Republic of Malawi

Malawi Emergency Operation to Protect Essential Health Services (P180231)

DRAFT STAKEHOLDER ENGAGEMENT PLAN (SEP)

This existing COVID-19 SEP was initially approved and disclosed on 19 June 2020 and was updated for Additional Financing II (AF 2) in May 2022, will be updated for this project.

November 2022

EXECUTIVE SUMMARY

As the COVID-19 pandemic continues to evolve, Malawi is currently experiencing the fourth wave of the pandemic. The Malawi Government declared a state of national disaster in the country on March 20, 2020 and instituted public health and social preventive measures to mitigate its severity that included the closure of all schools in the country and a set of new COVID-19 rules for the prevention, containment, and management of the pandemic being gazetted as part of the ongoing review of the Public Health Act. After the first three COVID-19 cases were detected on April 2, 2020, the activated Public Health Emergency Operations Centre (PHEOC) has continued to leverage the existing structures and mechanisms put in place to fight the pandemic. The second wave of the pandemic hit the country from December 12, 2020, to June 2021 when another surge of cases started classified as a third wave which continued until early December 2021. The fourth and current wave started on December 6, 2021.

Since the first cases were reported, Malawi's response has centered on interventions to improve case tracing, contain, diagnose, reduce suffering and prevent deaths. These interventions have over time been extended to address broader effects of the pandemic. As of 1st February 2022, Malawi has recorded 84,632 cases including 2,564 deaths (3% CFR). Of the cases, 2,828 are imported infections and 81,804 are locally transmitted and 69,883 cases have now recovered (82.5% recovery rate). The most affected are men in both the infection transmission and mortality with a mean age of 34 years for infected people and 60 years for those who died.

Cumulatively, 530,456 COVID-19 tests have been conducted across 15 testing sites using RT-PCR, 53 GeneXpert, and 320 antigen rapid diagnostic testing sites in the country. As one of the interventions to curb the spread of the virus, Malawi rolled out of the COVID-19 vaccination on 11th March 2021 and as of 1st February 2022, 777,458 people were fully vaccinated

The Government of Malawi (GoM) with financing from the World Bank Group Fast Track COVID-19 Facility (FTCF) has been implementing the Malawi's COVID-19 Emergency Response and Health Systems Preparedness Project - P173806 (C-ERHSPP) and the GoM is proposing a second additional Financing (P178095) to the parent project.

The project development objective (PDO) statement is to prevent, detect and respond to the threat posed by COVID-19 in Malawi and strengthen national systems for public health preparedness. The project will address critical activities and fill financing gaps that have been identified and are not financed by other partners. The Project will comprise three components namely (i) Emergency COVID-19 response, (ii) Supporting National and Sub-national, Prevention and Preparedness, and (iii) Implementation Management and Monitoring and Evaluation.

The project has developed a Stakeholder Engagement Plan (SEP) that seeks to contribute to a coordinated and continued engagement of all relevant players (including affected persons and interested parties) throughout the project cycle. The purpose of the stakeholder engagement plan is to present a strategy for engaging stakeholders of the project to ensure that they understand the project and can provide their feedback and input into the project. This SEP describes the nature of the anticipated stakeholders as well as their information requirements, timing and methods of their engagement throughout the lifecycle of the project.

The SEP has identified the Affected Parties to include local communities, community members and other parties that may be subject to direct impacts from the Project. The SEP has also identified the vulnerable and points out that the vulnerability may stem from person's origin, gender, age, health condition, economic deficiency and financial insecurity, disadvantaged status in the community (e.g. minorities or fringe groups), dependence on other individuals or natural resources, etc.

In terms of approach, the SEP ensures the inclusivity and cultural sensitivity of the different activities, thereby guaranteeing that the stakeholders have a chance to participate in the Project benefits. While in general, this can include household-outreach and focus group discussions in addition to village consultations, the use of different languages, verbal communication or pictures instead of text, etc. Face to face meetings may not always be appropriate in the present situation. In specific cases, it will be important to consider whether the risk level would justify public/face-to-face meetings and whether other available channels of communication to reach out to all key stakeholders should be considered (including social media, for example).

In order to resolve all grievances effectively, the Project has established Grievance Redress and Management Committees at National, District and Community/Health Facility levels. Overall, the GRM will handle all types of grievances arising from implementation of all the interventions under the Project including work-related grievances. All committees will be trained in management of GBV cases and all referral pathways which will be developed in line with the requirements of Good Practice Note addressing Gender Based Violence to ensure cases are successfully concluded.

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AIDS	Acquire Immuno-Deficiency Syndrome
CoC	Code of Conduct
DGRMC	District Grievance Redress Management Committee
ESCP	Environmental and Social Commitment Plan
ESMP	Environmental and Social Management Plan
ESS	Environmental and Social Standard
GRM	Grievance Redress Mechanism
GVB	Gender Based Violence
HIV	Human Immuno-Deficiency Virus
ILO	International Labour Organization
LMP	Labour Management Procedure
MoH	Ministry of Health
PAD	Project Appraisal Document
PAP	Project Affected Person
PDO	Project Development Objective
PHIM	Public Health Institute of Malawi
PMT	Project Management Team
PGRC	Project Grievances Redress Committee
PoE	Point of Entry
PPDA	Public Procurement and Disposal of Assets Authority
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
SATBHSSP	Southern Africa Tuberculosis and Health Services Support Project
SEA	Sexual Exploitation and Abuse
SoP	Series of Projects
US$	United States Dollar
VAC	Violence Against Children
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
WGRC	Workers Grievance Redress Committee

1.0 INTRODUCTION

1.1 Background

An outbreak of coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019, from Wuhan, Hubei Province, China to 212 countries and territories. On March 11, 2020, the World Health Organization (WHO) declared a global pandemic as the coronavirus rapidly spreads across the world. On 20 March 2020, COVID-19 was declared a national disaster in Malawi and on 2 April 2020 Malawi registered the first case of COVID-19. On 6 May 2020, the President of the Republic of Malawi appointed a Presidential Taskforce on COVID-19.

Since registering its first case, Malawi experienced a high number of confirmed cases between June and August 2020 (first wave) followed by a second wave starting in mid-December 2020. In less than three months since the beginning of the second wave, the cumulative number of confirmed cases increased fivefold from 6,070 on December 19, 2020 to 32,008 on March 1, 2021. Similarly, a fivefold increase in cumulative number of deaths (from 187 to 1,048) was recorded during the same period. Unlike during the first wave, there is also a marked increase in the number of active cases and people needing hospitalization. Furthermore, most of the new COVID-19 cases in the second wave are locally transmitted, which indicates that the virus is rapidly spreading in communities.

The second wave spike in COVID-19 cases and deaths in Malawi was likely due to a more transmissible new COVID-19 variant that was first detected in South Africa (B.1.351). Gene sequencing of 24 COVID-19 positive samples collected between mid-December 2020 and mid-January 2021 found that 18 samples (75 percent) were the B.1.351 variant. As of February 1, 2022, cumulatively, Malawi has recorded 84,632 cases including 2,564 deaths (3% CFR). Of the cases, 2,828 are imported infections and 81,804 are locally transmitted and 69,883 cases have now recovered (82.5% recovery rate). As at February 1, 2022, 777,458 people were fully vaccinated. The outbreak continues to have the potential for greater loss of life, significant disruptions in global supply chains, lower commodity prices, and economic losses in both developed and developing countries. The COVID-19 outbreak continues to affect supply chains and disrupting manufacturing operations around the world. The outbreak is taking place at a time when global economic activity is facing uncertainty and governments have limited policy space to act.

The length and severity of impacts of the COVID-19 outbreak have largely depended on the length and location(s) of the outbreak, as well as on whether there is a concerted, fast track response to support developing countries, where health systems are often weaker. With proactive containment measures, the loss of life and economic impact of the outbreak continue to be tamed. It is hence critical for the international community to continue working together on the underlying factors that are enabling the outbreak, on supporting policy responses, and on strengthening response capacity in developing countries - where health systems are weakest, and hence populations most vulnerable.

1.2 Project Description

Malawi remains in a state of emergency following the dawn of the 4th wave with more efforts now being put into surveillance of incidence. In light of the second wave, the President declared a second "State of Disaster" on January 12, 2021 and identified testing and contact tracing, recruitment of additional medical personnel, procurement of medical equipment (e.g. oxygen) and increasing hospital space or infrastructure as priority needs. The country also requires urgent access to vaccination to contain the number of COVID-19 infections and deaths.

The Project Development Objective (PDO) of the parent project and this proposed AF2 is to prevent, detect and respond to the threat posed by COVID-19 in Malawi and strengthen national systems for public health preparedness. The parent project includes the following three components: Component 1- Emergency COVID-19 response; Component 2- Supporting national and sub-national prevention and preparedness; Component 3- Implementation management and monitoring evaluation and Component 4 – Contingency Emergency Response Component .

1.2.1 Component 1: Emergency COVID-19 Response (US$54.5million equivalent)

In this component provides immediate support to Malawi to prevent the spread of COVID-19 through surveillance and containment strategies. It supports enhancement of disease detection capacities through provision of technical expertise, laboratory equipment and systems to ensure prompt case finding and contact tracing, consistent with WHO guidelines; and strengthening of case management capabilities. This component will comprise four subcomponents: 1.1: Case detection, confirmation, contact tracing, recording, and reporting (Disease surveillance), subcomponent 1.2: Health system strengthening (Civil works, equipment, case management, oxygen, PFM and Clinical services), subcomponent 1.3: Vaccination Procurement and Deployment (Vaccines, and deployment) 1.4 Maintaining Essential Health Services (Service delivery).

1.2.1.1 Case Detection, Confirmation, Contact Tracing, Recording, Reporting.

The AF2 plans to enhance case detection, confirmation, rapid response and reporting of COVID-19 cases, building on the support provided under the parent project and the AF1. Support aims to increase diagnostic capacity as part of Malawi's comprehensive strategy to control COVID-19, by addressing limited laboratory capacity (e.g., shortage of test kits, reagents, suboptimal testing performance). Building on the AF1 that supported strengthening diagnostic testing in Malawi, including optimization of existing RT-PCR platforms, the proposed AF2 will support (i) lab capacity strengthening activities for COVID-19 and for other diseases including climate sensitive diseases through procurement of diagnostic equipment (gene-expert machines, axillary molecular equipment), procurement of re-agents and supplies, and training of health care workers in use and maintenance of equipment; (ii) training of health care workers and rehabilitation officers on rehabilitation of post COVID-19 disorders, and in cardio-pulmonary management of COVID-19 patients respectively; (iii) standardization of COVID-19 medical records and training of health care workers in management and use of standardized records; and (iv) strengthen mobility of district level rapid response teams to improve disease surveillance.

1.2.1.2 Health systems strengthening.

This subcomponent would be scaled up to strengthen the health system's ability to detect and manage COVID-19 cases and include new activities. Waves of surges in cases of COVID-19 has increased pressure on the health system which is already strained due to limited health care workers, infrastructure, equipment and supplies. Moreover, to cope with the volume of cases, immediate scale up of oxygen production capacity, equipment and supplies across health facilities particularly in health zones that do not have pressure swing absorption (PSA) plants was needed. The AF1 is supporting procurement and installation of a PSA plant and oxygen supply system at Zomba Central Hospital and supply of oxygen cylinders to neighboring district hospitals, and training of biomedical technicians/engineers to produce and manage the plant, and health workers on the proper provision of oxygen therapy. The AF2 will build on this and will support the health system through a phased approach to contribute to the following: (i) improved case detection of COVID-19 cases as well as other infectious disease detection and through procurement of digital health and diagnostic equipment (CT scanner, Magnetic Resonance Imaging (MRI) at Central Hospitals, digital X-ray machines, ultra sound machines); (ii) improved management of COVID-19 cases through procurement and installation of oxygen supply systems at 12 district hospitals around Zomba Central Hospital; (iii) improved skills of health care workers through (a) training in managing critically ill patients and dissemination of clinical guidelines including oxygen use and (b) in-country specialized training for nurse leaders in emergency critical care, and anesthetists; and (iv) improved infrastructure through (a) renovation of three PHC training center, expansion and renovation of health facilities and three district labs as well as data centers, and (b) construction of an infectious disease treatment center at Queen Elizabeth Central Hospital. Renovations will take into account design measures to help facilities more effectively withstand climate shocks, such as flooding and high winds.

The proposed AF2 will support the expansion of activities in the parent project and the AF1. The purpose of the proposed AF2 is to provide financing to continue to support the Government of Malawi (GoM) to purchase and deploy COVID-19 vaccines that meet the World Bank's vaccine approval criteria (VAC), strengthen relevant health systems that are necessary for a successful deployment, and ensure continuity of essential health services that have been disrupted by the COVID-19 crisis. The AF1 financed the procurement and deployment of COVID-19 vaccines for eight percent of the population and supported health system strengthening for emergency response and preparedness. The proposed AF2 will continue to support the GoM to reach its new vaccine coverage target of 70 percent of the country's population by June 2023 through financing both vaccine procurement and deployment. First, it will support procurement of vaccines covering 10 percent of the population and support deployment to enable GoM to fully vaccinate (complete primary series) about 40 percent of the country's population (an increase from 28 percent under AF1). Second, the proposed AF2 will support further strengthening of relevant health systems for effective deployment and health emergency response. Third, it will also support strengthening the systems to ensure continuity of EHS affected by the COVID-19 pandemic.

1.2.1.3 Vaccination

This subcomponent would be scaled up, and finance procurement of additional eligible COVID-19 vaccines. The proposed AF2 will finance the procurement and delivery to the port of entry of one million vaccine doses and associated supplies such as syringes to cover 2.5 percent of the Malawi population. The proposed AF2 will also expand support for deployment of vaccines and to further enhance immunization systems and service delivery capacity to the level required to sustain delivery of COVID-19 vaccines at scale. To this end, the proposed AF2 is geared to assist the GoM, working with the World Bank Group (WBG), WHO, UNICEF and other development partners, to overcome bottlenecks as identified in the most recent COVID-19 vaccine readiness assessment in the country. Most of the support under this subcomponent (US$12.5 million) will go towards sustaining and expanding complimentary support to deployment priorities identified in the NDVP and to address current gaps identified in the readiness assessment (see para 13) to accelerate deployment, increase uptake, and improve data reporting and use. Climate-sensitive vaccination planning and deployment will be taken into account. Accordingly, support includes the following: (i) update the NDVP document to ensure improved planning and coordination; (ii) recruitment and training of additional staff for vaccination in the communities and training of existing staff on new types of vaccines and regulations to enable accelerated deployment and uptake; (iii) strengthening of digital platforms linked to the One Health Surveillance Platform (OHSP) and the Health Management Information System (HMIS) including the e-Vaccination platform and open Logistic Management Information System (LMIS); (iv) enhance UCC storage capacity in all districts to support rollout of vaccines that require ultra-low temperature through purchase of low Global Warming Potential (GWP) ultra-low temperature cold chain equipment; (iv) procure and install solar panels to generate back-up power for the vaccines cold chain system at national, regional and district stores; (v) procure and repair solar panels to support vaccine cold chain at health facilities; (vi) enhance waste management capacity, including (a) support to operational costs of existing incinerators, and (b) procurement of biohazard bags; and (c) strengthen the logistics along the supply chain, including procurement of mobile van units, motorbikes and push bikes for periodic community-based vaccination campaigns to reach communities without contributing to greenhouse gas emissions (Express Vaccination Program).

Demand creation and risk communication and community engagement (RCCE) interventions are critical to the success of the COVID-19 vaccination efforts in Malawi. While the recently launched Express Vaccination Program (which involves community outreach including door-to-door delivery approach) has shown some positive results, misinformation leading to vaccine hesitancy and indifference might derail these efforts and compromise on the targets. This is another area of gaps/challenges identified in the recent vaccine readiness assessment. Therefore, the proposed AF2 will: (i) support periodic review of the communication campaigns to inform the design of effective community outreach strategies and messages; (ii) intensify and scale up dissemination of up-to-date messages through mass media, social media and community outreach to increase access and uptake in both urban and rural areas through the Express Vaccination Program; (iii) strengthen the community feedback system to track rumors to inform the design of correct messaging and effective community outreach strategies;

(iv) strengthen policy advocacy to increased uptake of the COVID-19 vaccines; (v) improve institutional delivery of the RCCE activities through provision of technical assistance to develop/update RCCE materials, including rumor tracker system and communication strategies; and (vi) improve coordination with all RCCE partners through regular meetings and monitoring field visits to assess progress and impact. Communication campaigns will include sensitization messages on climate shock emergency preparedness and response.

1.2.1.4 Subcomponent 1.4: Monitoring and maintaining Essential Health (US$10.0 million equivalent)

This is a new subcomponent. The proposed new subcomponent will assist the GoM mitigate EHS disruptions as identified in the Malawi Ministry of Health Guidelines on the Continuation of Essential Health Services during COVID-19 and MOH's monitoring of EHS during the COVID-19 period currently being undertaken with support from the GFF/WB and other partners. Malawi experienced moderate disruptions during the pandemic (March 2020 – November 2021) considering pre-pandemic trends and seasonality. During the observed period, half of public, private, and CHAM facilities report challenges to maintaining essential health services since the beginning of the pandemic. In November 2020, nearly 75 percent of public and CHAM facilities reported challenges to maintaining EHS. Quality of services has negatively been affected in half of facilities: as of November 2021, volumes of services for first antenatal visit, first postnatal consultation, and Pentavalent 3 administration in Malawi are lower than expected based on pre-pandemic trends and seasonality. There are ongoing subnational disruptions in outpatient consultation and Penta 3 administration and there are substantial and sustained disruptions in outpatient consultation since April 2020, and mostly in Blantyre, Thyolo, Ntcheu, Likoma and Chikwawa. There is also evidence of disruptions in Pentavalent 3 vaccination since the beginning of the pandemic, mostly in Mchinji and Blantyre.

The causes of disruptions in EHS include (i) fear by communities of being infected with the virus in the facilities, (ii) reduced access to EHS in the facility and in the community due to re-orientation of healthcare workers to COVID-19 related services, including vaccination, and movement restrictions during the COVID-19 pandemic, and (iv) commodities stockouts partly due to procurement inefficiencies and weak supply chain system. Furthermore, inadequate reporting in the routine health information systems as well as logistics management information system by health facilities results in (i) reporting delay and non-reporting on certain indicators; and (iii) misinformation on commodities and quantities needed at the health facility, which affects the provision of services. Finally, prolonged schools closure led to increased teenager pregnancies, resulting in increased caesarian sections and vaginal fistula, putting additional pressures on under-equipped health facilities. Although the GoM is committed to restoring and/or maintaining access to EHS as demonstrated by the inclusion of EHS as one of the priority pillars in the National COVID-19 Preparedness and Response Strategy and Plan (NCPRSP), most of the EHS interventions in the NCPRSP are either severely underfunded or not funded at all.

This new subcomponent will support the GoM in taking actions aligned to the NCPRSP to minimize disruption and maintain EHS during the period of surge in COVID-19 cases when health care workers providing EHS are mobilized to respond to COVID-19 cases, and also as they are mobilized for COVID-19 vaccine deployment at health facilities, communities and in schools. Key areas of support include: (i) strengthen human resources for health (HRH) through (a) temporary recruitment, training and deployment of community health workers and skilled birth attendants to ensure continued and expanded provision of quality routine services at community level, including antenatal, birth and postnatal services for pregnant adolescent girls, and (b) temporary hiring and training of Health Surveillance Assistants (HSAs) to deliver the package of EHS at the community level including family planning, children's routine vaccination, health promotion messages for women and children to seek EHS at health facilities, as well as transport for HSAs. While delivering the services during the funding period, the MOH will be engaging the Treasury to ensure that they are absorbed into the system after the funding period; (ii) procurement of essential medicines and supplies to mitigate stockouts and ensure continuity of EHS delivery (including family planning commodities, antenatal medicines and drugs for community management of childhood illnesses); (iii) IPC-WASH at health facilities through (a) review/finalization and dissemination of the national IPC policy and IPC training manual, (b) procurement of personal protective equipment (PPE) for frontline workers, and (c) undertaking health facility IPC WASH assessment; and (iv) strengthen the HMIS for timely data production and dissemination for evidence-based decision making through (a) the development of the Health Monitoring, Evaluation and Health Information Systems Strategy (2023-2030) and an operational plan, (b) revision and implementation of the HIS SOPs; (c) upgrading of the DHIS2 and training of users, and (d) strengthening of systematic monitoring, analysis, dissemination and use of quality EHS data both at national and sub-national levels of decision-making

1.2.2 Component 2: Supporting National and Sub-national, Prevention and Preparedness (US$2.5 million equivalent)

This subcomponent would be scaled up to further enhance the capacity of the public health system to prepare and respond to COVID-19 and to future pandemics and other threats to health security. Building on the support provided under the parent project and the AF1, the proposed AF2 will support strengthening of rapid response teams at the district level by enhancing their disease surveillance capacity and their mobility to respond to public health emergencies. Specifically, the AF2 will support: (i) development and dissemination of integrated disease surveillance and response (IDSR) guidelines, including for climate sensitive diseases; (ii) training of trainers for community-based surveillance in all 29 districts; (iii) training of frontline health workers on the third edition of the Integrated Disease Surveillance (IDSR) guidelines; (iv) roll-out event-based surveillance to all 29 districts; (v) One Health approach through enhanced media scanning and hotline to respond effectively to public health threats at the district level; (vi) procurement of ambulances for emergency response and in support of surveillance activities; and (vii) financing for surveillance operations including EOC surge capacity. Integration of climate emergency and response training and planning as part of emergency preparedness planning, training, and supervision will be undertaken. This component will also finance strengthening surveillance of climate-sensitive diseases.

1.2.3 Component 3: Implementation Management and Monitoring and Evaluation (US$3.0 million equivalent)

This component would be scaled up. To ensure equitable access to vaccines, especially by targeted vulnerable populations, there is need for close monitoring of the vaccine administration process and putting in place mechanisms to prevent some segments of the population taking advantage of others. In this regard, this component will build on AF1 and provide support towards: (i) strengthening monitoring and research activities, including clinical and epidemiological studies on COVID-19 and other infectious diseases, and vaccine hesitancy, and other studies to inform government's strategic direction with respect to health emergencies and climate related diseases; (ii) enhanced reporting of adverse occurrences such as elite capture through a grievance redress mechanism (GRM) and through a dedicated hotline and amplified citizen engagement activities; (iii) improved implementation of the Environmental and Social Commitment Plan (ESCP) and ongoing supervision and management of safeguard requirements by the district teams beyond the life of the project; and (iv) procurement of vehicles at the central level to strengthen project coordination and supervision of the expanded project activities including close supervision of execution of civil works as supervision of sub-national level activities.

1.2.4 Component 4: Contingent Emergency Response Component (US$0.0 million)

This CERC is included under the project in accordance with Bank Policy: Investment Project Financing, paragraphs 12 and 13, for situations of urgent need of assistance. This will allow for rapid reallocation of project proceeds in the event of a future natural or man-made disaster or crisis that has caused or is likely to imminently cause a major adverse economic and/or social impact during the life of the project. This component will have no funding allocation initially.

In the event of a future emergency, this component would allow the Government to request the World Bank to recategorize and reallocate financing from other project components to cover emergency response and recovery costs, if approved by the World Bank.

1.3 Stakeholder Engagement Plan Objectives

This Stakeholder Engagement Plan (SEP) seeks to contribute to a coordinated and continued engagement of all relevant players (including affected persons and interested parties) throughout the project cycle. The purpose of the stakeholder engagement plan is to present a strategy for engaging stakeholders of the project to ensure that they understand the project and can provide their feedback and input into the project. This SEP describes the nature of the anticipated stakeholders as well as their information requirements, timing and methods of their engagement throughout the lifecycle of the project. Specifically, this stakeholder engagement plan aims to;

- Identify and outline effective strategies of collaboration among stakeholders of the project;
- Promote widespread acceptability and participation of the project interventions among the target beneficiaries;
- Identify potential barriers that will negatively affect the accelerated implementation of the project and address them collectively; and
- Promote disclosure of project information to all stakeholders and project affected persons.

In view of the procurement and deployment of COVID-19 vaccination under the Additional Funding1 and 2 arrangement, this stakeholder engagement plan is key to communicating the principles of prioritization of vaccine allocation and the schedule for vaccine rollout, reaching out to disadvantaged and vulnerable groups, overcoming demand-side barriers to access (such as mistrust of vaccines, stigma, cultural hesitancy), and creating accountability against misallocation, discrimination and corruption.

2.0 STAKEHOLDER IDENTIFICATION AND ANALYSIS

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

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

Cooperation and negotiation with the stakeholders throughout the project development often require the identification of persons within the groups who act as legitimate representatives of their respective stakeholder group, i.e., the individuals who have been entrusted by their fellow group members with advocating the groups' interests in the process of engagement with the Project. Community representatives may provide helpful insight into the local settings and act as main conduits for dissemination of the Project-related information and as a primary communication/liaison link between the Project and targeted communities and their established networks.

Community representatives, cultural leaders and women leaders may also be helpful intermediaries for information dissemination in a culturally appropriate manner, building trust for government programs or vaccination efforts. Women can also be critical stakeholders and intermediaries in the deployment of vaccines as they are familiar with vaccination programs for their children and are the caretakers of their families. Verification of stakeholder representatives (i.e. the process of confirming that they are legitimate and genuine advocates of the community they represent) remains an important task in establishing contact with the community stakeholders. Legitimacy of the community representatives can be verified by talking informally to a random sample of community members and heeding their views on who can be representing their interests in the most effective way.

2.1 Methodology

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

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

engagement methods. Special attention is given to vulnerable groups, in particular women, youth, elderly, persons with disabilities, displaced persons, those with underlying health issues and the cultural sensitivities of diverse ethnic groups.

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

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

2.2. Affected parties

Affected Parties include local communities, community members and other parties that may be subject to direct impacts from the Project. This document has been put in line with the Covid-19 Vaccine Social Mobilisation and Risk Communication Strategy for Malawi 2021-2023. Priority audiences identified by the strategy are based on data from WHO guidelines, national guidelines and studies which identified the priority and key populations for COVID-19 Vaccination. The target audience are the target population for the vaccination and their influencers.

- ***The primary audience*** include: Health workers in private and public health care facilities, older people aged 60 and above, people that have chronic conditions and social workers who interact with many people on daily basis like teachers, security institutions i.e. Police, Prisons and immigration staff among others.

- ***The secondary audience*** include: The leadership of association of medical doctors, nurses, environmental health, pharmacy, laboratory and other allied health association, associations on PLHIV, cancer, diabetics and others, the nurses' council and medical council of Malawi, Teachers association of Malawi, the leadership of elderly people in Malawi, pensioners' association of Malawi, religious groupings, Malawi interfaith association, Pentecostal churches of Malawi, traditional leaders, youth groups, disability organizations and community-based volunteers' e.g. CHAGs.

- ***The tertiary audience*** include: Members of parliament, health right activists, Malawi healthy equity, MISA Malawi, media fraternity.

2.3. Disadvantaged / Vulnerable Individuals or Groups

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

Within the Project, the vulnerable or disadvantaged groups may include and are not limited to the following: the elderly, ethnic and religious minorities, people with disabilities, those living in remote or inaccessible areas, persons with disabilities and their caretakers; female headed households or single mothers with underage children; Child-headed households; the unemployed; persons with chronic diseases and in particular those with suppressed immunity or living with HIV.

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. For any vaccination interventions, the SEP will include targeted, culturally appropriate and meaningful consultations for disadvantaged and vulnerable groups before any vaccination efforts begin.

3.0 STAKEHOLDER ENGAGEMENT PROCESS

3.1 Summary of stakeholder engagement done during project preparation

Due to the emergency situation and the limited time to update the SEP for the AF2, no consultations were held with external public authorities and health experts; Health Services Joint Fund (HSJF); as well as international health organizations such as WHO, UNICEF, Africa CDC and GAVI. However, the MoH involved all its departments to highlight areas of need in view of current implementation and efficient preparedness to hand future resurgences of Covid19 and other pandemics. Thus, findings of AF1 proposal development will be a basis for stakeholder engagement throughout the AF2 project implementation.

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

Stakeholder engagement for the Project in Malawi was guided by the Covid-19 Vaccine Social Mobilisation and Risk Communication Strategy for Malawi (2021-2023). The Ministry of Health recognizes the Health Education Services Directorate as the apex institution in the country to lead and coordinate implementation of this Risk and Crisis Communication Response Plan. The Health Education Services Directorate will guide and coordinate partners in implementing the plan. Through this document, the MoH presents the risk communication in the context of Coronavirus disease outbreak which refers to real time exchange of information, opinion and advice between frontline responders and people who are faced with the threat of Coronavirus disease to their survival, health, economic or social wellbeing.

It is observed that to effectively implement risk and crisis communication, community engagement approaches will be required, response teams must approach community leaders and members in a manner that seeks first to understand their perspectives, solicits their inputs, shares information, and engages them in the response to the outbreak. In addition, information must be shared in a manner that allows individuals and communities to learn (receive information and ask questions) and to make informed decisions about how to protect themselves, their families, and communities. Community leaders and members from many sectors of society must be a part of, and have an influence on, response efforts. The proposed AF2 has adopted the same method and technique of engaging stakeholders.

The MoH recognizes that this is a situation that is developing quickly as the understanding of Covid-19 grows, therefore the SEP will be revisited by the PMT on a regular basis and updated as necessary. Table 3-2 provides a summary of stakeholder groups and key methods for communication and stakeholder engagement.

Table 3-2: Description of key stakeholder groups and preferred engagement methods

Stakeholder group	Key characteristics	Preferred notification Means
1.0 COVID-19 vaccine Concentration		

Stakeholder group	Key characteristics	Preferred notification Means
Health workers	All people engaged in actions whose primary intent is to enhance health in private and government facilities. Health workers infected with COVID-19 may contribute to health care-associated infection transmission of infection to their patients and people they care for, including those at high risk for developing severe COVID-19 disease and complications.	**Interpersonal Communication:** Face to Face Orientation, Focus Group discussions, digital media e.g. WhatsApp groups, power-point slide decks. **Mass media:** Radio/TV programs & spots.
Elderly	People aged 60 years and above due to their age-related lowered immunity exposing them to higher risk of many infections including COVID-19	**Interpersonal Communication:** community dialogues **Community Mobilization:** Door to Door, Mobile van announcements, influential leaders, religious leaders, community-based volunteers' e.g. CHAGs. **Mass Media:** radio and TV spots/programs. **Print media:** Posters, flyers, leaflets, stickers.
Persons with underlying health conditions, persons with disabilities, and displaced persons.	People of all ages that are diabetic, live with HIV, have high blood pressure, asthma and other chronic conditions who are at significantly higher risk of severe disease or death due to COVID-19.	**Interpersonal Communication:** community dialogues. **Community Mobilization:** Door to Door, Mobile van announcements, influential leaders, religious leaders, community-based volunteers' e.g. CHAGs. **Mass Media:** radio and TV spots/programs. **Print media:** Posters, flyers, leaflets, stickers.
2.0 COVID-19 RCCE		
Teachers, security staff, immigration staff, MRA staff, drivers, sex	Due to the nature of their job, these workers interact with a lot people and most of the time it can become	**Interpersonal Communication:** Face to Face Orientation, digital media e.g. WhatsApp groups, power-point slide decks.

Stakeholder group	Key characteristics	Preferred notification Means
workers, hospitality staff.	difficult to adhere to preventive measures.	**Mass media:** radio/TV programs & spots.
Displaced persons and people around borders/POEs (general populations).	They are at high risk of getting infected with COVID-19 as they may get exposed to travelers.	**Mass communication:** leaflets, banners, radio programs/spots. **Community Mobilization:** community dialogues, meetings, Door to Door, Mobile van announcements, influential leaders, religious leaders, community-based volunteers' e.g. CHAGs.
Travelers.	They are highly exposed to COVID-19 during travel.	**Mass communication:** leaflets, banners.
General population.	They may have low risk perception due to misconceptions and myths.	**Interpersonal Communication:** Community dialogues. **Interpersonal Communication (for children and youth):** Creativity Competitions (art, story, theatre, video) on themes that promote vaccine uptake (from T/A-level). **Community Mobilization:** Door to Door, Mobile van announcements, influential leaders, religious leaders, community-based volunteers' e.g. CHAGs. **Mass Media:** radio and TV spots/programs. **Print media:** Posters, flyers, leaflets, stickers.
Children & Young People	Children are particularly vulnerable to the socio-economic impacts and, in some cases, by pandemic mitigation measures e.g. school closures. They may not be able to access appropriate information or understand the recommended behaviors and also suffer from the psychosocial impacts of the pandemic. There may also be disruptions in care	**Interpersonal Communication:** interactive guides, sensitization at school by School Health Committees or teachers. **Mass Media:** comic books, animations. **Community Mobilization:** Door to Door, Mobile van announcements, influential leaders, religious leaders,

Stakeholder group	Key characteristics	Preferred notification Means
	due to the socio-economic impacts. On the other hand, children and young people may be great spreaders of the word to their families and communities.	community-based volunteers' e.g. CHAGs.
The homeless	They may live isolated from society and not have a network of family and friends to share information. They may be more focused on surviving and obtaining food than accessing official public health information and may be suspicious or fearful of government services while being at high-risk of getting severe COVID-19.	**Interpersonal Communication:** Guides for child protection frontline workers.
GBV Survivors	Gender-based violence (GBV) increases during every type of emergency, including disease outbreaks. Care and support for GBV survivors may be disrupted, including safety, security and justice services.	**Interpersonal Communication:** Victim support materials (integrated with COVID-19 messages). **Print media:** Posters, flyers, leaflets, stickers.
Persons with disabilities.	Even under normal circumstances, people with disabilities are less likely to access health care, education and employment and to participate in the community. They are more likely to live in poverty, experience higher rates of violence, neglect and abuse, and are among the most marginalized in any crisis-affected community. They are often excluded from decision-making spaces and have unequal access to information on outbreaks and availability of services, especially those who have specific communication needs.	**Interpersonal Communication:** Special materials for PwDs e.g Braille, sign language. **Print media:** Posters, flyers, leaflets, stickers.
Youth	15 to 30 year olds, especially school graduates living at home, and people already volunteering	**Interpersonal Communication:** Creativity Competitions (art, story, theatre, video) on themes

Stakeholder group	Key characteristics	Preferred notification Means
	in community initiatives, currently unemployed.	that promote vaccine uptake (from T/A-level). **Multi-media:** WhatsApp groups, U-Report, Radio**.**

3.3 Proposed Strategy for information disclosure

In terms of approach, it will be important to ensure the inclusivity and cultural sensitivity of the different activities, thereby guaranteeing that the stakeholders outlined above have a chance to participate in the Project benefits. While in general, this can include household-outreach and focus group discussions in addition to village consultations, the use of different languages, verbal communication or pictures instead of text, etc. Face to face meetings may not always be appropriate in the present situation. In specific cases, it will be important to consider whether the risk level would justify public/face-to-face meetings and whether other available channels of communication to reach out to all key stakeholders should be considered (including social media, for example).

The project will adapt to different requirements. While country-wide awareness campaigns will be established, specific communication around borders and international airports as well as quarantine/isolation centres and laboratories will have to be timed according to need and be adjusted to the specific local circumstances. Table 3-3 summarizes the key methods that will be used for disclosure of project information at different stages of the project.

Table 3-3: Methods for disclosure of project information

Project stage	List of information to be disclosed	Target stakeholders	Methods proposed	Timeline	Responsibilities
Project Preparation	Project Design Summary or Project Appraisal Report Stakeholder Engagement Plan Environmental and Social Commitment Plan Labour Management Procedures Grievance Redress Mechanism Environmental and Social Management Framework Infection Control and Waste Management Plan	National- MoH and other relevant government Ministries, Departments and Agencies; National and international health organizations; National & International NGOs. Districts-Local Councils; Health Facilities; Community	In-person Consultation meetings / Roundtable discussions; Virtual meetings	March - May 2022	PHIM and PIU
Project implementation	Project Progress Reports Stakeholder Engagement Plan Environmental and Social Commitment Plan Labour Management Plans Grievance Redress Mechanism Environmental and Social Management Plans Infection Control and Waste Management Plan	**National**- MoH and other relevant government Ministries, Departments and Agencies; National and international health organizations; National & International NGOs. **Districts**-Local Councils; Health Facilities. **Community** - Project affected persons; vulnerable groups and local populations	Information leaflets, posters and brochures; audio-visual materials, social media and other direct communication channels such as mobile/ telephone calls, SMS, etc; Public notices; Electronic publications and press releases on the MoH/PHIM websites; Press releases in the local media; and meetings; virtual and In-person meetings/trainings	2022 – 2023 (Continuous but on quarterly basis)	PHIM and PIU
Project Closure	Project Completion and evaluation Report	**National**- MoH and other relevant government Ministries, Departments and Agencies; National and international health organizations; National & International NGOs. **Districts**-Local Councils; Health Facilities. **Community** - Project affected persons; vulnerable groups and local populations	Virtual and In-person review meetings; information leaflets, posters and brochures; audio-visual materials, social media; Electronic publications and press releases on the MoH/PHIM websites; Press releases in the local media (both print and electronic); media	December 2023	PHIM and PIU

3.4 Covid-19 Vaccine Key Messages

Communication to the health workers and community about the vaccine to clarify the intended role of COVID-19 vaccine in the control and prevention of COVID-19 is very much needed and will be in line with WHO guidelines on prioritization. According to the Covid-19 Vaccine Social Mobilisation and Risk Communication Strategy for Malawi (2021-2023), the right information on COVID-19 vaccine would be needed to promote acceptance and uptake of the vaccine, by addressing peoples' questions, concerns, vaccine's safety, and demystify myths and rumours that would circulate. The communication on COVID-19 vaccine would raise awareness of the safeguards in place to protect public health and safety. This will be achieved through coordination with the Health Education Unit and Quality Management Department for standardized messages on the vaccine. In line with this context, the SEP would address the following:

- **Build on generally positive attitudes toward vaccines***:* Evidence suggests that childhood vaccination has high acceptance and uptake because the vaccines have demonstrated to prevent life threatening diseases like polio and measles. Recently we have also seen no cases of Cholera outbreaks in hotspots where Oral Cholera Vaccine (OCV) has been administered successfully. The messages should be framed basing on child immunization as an intervention that has an impact in reducing life threating diseases.

- **Manage expectations about the COVID-19 vaccine:** Administration of the COVID-19 vaccine may raise unrealistic expectations about the vaccine's protective ability. People may think that the vaccine will eliminate COVID-19 within a short period of time. Messages should be framed that the vaccine is an additional intervention to already existing preventive measures of hand washing with soap, physical distancing and wearing of masks and messages should stress continued use of existing COVID-19 preventive measures. Explanations on why vaccine alone is not sufficient to protect against and eliminate COVID-19 will be given to assist with adherence to other preventive measures.

- **Emphasize COVID-19 symptoms:** Signs and symptoms of COVID-19 may be similar to other diseases like malaria, pneumonia and cough. This has implications as communities may say that COVID-19 vaccine has no or little effect in reduction of COVID-19 cases. Messages should promote early health seeking behaviours and testing if people have signs and symptoms similar to that of COVID-19 to rule out or confirm COVID-19 and act accordingly.

- **Explain who should get the vaccine and why**: Messages should describe the priority beneficiaries of the COVID-19 vaccine and the reasons for targeting them.

- **Explain the schedule and delivery mode***:* Communities should be informed on the schedule, where the vaccine will be administered and the number of doses to promote uptake of the vaccine whilst observing COVID-19 preventive measures.

- **Phased introduction of the COVID-19 vaccine:** The messages should explain why the phased approach is being used and that people that are at high risk of contracting COVID-19 or at high risk of having severe form of COVID-19 will receive the vaccine in the first phase and others will get in the subsequent phases up until 80% of the population is vaccinated.

- **Vaccine safety and efficacy**: Messages should provide assurance of the safety of the vaccine and efficacy in reducing number of COVID-19 cases if herd immunity is reached.

- **Communicate the dates and places where the vaccine will be delivered:** The messages should provide information on where and when to get the vaccine to avoid doubts and confusion thus possible missed opportunities for vaccine administration.

Misinformation can spread quickly, especially on social media. During implementation, the government will monitor social media regularly for any such misinformation about vaccine efficacy and side effects, and vaccine allocation and roll out. The monitoring will cover all languages used in the country. In response, the government will disseminate new communication packages and talking points to counter such misinformation through different platforms in a timely manner. These will also be in relevant local languages.

3.5 Stakeholder engagement process

The project includes considerable resources to implement the stakeholder engagement activities. The project will utilize various methods for consultations that will be used as part of its continuous interaction with the stakeholders. Stakeholders will be kept informed as the project develops and evolves, including reporting on project environmental and social performance and implementation of the SEP and grievance redress mechanisms (GRM). This will be important for the wider public, but equally and even more so for suspected and/or identified COVID-19 cases as well as their relatives. Table 3-4 presents the key milestones to be achieved by the project as part of this SEP. It is notable that the responsibility for execution will lie solely with the MoH.

Table 3-4: key milestones to be achieved by the project

Project stage	Topic of consultation / message	Method used	Target stakeholders	Responsibilities
Project Inception	Introduction of the project and information about time and venue of training, , Health & safety and sub-management plans GRM tools for filing complaints and providing feedback	Emails, official letters, consultation meetings, phone calls.	Health Personnel Other government personnel such as Immigration, police, local council officers Contractors, service providers, suppliers and their workers	MoH
	General information of the project as stipulated in the PAD; fiduciary issues; announcements of planned activities, associated risks and mitigation measures.	Emails, official letters and virtual meetings and round table discussions with relevant organizations	Government officials; media, private sector; Civil society groups and NGOs; National and international health organizations	MoH
Project Implementation	• Project status • Project progress in containing and	Information leaflets, posters and	General population, including Vulnerable households Government	MoH

Project stage	Topic of consultation / message	Method used	Target stakeholders	Responsibilities
	treating the infection • Risks and mitigation measures • Communication campaign: Press releases in the local media (both print and electronic), written information will be disclosed including brochures, flyers, posters, etc. MoHP/PHIM Website, to be updated regularly	brochures; audio-visual materials, social media and other direct communication channels such as mobile/ telephone calls, SMS, etc; Public notices; Electronic publications and press releases on the MoHP/PHIM websites; Press releases in the local media (both print and electronic)	agencies, media, private sector etc.	
	Information about Project development updates, health and safety, employment and procurement, environmental and social aspects, Project-related materials.	Official letters, emails, phone calls and individual meetings (if needed)	All stakeholders	MoH
Supervision & Monitoring	Project's outcomes, overall progress and major achievements	Press releases in the local media; Consultation meetings (virtual); Round table discussions	Government officials; Civil society groups and NGOs; National and international health organizations	MoH

4.0RESPONSIBILITIES AND RESOURCES FOR IMPLEMENTING STAKEHOLDER ENGAGEMENT ACTIVITIES

4.1 Management functions and responsibilities

The Stakeholder Engagement activities will form part of the Environmental and Social Commitment Plan (ESCP). The implementation arrangement for the project will be done at several levels at National, District and Community. At national level, the daily implementation of the SEP will be coordinated by the Project Implementation Unit (PIU) in collaboration with PHIM and Health Education Services Directorate within the MoH. The project's SEP will be implemented in collaboration with the National COVID-19 RCCE Committee that is chaired by the Deputy Director of Health Education Services. This committee draws its participation from participating line Ministries that includes Ministry of Information, Ministry of Civic Education and National Unity and Ministry of Local Government and local and international partners and Civil Society. The committee will be responsible for

- Mapping interventions
- Monitoring implementation
- Coordinating monitoring and evaluation activities e.g. joint monitoring, coordinating partners conducting rapid assessment
- Providing guidance for leveraging resources
- Providing guidance for strategic approaches at the national level

The implementation arrangement for the project at District level is piggy backed on the decentralized government structures at District and Community level. At district level, the MoH has District Health Promotion officer (DHPO) who chairs the District COVID-19 RCCE Committee that works in collaboration with the various cluster within the District Council. The District COVID-19 RCCE Committee, will be responsible for the following:

- Mapping interventions.
- Monitoring implementation.
- Coordinating monitoring and evaluation activities e.g. joint monitoring, coordinating partners conducting rapid assessment.
- Providing guidance for leveraging resources.
- Providing guidance for strategic approaches.

As such, stakeholder engagement activities at district and community levels will mostly be done through the District COVID-19 RCCE Committee who will be supported by the DHPO.

At community level, the Health Promotion Focal person at Health Centre level will chair the Community COVID-19 RCCE Committee, which will be strengthened to increase participation of partners. The committee will be responsible for the following:

- Mapping interventions
- Monitoring implementation by community agents
- Coordinating monitoring and evaluation activities e.g. joint monitoring, coordinating partners, monitoring and reporting AEFIs

The project preparation team is comprised of qualified and experienced people drawn from the Ministry of Health with support from Ministries of Finance Economic Affairs and Ministry of Justice. The Project Management Unit will have a qualified and dedicated Environmental and Social Safeguard Specialist who will facilitate the implementation of the Stakeholder Engagement Plan. Overall management responsibility for implementing the SEP will rest with the Secretary for Health.

The contact details for the Secretary for Health are as follows:

Ministry of Health
P.O. Box 30377,
Lilongwe 3,
MALAWI
Phone: (+265) 1 789 400

4.2 Resources Requirements

The overall budget of implementing the Covid-19 Vaccine Social Mobilisation and Risk Communication Strategy for Malawi (2021-2023) is estimated to be USD 3,425,964 (refer to Annex 5). The key stakeholders supporting the budget are Government of Malawi (through the MoH), WHO and UNICEF.

- ***Revision/updating of Social Mobilisation, Risk/Crisis Communication Strategy and Vaccine communication material***
- ***Media Interface***
    - Conduct Regional Press Briefings;
    - Conduct Regional Media Tours;
    - Media press releases on COVID-19 Vaccine
- ***Airing of Radio & TV Programs, PSA's & Jingles in Different Languages***
    - Production of Radio and TV, Radio Programs, PSAs and Jingles in different languages;
    - Airing of Radio and TV, Radio Programs, PSAs, Jingles and Live Panel Discussions;
- ***Community Engagement***
    - Briefing of local and religious leaders;
    - Conduct Door to Door meetings by HWs in 29 districts;
- ***Monitoring of Communication interventions with district task teams***

An estimated USD 520,000.00ill be used for the monitoring and operation of the GRM and managing the hotline service for the entire project period.

5.0 GRIEVANCE REDRESS MECHANISM

A well-designed and implemented complaints handling mechanism significantly enhances operational efficiency in a variety of ways, including generating public awareness about the project and its objectives; deterring fraud and corruption; mitigating risks; providing project staff with practical suggestions/feedback that allow them to be more accountable, transparent, and responsive to beneficiaries; assessing the effectiveness of internal organizational processes; and increasing stakeholder involvement in the project. An effective GRM can help catch problems before they become more serious or widespread, thereby preserving the project funds and reputation. Specifically, the GRM:

- Provides affected people with avenues for making a complaint or resolving any dispute that may arise during the course of the implementation of a project;
- Ensuring that disputes related to implementation of this project are treated separately and with expeditiousness;
- Ensuring that project implementation timelines and overall schedules are not compromised due to delays in resolving grievances;
- Cutting down on lengthy and expensive litigation that project affected persons (PAPs) might have to indulge in otherwise.
- Building citizen trust and constructive engagement
- Promoting inclusion and ownership of the project
- Ensures that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants; and
- Avoids the need to resort to judicial proceedings.

An accessible grievance mechanism shall be established, publicized, maintained and operated to receive and facilitate resolution of concerns and grievances in relation to the Project, promptly and effectively, in a transparent manner that is culturally appropriate and readily accessible to all Project-affected parties, at no cost and without retribution, including concerns and grievances filed anonymously. The grievance mechanism shall also receive, register and address concerns and grievances related to the, sexual exploitation and abuse, sexual harassment in a safe and confidential manner, including through the referral of survivors to gender-based violence service providers. The grievance mechanism shall also receive, register and address concerns arising from unintended health consequences after vaccination especially those resulting in serious adverse effects.

5.1 Description of GRM

In order to resolve all grievances effectively, the Project will establish Grievance Redress and Management Committees at National and District/Health Facility levels. Overall the GRM will handle all types of grievances arising from implementation of all the interventions under the Project including work-related grievances. All committees will be trained in management of GBV cases and all referral pathways which will be developed in line with the requirements of Good Practice Note addressing Gender Based Violence to ensure cases are successfully concluded.

The implementation of the Project may generate several complaints and grievances. Some examples of possible complaints may include:

i. Breach of Doctor-Patient Confidentiality;
ii. Discrimination;
iii. Disrespecting Individual's Dignity;
iv. Matters relating to the recruitment, appointment, or contract of health workers implementing project activities;
v. Neglect of Duty by Project Implementers;
vi. Negligence or Carelessness by Project Implementers;
vii. Incompetence by Project Implementers
viii. Turpitude by Project Implementers
ix. Actions Taken without Proper Authority and Unlawful Delegation
x. Lack of Courtesy by Project Implementers
xi. Deprivation of an Opportunity to Object or to Appeal Against a Decision
xii. Gender based violence (GBV);
xiii. Sexual exploitation and abuse (SEA);
xiv. Theft of property during construction and public works etc.
xv. Contractual or commercial transactions (e.g. related to procurement of goods and services by the project)

Grievances from contractor workers under the project may include:

i. Unfair dismissal from work;
ii. Suspected corruption cases;
iii. Low wages;
iv. Delayed wages;
v. Overtime;
vi. Child labour;
vii. Gender based violence;
viii. Sexual exploitation and abuse;

Negotiation and agreement by consensus between the project implementing teams and affected persons will provide as the first step to resolve grievances. Nevertheless, PIU and the Quality Management Directorate (QMD) from MoH will ensure that Grievance Management Committees are established at Health facility, District and National Levels. These committees will ensure the capturing and resolution of all issues within the prescribed timeframes. PIU and QMD shall ensure that communities and Project Affected Persons (PAPs) are sensitized to make use of the existing GRM committees. Furthermore, there will be workers GRM Committee to manage grievances that may arise from workers from construction works among, other works. The existing hospital ombudsman will be central to ensuring that health care facilities are implementing the GRM and will be the desk officers of the GRCs at the District level. The GRCs shall ensure that they are gender sensitive by including in the committees at least 40% females and the composition of the GRCs is provided in

Table 5-1.

Table 5-1: Composition of GRCs

GRC Level	Proposed Composition
National Grievance Redress Committee	• Quality Management Directorate (QMD) representative; • Public Health Institute of Malawi (PHIM) representative; • National TB Control Program (NTP) representative; • Social Safeguards Specialist (PIU); • Hospital Ombudsman representatives; • Representative of the Human Resources Department in MoH; • Community Health Directorate respresentative; and • Health Education Services Directorate representative..
District Grievance Redress Committee	• Chairperson/Vice District Health Management Committee; • Hospital Ombudsman (GRC Secretary); • District Hospital Management Committee representative; • Womens representative; • Youth representative; • Religious Leaders representative; • Representative of people with disabilities; • Representative from very hard to reach areas; and • Representative of community police group
	•
Health Facility Grievance Redress Committee	• Chairperson/Vice District Health Management Committee; • Hospital Ombudsman (GRC Secretary); • District Hospital Management Committee representative; • Womens representative; • Youth representative; • Religious Leaders representative; • Representative of people with disabilities; • Representative from very hard to reach areas; and • Representative of community police group

The grievance redress mechanism will be communicated to health workers, the communities, contractors and employees including all relevant stakeholders so that they are aware of its objective and how the system will be functioning.

5.2 GRM Stages

The GRM will be accessible to all project's stakeholders, including affected people, community members, health workers, civil society, media, and other interested parties. Stakeholders can use the GRM to submit complaints related to the overall management and implementation of the project. The PIU will inform the stakeholders about the system and will keep a log of the complaints at hand. Grievance feedback shall be communicated with complainants by telephone, fax, email, or in writing.

The GRM will include the following:

- Provide directly affected people (those infected and/or in quarantine) with avenues for making a complaint or resolving any dispute that may arise during the course of the implementation of the project;
- Ensure that those providing services (healthcare workers, uniformed services providers, ambulance workers, etc.) can lodge complaints securely and confidentially;
- Ensure that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants; and
- Avoid the need to resort to judicial proceedings, unless the complainant decides that the process provided has failed.

The grievance procedure for Project will have six major stages. These stages include: (i) the complaint or grievance uptake (ii) Assessment, analysis and response (iii) Resolution and closure (iv) Registry and monitoring (v) GRM Monitoring and Evaluation (vi) Appeals process

Step 1: Submission of grievances

Multiple channels will be availed to the public for channelling complaints on the project, including:

a. telephone and texts (a dedicated line will be purchased for this purpose);
b. in person visits to the PHIM/PIU offices, health facilities and vaccination sites across the country;
c. email – a dedicated email address will be shared for public use; and
d. a public hotline.

The project will acquire a 24-hour toll free hotline which will be established as part of the Emergency Operations Centre (EOC) within the PHIM. The grievance hotline will be handled by two trained grievance handlers (the number of handlers will be increased depending on demand) who speak Chichewa and English, which are the official national languages. Efforts will be made to seek handlers who are empathetic and can communicate to vulnerable people. A protocol for handing complaints, including staff complaints and confidential information e.g. GBV/SEA complaints will be developed and disseminated.

Anyone believing they are affected by the Project (referred to as Project Affected Persons – PAPs) or anyone from the affected communities can submit a grievance to a respective Grievance Redress Committee (GRC). The PAPs includes but is not limited to, individual patients, guardians, community members, health care workers, local leaders, community based

organisations, faith based organisations and others. Grievances at national level will be handled at the project's level by the Projects Grievance Redress Committee (PGRC). For district or community specific grievances, they will be handled by the District GRC (DGRC) and Health Facility GRC (HFGRC) respectively.

The GRC's will record all received complaints or grievances in a Grievance Reporting Form as attached in Annex 1. The case shall only be referred to a superior GRC when it has not been resolved at the lower level such as the HFGRC refers to the DGRC which in turn can refer to the PGRC.

Stage 2: Assessment, Analysis and Response:

When a complaint is received, a maximum of 7 days has been provided for a receiving GRC to resolve the complaint or respond to the PAP. This is so to make sure that grievances/complaints are resolved as early as possible.

Once complaints are received, the GRCs shall assess whether the complaint or grievance is related to this Project activity implementation or not. In a situation where the complaints are not related to the project, PAPs shall be advised to channel their complaints to the right institutions. For Project specific complaints or grievances, GRCs shall hear such cases and make necessary follow ups to gather evidence and make necessary determination. The outcome of the analysis shall be communicated to the PAP and shall be recorded on a grievance resolution agreement minute (GRAM) as attached in Annex 2.

Stage 3: Resolution and Closure:

Where a resolution has been arrived at and the PAP accepts the resolution, the PAP shall be required to sign the resolution and closure section as attached in Annex 3. Two members of the specific GRC (Chairperson and Secretary) shall also be required to counter sign. This shall signify that the complaint or grievance which was presented, has been fully discussed resolved and closed.

Stage 4: GRM Registry:

A register shall be kept at all GRCs at all levels to ensure proper record of all complaints and their resolutions. For any case heard, closed or referred to an upper level GRC, a copy of logs and resolution forms for every case shall be submitted as well. This shall enable the GRCs to keep a register (Annex 4), of all cases recoded and handled by them. Using this information, the GRM will be able to generate a matrix of cases and agreed resolutions and be able to follow up if the resolutions are being implemented.

Stage 5: GRM Evaluation:

The GRM evaluation can be undertaken alongside any other evaluation exercises for the project. This will be possible using copies of registers that the GRCs will be keeping. This may assist to trace whether the GRM system was efficient and effective to respond to peoples' complaints and whether the GRM principles were met during the project implementation.

The grievance redress mechanism shall contribute a lot to the efficient running of the project as it shall assist to investigate complaints and bring up a much clear version of the complaint

at an earliest time possible, provide a fair and speedy means of dealing with complaints, prevent minor disagreements from developing into more serious disputes, thereby, providing a simple, speedy and cost-effective mechanism of re-installing satisfaction to the ones that were affected.

Step 6: Appeals process:

Where the complainant is not satisfied with the outcome of his/her complaint, the staff in charge for complaints at the PMU shall advise the complainants that if they are not satisfied with the outcome of their complaint, they may re-address the issue to the Minister of Health. Once all possible redress has been proposed and if the complainant is still not satisfied then they should be advised of their right to legal recourse. Some cases such as rape and theft which need evidence in the court may go through referral pathway including the police to avoid destruction of evidence required legally. The project personnel, where required to provide additional information or evidence as witnesses in a court of law, they will be encouraged to do so. Figure 5-1 provides a summary of the processes and Institutional arrangement for the Grievance Redress Mechanism.

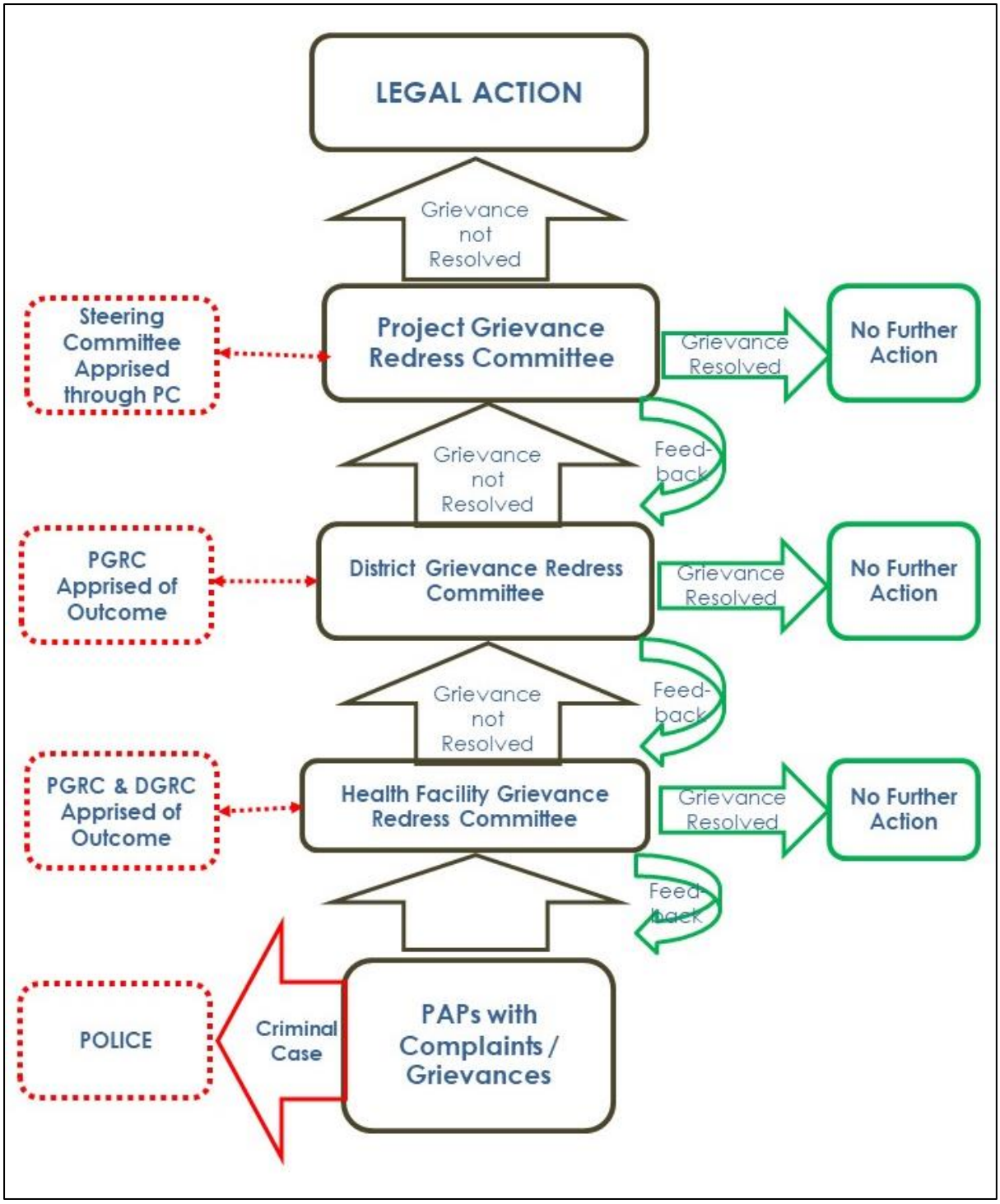

Figure 5-1: Processes and Institutional arrangements for the GRM

5.3 Recommended Grievance Redress Time Frame

Table 5-2 presents the recommended time frames for addressing grievance or disputes.

Table 5-2: Proposed GRM Time Frame

Step	Process	Time frame
1	Receive and register grievance	within 24 hours of receiving complaint
2	Acknowledge	within 24 hours after registering grievance
3	Assess grievance	Within 24 hours after acknowledgement
4	Assign responsibility	Within 2 Days after assessing grievance
5	Development of response	within 7 Days after receiving grievance
6	Implementation of response if agreement is reached	within 7 Days after receiving grievance
7	Close grievance	within 2 Days after agreement is reached
8	Initiate grievance review process if no agreement is reached at the first instance	within 7 Days from date when agreement is not reached
9	Implement review recommendation and close grievance	within 14 Days after receiving grievance
10	Grievance taken to court by complainant	-

5.4 Workers' Grievance Mechanism

The Project will require contractors to develop and implement a grievance mechanism for their workforce prior to the start of civil works. The construction contractors will prepare their labour management procedure before the start of civil works, which will also include detailed description of the worker's grievance mechanism. The worker's grievance mechanism will include:

- a procedure to receive grievances such as comment/complaint form, suggestion boxes, email, a telephone hotline;
- stipulated timeframes to respond to grievances;
- a register to record and track the timely resolution of grievances;
- an assigned staff to receive, record and track resolution of grievances.

The worker's grievance mechanism will be described in staff induction trainings, which will be provided to all project workers. Information about the existence of the grievance mechanism will be readily available to all project workers (direct and contracted) through notice boards, the presence of "suggestion/complaint boxes", and other means as needed. The PIU will monitor the contractors' recording and resolution of grievances, and report these in the progress reports.

6.0 Monitoring and Reporting

6.1. Involvement of stakeholders in monitoring activities

The Project provides the opportunity to stakeholders, especially Project Affected Parties to monitor certain aspects of project performance and provide feedback. GRM will allow PAPs to submit grievances and other types of feedback.

6.2. Reporting back to stakeholder groups

The SEP will be periodically revised and updated as necessary in the course of project implementation. This will ensure that the information presented herein is consistent and is the most recent, and that the identified methods of engagement remain appropriate and effective in relation to the project context and specific phases of the development. If significant changes are made on the SEP, the PIU will disclose the updated SEP.

The Malawi COVID-19 Risk and Crisis Communication Response Plan is envisioned as being inclusive of a wide range of stakeholders including government, donors, local NGOs and the private sector. The role of these varied stakeholders is three-fold: to ensure the use and implementation of the plan in relation to communication about COVID 19; and to contribute resources for its undertaking. As such, the Health Education Services Directorate will on monthly and quarterly basis, compile activity reports from various stakeholders and provide compiled summaries and progress reports regarding the implementation status of the Risk and Crisis Communication Response Plan at national level. These reports shall form the basis for reporting on implementation status of the SEP by the PIU. Furthermore, the PIU shall provide monthly summaries and reports on public grievances, enquiries and related incidents, together with the status of implementation of associated corrective/preventative actions in relation to the GRM. These monthly summaries will provide a mechanism for assessing both the number and the nature of complaints and requests for information, along with the Project's ability to address those in a timely and effective manner. Information on public engagement activities undertaken by the Project during the year may be conveyed to the stakeholders in two possible ways:

- Publication of a standalone annual report on project's interaction with the stakeholders.
- A number of Key Performance Indicators (KPIs) will also be monitored by the project on a regular basis, including the following parameters:
    - Frequency of public engagement activities;
    - Number of public grievances received within a reporting period (e.g. monthly, quarterly, or annually) and number of those resolved within the prescribed timeline; and
    - Number of press materials published/broadcasted in the local, and national media.

6.3 Disclosure

This SEP will be approved by the GoM and WB and disclosed locally with translation into Chichewa, the national local language. This SEP will be disclosed on MoH website and through the World Bank's external website.

ANNEX 1: GRIEVANCE REPORTING FORM

GRIEVANCE REPORTING

PHIM/GRM ……/……
(Location) (Reference No.)

1. Complainant's Information				
(This information must be provided. The identity of complainants will be kept confidential if they request so.)				
Names and Titles (Dr/Mr/Ms/Mrs)	Signatures	Positions/ Organizations *(If any)*	Addresses: Contact Tel.	E-mail: TA/VGE
Authorised Representative? ☐	If yes	Description of Group		
Please indicate how you prefer to be contacted (e-mail, mobile, etc.):				
2. Brief Description of the problem:				
3. Description of the Complaint				
(a) What harm do you believe the COVID-19 Emergency Project caused or is likely to cause to you?				
(b) Why do you believe that the alleged harm results directly from the COVID-19 Emergency Project?				
(c) Do you have any other supporting documents that you would like to share?				
4. Previous Efforts to Resolve the Complaint				
(a) Have you raised your complaint with any other authorities? No☐ Yes ☐				
(a)Have you raised your complaint with any other authorities? No ☐ Yes ☐				
If Yes (Please, provide the following details): When?:				
• How and with whom the issues were raised?				
• Please describe any response received from and/or any actions taken by the project level grievance mechanism. • Please also explain why the response or actions taken are not satisfactory.				
If No, Why?				
(b) How do you wish to see the complaint resolved?				
5. Name of the person who completed this form:		**Signature:**		**Date:**

ANNEX 2: GRIEVANCE RESOLUTION AGREEMENT MINUTE (GRAM)

GRIEVANCE RESOLUTION AGREEMENT MINUTE (GRAM)

REE NO.: PHIM/GRM/……/……
(Location) (Reference No.)

RESPONDENT DETAILS		**COMPLAINANT DETAILS**	
Full name		Full name	
Address:		Address:	
Phone No. (home/cell) IF ANY		Phone No. (home/cell) IF ANY	
Email:		Email:	
Date of complaint resolution		Location	
SUMMARY OF RESOULTION			
(a) Brief description of Complaint:			
(b) Brief description of Resolution			
SIGNATURES			
Chairperson Signature		**Complainant** Signature	
Name of Chairperson		Name of Complainant	
Date		Date	
Secretary Signature		**Witness** Signature	
Name of Secretary		Name of Complainant's Witness	
Date		Date	

ANNEX 3: GRIEVANCE RESOLUTION IMPLEMENTATION MINUTE (GRIM)

GRIEVANCE RESOLUTION IMPLEMENTATION MINUTE (GRIM)

REE NO.: PHIM/GRM/……/……
(Location) (Reference No.)

RESPONDENT DETAILS		**COMPLAINANT DETAILS**	
Full name		Full name	
Address:		Address:	
Phone No. (home/cell) IF ANY		Phone No. (home/cell) IF ANY	
Email:		Email:	
Date of complaint resolution			
SUMMARY OF RESOULTION IMPLEMENTATION			
SIGNATURES			
Chairperson Signature		**Complainant** Signature	
Name of Chairperson		Name of Complainant	
Date		Date	
Secretary Signature		**Witness** Signature	
Name of Secretary		Name of Complainant's Witness	
Date		Date	

ANNEX 4: COMPLAINTS LOG

Date and complaint from	Complaint e.g. non-issuance of ID	Officer/ department complained against	Nature of complaint/ service issue, e.g. delay	Type of cause – physical (e.g. system failure), human (e.g. inefficient officers, slow, unresponsive) or organization (e.g. policies, procedures, regulations)	Remedy granted	Corrective/ preventive action to be taken	Feedback given to complainant

ANNEX 5: PLAN AND BUDGET FOR COVID-19 MALAWI RISK AND CRISIS COMMUNICATION PLAN

		• Care mother groups, CBOs, FBOs, CHAG's, VHCs, HCMCs, HMCs, VDCs, ADCs.				
		Awareness meetings conducted by community groups: • Care mother groups, CBOs, FBOs, CHAG's, VHCs, HCMCs, HMCs, VDCs, ADCs.				
		Monitor vaccine implementation using the Community Health Register.				
		Review meetings with communities on implementation of vaccine.				
	Online presence					
15		Strengthen the online presence				28,699
16		Virtual National Launch of COVID-19 vaccine by H.E.				43,974
	M & E					25,564
17		Monitoring of Communication interventions with district task teams				33,418
18		Procurement of vehicles and PA Systems				215,385
		Grand Total				**3,425,964**

ANNEX 6: LIST OF PEOPLE CONSULTED

Name	Gender	Position	Institution	Contact
Flora Dimba	Female	Principal Environmental Officer, Ministry of Health	MOH	0888891574
Holisterious Kafanikhale	Male	Principal Environmental Officer (Sanitation and Hygiene)	MOH	0888851089
B. G. Nyirenda	Male	Chief Inspector of Mines	Department of Mines	0993181946
Precious Phiri	Male	Principal Environmental Officer for Primary Health Care	MOH	0999203449
Caseby Banda	Male	Principal Environmental Officer	MOH	0881743511
Dr Chipolombwe	Male	Medical Doctor	Mzuzu Central Hospital	jochipolombwe@yahoo.co.uk
Dr Shumba	Male	DHO	Mzimba North	0995625592 Kshumba03@yahoo.com
Mrs Florence Chisi	Female	TB Officer/ Nurse	Mzuzu Central Hospital	09999370164
Mr Chiwaula	Male	Deputy Director, Clinical	Kamuzu Central Hospital	0999511882
Agness Mtambo	Female	HSA	Mzuzu Health Centre	0999265823
Kenani Mushani	Male	Environmental Supervisor	Mchenga Coal Mine	0881583136
Dr Beatrice Nyenje	Female		MOH	
Dr Mathews Kagoli	Male		MOH	
Mr Mavuto	Male		MOH	
Dr Chitsa Banda	Male		MOH	
Dr Anne Chaima	Female		MOH	
Paul Chunga	Male	DEHO	MOH	p4chunga@yahoo.com
Thomas Mchipha	Male	DEHO	MOH	masot2007m@gmail.com
Mathews Kalaya	Male	DEHO	MOH	mjkalaya@yahoo.co.uk
HUS Kadyampakeni	Male	DEHO	MOH	hkadyampakeni@ymail.com
Veronica Nkukumila	Female	DEHO	MOH	veronicankukumila@gmail.com
Sam Chirwa	Male	DEHO	MOH	samchirwa3@gmail.com
Mr. John. O. Mpoha	Male	DEHO	MOH	osmpoha@yahoo.com
Grace Funsani Munthali	Female	DEHO	MOH	gracefunsani@yahoo.com
Minyaliwa		DEHO	MOH	minyaliwax@live.com
Thomson Kajombo	Male	DEHO	MOH	thomkajombo1@gmail.com / yahoo.com
David Sibale	Male	DEHO	MOH	davidsibale26@gmail.com / sibaledavid11@gmail.com
Emily Gondwe	Female	DEHO	MOH	enyagondwe@gmail.com
Mwatikonda Mbendera	Male	DHO	MOH	mmwatikonda@gmail.com
Stephen Macheso	Male	DEHO	MOH	stemacheso@gmail.com
Munthali Lumbani	Male	DEHO	MOH	lumbani2001@yahoo.com
Emmanuel Golombe	Male	DEHO	MOH	egolombe@medcol.mw
Alexander Chijuwa	Male	DEHO	MOH	achijuwa@gmail.com alexchijuwa@yahoo.co.uk
Peter Makoza	Male	DEHO	MOH	pkmakoza@gmail.com
Alinafe Mbewe	Female	DEHO	MOH	nafekmbewe@gmail.com
Regina Chimenya	Female	DEHO	MOH	rlchimenya@gmail.com
Juliana Chezbabe Mubanga	Female	DEHO	MOH	mubangajulz@gmail.com