

**Republic of Malawi**

**MALAWI COVID-19 EMERGENCY RESPONSE AND HEALTH SYSTEMS PREPAREDNESS PROJECT AF 2**

**(P178095)**

**STAKEHOLDER ENGAGEMENT PLAN**

**(SEP)**

*This is an update of an already existing SEP that was initially approved and disclosed on 19 June 2020 and is being updated for Additional Financing II (AF 2). The AF 2 is still in line with the parent project setup and the project components have not changed but several subcomponents have been added to reflect more health systems strengthening, procurement and deployment of vaccines, which is core reason for AF. This update focuses on aligning the SEP to the* ***Covid-19 Vaccine Social Mobilisation and Risk Communication Strategy for Malawi (2021-2023).*** *Specific updates mainly focussed on Chapter 1 (Sections 1.1 and 1.2), Chapter 2 (Section 2.2), Chapter 3 (Sections 3.2 and 3.4) and Chapter 4.*

**MAY 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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# LIST OF ACRONYMS

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

#  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 .

### Component 1: Emergency COVID-19 Response (US$54.5 million 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).

#### Subcomponent 1.1: Case Detection, Confirmation, Contact Tracing, Recording, Reporting (US$3.38 million equivalent)

Laboratories have been overwhelmed with increased demand for diagnostic testing for ‎‎SARS-CoV-2. Although diagnostic testing is part of a comprehensive strategy to control COVID-19, limited laboratory capacity especially in resource constrained settings poses a great challenge in the diagnosis of the ever-increasing cases and the overall management of the disease. The COVID-19 testing in Malawi is being done in 16 testing sites using reverse transcription-polymerase chain reaction (RT-PCR) and GeneXpert as well as 206 sites using antigen rapid diagnostic tests. Although the country has considerably expanded its diagnostic capacity, most laboratories still struggle with testing due to inadequate supplies and equipment, untrained laboratory personnel, inadequate funding, and lack of policies. There is also a limited capacity for SARS-CoV-2 gene sequencing to understand the dynamics of the pandemic and evaluate the efficacy of control measures. The parent project supports procurement of diagnostic equipment and supplies (e.g. test kits) as well as training of laboratory staff. With the rise in cases during the second wave of the pandemic, the laboratory needs to be actively supported to ensure that services are not disrupted in the fight against COVID-19.

#### Subcomponent 1.2 Health systems strengthening (US$23.62 million equivalent).

COVID-19 has dramatically increased hypoxemia (low blood oxygen) prevalence and the need for medical oxygen. According to WHO treatment guidelines, COVID-19 patients require two to six times more oxygen than the average non-COVID-19 ICU patient. As hospitalizations increase and the need for medical oxygen skyrockets, it has become apparent that underdeveloped oxygen supply systems prohibit patients from receiving sufficient and reliable respiratory care. As a result, many lives are being lost.

Without immediate investment in oxygen production, equipment and supplies, more lives were lost as countries faced second wave and new variants that ratchet up the pressure on health systems that are already severely strained. A biomedical equipment survey conducted in health facilities across Malawi found a significant scarcity of oxygen production and delivery equipment and supplies, limited health facility capacity and infrastructure to treat patients, and inequitable distribution of resources for respiratory care across health zones in the country. The survey further reveals that the country would need 361 million litres of oxygen during a six-months period of COVID-19 outbreak against the current health system oxygen production capacity of 163 million litres. This necessitates immediate scale up of oxygen production capacity, equipment and supplies across health facilities.

The AF2 is supporting: (i) procurement of basic respiratory therapy equipment and supplies (i.e. oxygen cylinders and concentrators, pulse oximeters, patient monitors, and additional ventilators) and promotion of climate-smart technologies, for district hospitals located in remote, rural areas and medicalized health centers operating in high population density locations; and (ii) related training. The AF2 is further supporting (i) the procurement of equipment and supplies and staff training, (ii) civil works that include the construction and equiping of infectious disease centre at Queen Elizabeth central Hospital (QECH), (iii) the refurbishment and renovation of two rooms (data centers), isolation centers in central hospitals and (iv) technical assistance for the preparation works in the construction of PHIM offices and points of entry.

#### 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.

#### Subcomponent 1.3: Vaccination (US$17.5 million equivalent).

This subcomponent is aligned to the NVDP, revised COVID-19 Preparedness and Response Plan and is informed by the VIRAT described above. This subcomponent will focus on: (i) vaccine procurement and deployment; and (ii) risk communication and citizen engagement.

The proposed AF2 will continue supporting: (i) procurement of COVID-19 vaccines to complement financing under the COVAX Facility and; and (ii) deployment and related system strengthening. The latter includes: (i) strengthening supply chain and logistics systems to comply with the cold chain requirements as needed and to promote energy efficient solutions; (ii) supporting training of health providers, health surveillance assistants, community health workers and other personnel responsible for the delivery, storage, handling, transportation, tracking and safety of vaccines; (iii) conducting assessments to inform the deployment of vaccines; and (iv) strengthening the policy environment through production of guidelines, standard operating procedures and protocols, supporting planning and coordination of the vaccine deployment; and (v) strengthening health care waste management. To this end, the proposed AF2 will support procurement of vaccines, energy efficient cold chain equipment to reduce green-house gas emissions; medical supplies and consumables (e.g. PPE, syringes, safety boxes); technical assistance; and operating costs considering evolving needs and the evolving donor landscape

***Subcomponent 1.4 Maintaining Essential Health Services -Service delivery (US10.0 million equivalent).***

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

This component will support the strengthening of the capacity of the public health system for preparedness and response to the COVID-19 pandemic and to future pandemics and other threats to health security. The component will support improving prevention of and response planning for emerging infectious diseases in the context of human and animal health system development. The financing of this component will target existing institutions such as the Emergency Operations Centre (EOC) within the Public Health Institute of Malawi (PHIM) and strengthen capacity of health workers to respond to emerging infectious diseases. It is estimated that this intervention activity will include the following:

* Advanced training of healthcare workers at both national and district level in emerging infectious diseases and control.
* Building the capacity of the EOC through minor renovations of the EOC office building, and financing of information technology equipment and infrastructure

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

The existing PIU of the ongoing SATHSSP will lead coordination of the Project activities as well as fiduciary tasks of procurement and financial management, M&E and environmental and social safeguards. If needed, the PIU will be strengthened by the appointment of additional staff/consultants responsible for specific activities under the Project. To this end, this component will support costs associated with Project management and coordination, M&E and operational reviews to assess implementation progress and logistical support. The component will also support the grievance redress mechanism and other activities in the Environmental and Social Commitment Plan (ESCP).

### 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.

#  STAKEHOLDER IDENTIFICATION AND ANALYSIS

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

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

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.

#  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 ‑2: Description of key stakeholder groups and preferred engagement methods

| **Stakeholder group**  | **Key characteristics**  | **Preferred notification** **Means** |
| --- | --- | --- |
| **1.0 COVID-19 vaccine Concentration** |
| **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 workers, hospitality staff.**  | Due to the nature of their job, these workers interact with a lot people and most of the time it can become difficult to adhere to preventive measures.  | **Interpersonal Communication:**Face to Face Orientation, digital media e.g. WhatsApp groups, power-point slide decks.**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 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. | **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, 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 in community initiatives, currently unemployed.  | **Interpersonal Communication:**Creativity Competitions (art, story, theatre, video) on themes 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: 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 | 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 |
| 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 |
| Project implementation | Project Progress Reports | **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 |
| 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 |
| 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 ‑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 officersContractors, 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 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
 | 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 MoHP/PHIM websites; Press releases in the local media (both print and electronic) | General population, including Vulnerable households Government agencies, media, private sector etc. | MoH |
| 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 |

# RESPONSIBILITIES 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.

#  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:

1. Breach of Doctor-Patient Confidentiality;
2. Discrimination;
3. Disrespecting Individual's Dignity;
4. Matters relating to the recruitment, appointment, or contract of health workers implementing project activities;
5. Neglect of Duty by Project Implementers;
6. Negligence or Carelessness by Project Implementers;
7. Incompetence by Project Implementers
8. Turpitude by Project Implementers
9. Actions Taken without Proper Authority and Unlawful Delegation
10. Lack of Courtesy by Project Implementers
11. Deprivation of an Opportunity to Object or to Appeal Against a Decision
12. Gender based violence (GBV);
13. Sexual exploitation and abuse (SEA);
14. Theft of property during construction and public works etc.
15. 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:

1. Unfair dismissal from work;
2. Suspected corruption cases;
3. Low wages;
4. Delayed wages;
5. Overtime;
6. Child labour;
7. Gender based violence;
8. 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 ‑: 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:

1. telephone and texts (a dedicated line will be purchased for this purpose);
2. in person visits to the PHIM/PIU offices, health facilities and vaccination sites across the country;
3. email – a dedicated email address will be shared for public use; and
4. 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 ‑: 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 ‑: 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.

#  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**

**REE NO.: PHIM/GRM/.............…….…………/…….………………**

 **(Location) (Reference No.)**

**MINUTE (GRAM)**

|  |  |
| --- | --- |
| **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**

**REE NO.: PHIM/GRM/.............…….…………/…….………………**

 **(Location) (Reference No.)**

**IMPLEMENTATION MINUTE (GRIM)**

|  |  |
| --- | --- |
| **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



# 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 | 0995625592Kshumba03@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 |