow-up and verification are pre-identified based on geographic and thematic criteria. Cases that do not require further action (e.g. requests for information, positive feedback) are addressed directly by CFM operators based on available information and, if the	Upon receipt of feedback and/or complaint	CFM operators, CFM Manager

Step	Description of process (e.g.)	Timeframe	Responsibility
	CFM user is satisfied about the received feedback, are closed on the spot (so called First Case Resolution – FCR).		
Acknowledgement and follow-up	Each single feedback and complaint received through any CFM channel is acknowledged by the same operators who receive the case and logged into the central database.	Escalated at the time of intake, however, the verification may take time	CFM operators
Verification, investigation, action	Received feedback and complaints that necessitate follow up and verification are internally escalated to relevant activity managers/focal points at both the Country Office and Area Offices. The outcome of the verification and action taken to address the query is inputted back in the system to trigger case resolution and closure. Upon receipt of the system notification related to the case verification and action taken, the CFM team communicate back with the user/complainant to close the loop and close the case in the system, unless futher action is requested/feasible. Cases that fall under the definitions of allegations of misconduct are escalated to OIGI who is then responsible for the investigation processes.	Activity manager s/focal point act within the case priority (High, Medium, Normal). The resolution vary depending on the nature of the case, location, etc.	CFM operators, CFM focal points at CO and AO level, CFM Manager
Monitoring and evaluation	Data on complaints are collected in SugarCRM, WFP's corporate information and case handling system, analyzed on a regular basis and reported to relevant stakeholders (e.g. WFP's programme and management, donors) every month and upon ad hoc request.	Monthly and upon ad hoc request	CFM and M&E teams at CO level
Provision of feedback	Users' satisfaction from the information provided and/or follow up and action taken by WFP and its partners is collected at the time of case resolution as part of the loop closure, and it is systematically recorded in CFM database. Moreover, feedback from complainants regarding their satisfaction with complaint resolution is collected through	Monthly and quarterly	CFM and M&E teams

Step	Description of process (e.g.)	Timeframe	Responsibility
	regular quality assurance exercises carried out by the CFM team on a monthly basis with a randomized sample of CFM users as well as through monitoring exercises.		
Training	CFM Operators are frequently updated and provided with refresher training on programmatic updates and revised in-take and escalation requirements whenever changes are introduced. The CFM also maintains a standard messaging repository/FAQs which is frequently updated for the CFM team to use to respond to users' queries. With the recent introduction of a new helpdesk management technical guidance package, CP operators were trained on the new requirements.	Monthly and whenever changes are introduced	CFM team
If relevant, payment of reparations following complaint resolution	n/a		
Appeals process	Community members across targeted communities are extensively informed about all relevant details related to participation in WFP's programmes, including on targeting criteria, nature, duration and timing of assistance, how to submit appeals related to inclusion/exclusion errors, etc. Appeals received through the CFM are logged in by CFM operators as complaints and immediately referred internally to relevant CFM focal points (e.g. vulnerability assessment and programme focal points) for further verification. Based on the results of verification and action taken, CFM operators communicate back to the CFM users to close the loop. The CFM maintains a standard messaging repository where standard responses for frequently asked questions, appeal processes, targeting criteria, how to register for WFP assistance, etc., are documented and	During targeting	CFM operators, vulnerability assessment and relevant programme teams

Step	Description of process (e.g.)	Timeframe	Responsibility
	used to guide users on the appeal process. CFM operators are regularly briefed on how to pass this information to CFM users and updated whenever programmatic changes occur. Based on case verification, it can happen that an appeal related to an exclusion error is found substantiated as the complainant was eligible to receive WFP assistance and was erroneously excluded; in this case the complainant would be typically included for assistance. However, exclusion complaints are often found to be not substantiated as complainants, despite being vulnerable, do not meet targeting criteria; in this case, CFM operators provide the required explanation to the complainants and close the case.		

7 Monitoring and Reporting

7.1 Summary of how SEP will be monitored and reported upon (including indicators)

The SEP is monitored based on both qualitative reporting (based on progress reports) and quantitative reporting linked to results indicators on stakeholder engagement and grievance mechanism performance.

SEP reporting will be done as part of regular narrative progress reports, including qualitative and quantitative reporting on the overall activities undertaken as part of stakeholder engagement commitments, including on:

i. Qualitative reporting on the feedback received during stakeholder engagement activities, in particular (a) issues that have been raised that can be addressed through changes in project scope and design, and reflected in the basic documentation such as the Project Appraisal Document (PAD), ESMF, or GBV/SEA/SH Action Plan, if needed; (b) issues that have been raised and can be addressed during project implementation; (c) issues that have been raised that are beyond the scope of the project and are better addressed through alternative projects, programs or initiatives; and (d) issues that cannot be addressed by the project due to technical or jurisdictional issues.

ii. Quantitative reporting based on the indicators developed to measure the implementation of the SEP. A set of indicators for monitoring and reporting for component 1 and 2 is included in Annex 3.

iii. For Component 3, quantitative reporting linked to results indicators includes an intermediate results indicator on the percentage of grievances, complaints, and inquiries related to the MCBP intervention that are addressed within the timeline outlined in the project operations manual

(target of 80%). Monitoring and reporting of GM cases will follow the process described in Table 6 above.

7.2 Reporting back to stakeholder groups

The SEP will be revised and updated as necessary during project implementation. Summaries and internal reports on public grievances, enquiries, and related incidents, together with the status of implementation of associated corrective/preventative actions will be collated by responsible staff and referred to the respective UNICEF and WFP project managers.

Specific mechanisms to report back to the stakeholders include the following: phone calls and SMS to complainants, community consultations and informal or formal meetings. This reporting back to the stakeholders is performed upon grievance resolution, in the next community meeting, or as needed.
Specific mechanisms to report back to the stakeholders for Component 3 include the following:

- Aggregated analysis of CFM cases related to MCBP, including number and type of cases, geographic concentration, resolution status, possible red flags. This analysis will be presented to the stakeholder group through a dedicated dashboard on a monthly basis;
- Engagement with community members and their representative bodies, especially the CFACs, will be ensured on a regular basis, before, during, and after distributions. CPs engage with relevant community-based stakeholders through dedicated consultations before distributions. Any community-level issues that might arise during these consultations will be shared with WFP and adequate measures will be implemented, as much as possible, to address raised issues. The same community-level stakeholders will be informed about measures adopted during the next pre-distribution consultations related to the following distributions.
- Possible individual cases that might be raised during community consultations will not be discussed publicly, instead, interested individuals will be encouraged to access available CFM channels, for which the loop closure procedures described earlier will apply.

Annexes

- Annex 1. Template to capture minutes/records of consultation meetings
- Annex 2. Monitoring and Reporting on the SEP

Annex 1: Template to Capture Consultation Meetings

The below Table presents a template, in which the results of consultation meetings can be captured throughout project implementation.

Template to Capture Consultation Summaries for Component 1 and 2 and 3.

Stakeholder(s)	Date	Location	Number of Female participants	Number of Male participants	Total number of participations	Participation of vulnerable groups	Summary of Feedback	Response of Project Implementation Team	Follow-up Action/Next Steps

Annex 2: Monitoring and Reporting on the SEP

The below Tables presents key indicators and evaluation questions for monitoring activities in relation to the SEP implementation under the components 1 and 2.

SEP Performance questions	Indicators	Data Collection Method
- How quickly/effectively are the grievances resolved? Are grievances resolved according to the processing and resolution time?	- Percentage (%) of complaints resolved in 45 days or less through UNICEF GM.	GM MIS records
- How many stakeholder groups were consulted throughout project implementation? - How many people were engaged in consultation activities?	- Number (#) of meetings with stakeholders at national, provincial level (includes the cluster meetings, meeting with MoPH and PPHDs and meeting with Partners). - Number (#) of meetings at community level (health facilities, health shuras and others). - Number of participants in community meetings, consultations, etc. disaggregated by gender, vulnerable group, etc.	- List of meeting participants - Munities of meetings. - Evaluation forms. - Social media/traditional media entries on the project results - Face-to-face meetings and/or Focus Group discussions with Vulnerable Groups or their representatives. - Meeting summary template