Republic of Malawi

MPA HEALTH EMERGIENCES PREPAREDNESS, RESPONSE AND RESILINCE
PROJECT NO: P505187

STAKEHOLDER ENGAGEMENT PLAN
(SEP)

APRIL 2024

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LIST OF ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
CoC	Code of Conduct
CSOs	Civil Society Organizations
DEHO	District Environmental Health Officer
DGRMC	District Grievance Redress Management Committee
DHSS	Director of Health and Social Services
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
HCMC	Health Centre Management Committee
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
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

Malawi is a land-locked low-income country in south-eastern Africa, with a recent increase in poverty. With low agricultural productivity and limited commercialization, the majority of Malawians face stagnant incomes. Alongside persistent inflation, rising domestic food prices, and recurrent climate shocks, extreme poverty as measured by the international poverty line (US$2.15 a day, 2017 purchasing power parity) has increased from 70.7 percent in 2020 to an estimated 71.7 percent in 2023.[1] Economic development is heavily dependent on the agriculture sector. With limited land, Malawi's environment is already under stress, and sustained population growth will only increase the burden. These challenges are further complicated by Malawi's limited regional integration, landlocked geography, lack of agricultural diversification, and the growing frequency of climate-related natural disasters, which require improved economic, social, and physical risk management.

While Malawi has taken bold steps to stabilize the economy, economic growth was low in 2023 and macroeconomic imbalances continue into 2024. While the resumption of electricity production at the storm-damaged Kapichira hydroelectric power plant has supported economic activity, particularly in the industry and services sectors, production inputs have often been unavailable throughout 2023 and economic growth was just 1.6 percent in 2023.[2] Recently, Malawi has taken important steps towards macroeconomic stabilization including an adjustment of the exchange rate, announcing increased flexibility of the kwacha, agreement with the IMF on an Extended Credit Facility and a reform program supported by a World Bank Development Policy Operation (175072), progress on debt relief, and steps towards monetary tightening. These steps are expected to increase economic growth in 2024 and beyond, but numerous downside risks persist including vulnerability to natural disasters and volatile commodity prices.

Malawi faces significant climate-related challenges that directly and indirectly impact health. Coupled with human-made health stressors, climate change can exacerbate the existing health burdens while creating new health risks. Changes in the temperature and precipitation patterns affect the geographic range and burden of a variety of climate-sensitive health risks while impacting the functioning and capacity of Malawi's health system. Climate change-related challenges that increase Malawi's vulnerability to poor health outcomes include a wide range of climate hazards, such as extreme temperature and humidity conditions, potential changes to precipitation patterns, extreme precipitation events, seasonal aridity, droughts, and cyclones. The country is affected by these climate hazards due to its geographical position; a strong dependency on rainfed agriculture, which is susceptible to regular climatic shocks; ongoing population growth; chronic and widespread malnutrition; as well as the high prevalence rates of HIV/AIDS.

Over the past twenty years, climate related disasters in Malawi have increased in frequency, intensity, and magnitude contributing to destruction of infrastructure and loss of lives. Floods are among the most significant and recurring climate-related hazards, especially for the low-lying areas along the Lake Malawi lakeshore in the Central and Southern regions. Since 2010, Malawi has experienced 16 major flooding events, a rainfall related landslide, and five storm related disasters (Malawi Country Climate & Development Report, 2022). The greatest flood potential occurs in the rainy season between, November and April, peaking in December and January with approximately 100,000 Malawians exposed to flooding each year. In the last three years, four major cyclones: Cyclone Idai (2019), Tropical Storm Anna (2022), Tropical Cyclone Gombe (2022) and Cyclone Freddy (2023) caused severe damage to infrastructure in the country. The frequent climate related disaster and related

[1] World Bank, October 2023. Malawi Macro-Poverty Outlook.

[2] World Bank, February 2024. Malawi Economic Monitor 18th Edition: *Turning the Corner?*

health emergencies pose a significant threat to the country's efforts to achieve universal health coverage.

The Malawi's Health Sector Strategic Plan III recognizes weak disaster risk management and climate change planning and practices as one of the health systems challenges. Health facilities are involved in responding to immediate climate related disasters as well as its aftermath. However, most health facilities in Malawi are themselves vulnerable to climate related disasters, including flooding of facilities, electricity black outs and poor access to WASH. Hence, during the times when health facilities are needed the most to respond to population needs, they are themselves dysfunctional. Moreover, lack of climate-resilient and health care infrastructure exacerbates geographical health disparities and compromise the quality of health service delivery. Finally, the high cost of repairing the damage caused by disasters diverts already-scarce resources from longer term development priorities. Therefore, building climate and disaster resilient infrastructure that can withstand repeated climate shocks is a top priority.

The Government of Malawi, through the Ministry of Health will implement the HEPRR (the Project), with the involvement of the Ministries of Finance and Gender, as set out in the Financing Agreement. The International Development Association (the Association) has agreed to provide financing for the Project, as set out in the referred agreement(s).

In consideration of the potential risks and impacts of the project on the environment and the communities around the project areas all public health facilities in Malawi); a stakeholder engagement plan (SEP) has been prepared. The SEP for HEPRR is essential for the successful management of environmental and social risks and advancement of good governance during implementation of the proposed project activities as per financing agreement.

As stipulated in the ESCP, The Government of Malawi (the Recipient), through the Ministry of Health is responsible for the implementation of the SEP which aligns with the ESCP commitments and the ESF.

This SEP is the main tool for managing potential social risks including grievance redress, community awareness as well as quality improvement feedback mechanisms. The SEP will serve as a guideline for identifying, and engagement of the various stakeholders for the smooth implementation of all activities proposed in the operation including, health care workers, health care clients, suppliers, contractors and the general public.

1.2 Project Description

The Project Development Objective (PDO) is to strengthen health system resilience and multisectoral preparedness and response to health emergencies in Malawi.

1.2.1 Project Components

Component 1: Strengthening the Preparedness and Resilience of the Health System to manage Health Emergency (US$ xx million).

This component supports a comprehensive approach to enhancing the preparedness and resilience of Malawi's health system to effectively manage health emergencies, while complementing overall health system strengthening. Four sub-components address key aspects of readiness and response.

Subcomponent 1.1: Enhancing Multisectoral Planning, Financing, and Governance for Improved Resilience to Health Emergencies (US$ xx million).

This subcomponent aims to enhance resilience to health emergencies through improved multisectoral planning, financing, and governance mechanisms. Key planning activities include developing costed National Action Plans for Health Security (NAPHS) and One Health, contingency response plans for high-risk hazards (including climate related risks), enhancing operational plans for infection prevention and control (IPC), and integrating climate and health vulnerability assessments into national strategies. All plans will identify and address key gender and equity issues. This sub-component will also strengthen financing and governance mechanisms for better preparedness and response to health emergencies, including legal analysis for public health emergencies, strengthened coordination mechanisms, budgeting, and reporting mechanisms, supporting district and health facility planning, and conducting joint multisectoral reviews.

Subcomponent 1.2: Strengthening Health Workforce Development (US$ xx million)

This subcomponent seeks to enhance the expertise and capabilities of the health workforce, with an emphasis on female participation as well as strengthen regulatory and management mechanisms in readiness for and response to health and climate related emergencies. Capacity building will focus on training initiatives like the Field Epidemiology Training Programs (FETP) as well as climate and health emergency preparedness and response that integrates occupational health and safety measures and gender sensitive interventions at all levels of the healthcare system. This will include updating pre-service curricula, implementing on-the-job training, enhancing existing e-learning platforms, and will be integrated with ongoing Continuous Professional Development (CPD). To facilitate rapid mobilization of health workers at all levels of the system during crises, surge staff management guidelines will be developed, and the health workforce related information systems will be enhanced.

Subcomponent 1.3: Improving Access to Quality Health Commodities (US$xx million).

This subcomponent is geared towards improving access to high-quality health commodities for essential health services and during health and climate related emergencies. This will focus on strengthening supply chain management systems using digital technologies for better forecasting, efficient allocations, and tracking of resources during crises response. Support will be extended to the development of Framework Contracts to ensure the timely delivery of Health Emergency commodities during crises, accompanied by robust logistical support. Systems to ensure quality assurance throughout the supply chain will be strengthened using innovative digital technology. An initial scoping study to understand the feasibility of local pharmaceutical production will be done.

Subcomponent 1.4: Enhancing Information Systems for Health Emergencies and Digitalization of the Health Sector (US$xx million).

This subcomponent aims to strengthen the capacity for comprehensive utilization of interconnected information systems and digital tools to enhance surveillance, laboratory services, health workforce, supply chain, governance, and coordination for effective health emergency preparedness and response. This will focus on enhancing existing information systems such as District Health Information System (DHIS2), Electronic Logistics Management Information System (eLMIS), Integrated Human Resources Information System (iHRIS) and Malawi Healthcare Information System (MaHIS) and enable them to be fully operational across Malawi. This will also include development and use of an integrated web-based dashboard to provide automated analytics on key metrics related to surveillance, human resources, supply chain, and coordination. This will also support enhancement of a primary care telehealth application developed during COVID-19 for other essential health services, including for Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (RMNCAH+N), Non-Communicable Diseases (NCDs) and other Communicable Diseases CDs).

Component 2: Improving Early Detection and Response to Health Emergencies Through a Multisectoral Approach

This program component focuses on enhancing early detection and response to health emergencies (HEs) through a collaborative and multisectoral approach. It consists of three sub-components aimed at addressing key aspects of preparedness and response.

Subcomponent 2.1: Collaborative Multisectoral Surveillance and Laboratory Diagnostics

The subcomponent aims to strengthen early detection and response to health emergencies through enhanced use of surveillance data at national and sub-national level as well as support to laboratory diagnostics. The focus will be on enhancing the analytic capabilities of existing indicator and event-based surveillance systems through the development and use of an Integrated Early Warning System EWS), integrating data from diverse sources for real-time outbreak detection and visualization. This will include information from include the One Health Surveillance Platform, Epidemic Intelligence from Open Sources, and other systems outlined under Subcomponent 1.4. This will also support capacity building for sub-national Public Health Emergency Operations Centers (PHEOCs) personnel on surveillance and Integrated Disease Surveillance and Reporting (IDSR - 3rd Edition). Through these initiatives, the goal is to create a network of sub-national PHEOCs that provide proactive surveillance and response actions for priority diseases that are informed by real-time outbreak data that is disaggregated by sex, age, pregnancy status and other equity dimensions.

Support will also be extended towards the operationalization of a One Health Laboratory Network, enhancing laboratory capacity and collaboration across human, animal, and environmental health sectors. This network will enable timely and accurate diagnostics during health emergencies, including the surveillance of antimicrobial resistance (AMR) pathogens. Additionally, the subcomponent includes the development and implementation of guidelines and operational plans to ensure appropriate antimicrobial use in the health system. It also prioritizes establishing national quality standards for laboratories, strengthening laboratory management, biosafety, and biosecurity measures.

Subcomponent 2.2: Emergency Management, Coordination, and Essential Service Continuity

This subcomponent addresses four key areas that focus on strengthening emergency management systems for crises response, maintaining continuity of essential health services, availability of Water, Sanitation and Hygiene (WASH) at health facilities in remote and climate risk prone areas, and building climate resilience in health facility infrastructure. The comprehensive emergency management system will support integrating logistics, transport, and communication capabilities, by leveraging systems

outlined in sub-component 1.4 and introducing new systems for emergency transport (for example, "**m-mama**" technology) for efficient medical and recovery support during emergencies. This will also support essential health service continuity (for RMNCAH+N, NCDs and other CDs) via integrated outreach services and mobile clinics, with a focus on addressing equity and gender gaps. The project will also support development of plans to enhance WASH infrastructure at health facilities, especially in remote and climate risk prone areas. Focus will also be on supply of WASH commodities, with a gender focus (for example, supply of sanitary pads for adolescent girls and women).

While the project will not finance actual construction or infrastructure development, it will invest in developing documents and tools for climate-smart and resilient infrastructure development that would be financed by the Capital Investment Plan (CIP) for HSSP III. Specific focus would be on developing tools on addressing climate-related challenges such as flooding, promoting access and use of clean energy and energy-efficient buildings and equipment. This approach leverages investments made beyond this project in terms of realizing Climate Co-Benefits (CCBs).

Subcomponent 2.3: Risk Communication and Community Engagement (RCCE), Empowerment, and Social Protection During Health Emergencies

For this subcomponent, the project will focus on enhancing risk communication, community engagement, empowerment, and social protection during health emergencies, with a particular emphasis on ensuring equitable reach to all populations, using gender sensitive approaches. Key activities include updating multisectoral RCCE plans, guidelines, and policies at national and subnational levels, emphasizing the use of modern communication channels such as social media and digital tools. Stakeholder mapping and engagement initiatives will target diverse groups, including religious leaders, civil society, and community-based organizations, ensuring gender-equitable inclusion. A two-way community feedback mechanism will be established to inform emergency response strategies, with a focus on gender sensitivity. Training programs for RCCE personnel will emphasize transparent, systematic, and gender-specific communication strategies. Infodemic management plans will be developed to address gender-specific perceptions, while community members and structures will be actively engaged in defining and evaluating health service delivery. Focus will also on developing and sharing health advisories for climate related events and mainstreaming of climate resilience in social protection initiatives. The activities will be aligned and implemented alongside the broader Grievous Redress Mechanisms for the project. By supporting vulnerable households and empowering communities, this sub-component aims to strengthen overall resilience and responsiveness to health emergencies, promoting inclusivity and gender equity.

Component 3: Project Management (US$5.0 million equivalent).

This component will ensure efficient and effective management and implementation of the project by the Program Coordination Unit (PCU).

Subcomponent 3.1: Enhancing Project Monitoring and Evaluation (M&E)

This sub-component will focus on implementing a unified M&E framework detailed in the project implementation manual to monitor performance effectively. Priority will be placed on the utilization of disaggregated data for informed decision-making across various levels, including sex, age group, residence, and relevant health conditions such as pregnancy status and disability. The PCU will be responsible for ensuring comprehensive data collection and regular project reporting.

Subcomponent 3.2: Delivering Tailored Technical Assistance and Facilitating a Learning Agenda
The project will forge collaborations with key partners like WHO, Africa CDC and other development partners through platforms such as the Technical Working Group on Health Emergencies to drive a proactive knowledge and learning agenda. This includes developing a structured learning plan, conducting evidence-based policy dialogues, and disseminating best practices internally and with other countries. Support will also be extended to participation in regional and South to South learning and experience sharing engagements.

Subcomponent 3.3: Strengthening Project Management through Support of the Implementing Institutions and Multisectoral Collaboration. Key areas of support will include: (i) recruitment of staff and developing work plans in accordance with the Financing Agreement; (ii) supporting procurement, financial management, environmental and social risk management, and reporting under the project through the provision of technical advisory services, training, operating costs, and acquisition of goods.

Component 4: Contingent Emergency Response Component (CERC) (US$0).
This component will facilitate access to rapid financing by allowing for the reallocation of uncommitted project funds in the event of a natural disaster in a country, either by a formal declaration of a national emergency or upon a formal request from the government. Following an eligible crisis or emergency, the government may request that the World Bank reallocates project funds to support emergency response and reconstruction. This component would draw upon uncommitted resources from other project components to cover emergency response. A CERC Manual and an Emergency Action Plan, acceptable to the World Bank, will be prepared and constitute a disbursement condition for this component. Annex XX presents the list of the activities included by subcomponent.

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.

Staff associations, 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 service improvement efforts. Women can also be critical stakeholders and intermediaries in the advancement of service delivery quality as they form a large percentage of health facility clientele. Verification of stakeholder representatives (i.e. the process of confirming that they are legitimate and genuine advocates of the grouping they represent) remains an important task in establishing contact with the 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 are 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 are divided into the following core categories:

- ***Affected Parties*** – persons, groups and other entities 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 (Health care workers, health care clients and surrounding communities).
- ***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. Specifically, the following individuals and groups fall within this category: health workers in 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, the leadership of association of medical doctors, and other allied health association, associations on People Living with HIV and AIDS (PLHIV), cancer, diabetics and others, the nurses' council and medical council of Malawi i.e. Police, Prisons and immigration staff among others.

The projects' stakeholders also include parties other than the directly affected communities, including 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, Members of parliament, health right activists, Malawi healthy equity, MISA Malawi, media fraternity and local businesses.

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, those living in remote or inaccessible areas, persons with disabilities through Malawi Council for the Handcapped (MACOHA) 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 through their related organisation such as National Association of People Living with HIV and AIDS (NAPHAM), Malawi AIDS Counselling and Resource Organisation (MACRO) and Malawi Network of AIDS Organisations (MANASO).

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

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

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. Through this document, the MoH presents the risk communication in the context of perennial health emergencies which refers to real time exchange of information, opinion and advice between frontline work force and people who are faced with the threat of poor and inadequate essential health services for 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 quality health care services. 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 quality health care service looks like.

The MoH recognizes that the scope of the operation will create a wide range of feedback points as its beneficiaries includes health care workers and the general public, thus the SEP will be kept open for updating to populate adequate feedback for continuous improvement during the emergency operation. 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
Health workers at various Facilities	All people engaged in actions whose primary intent is to enhance health service quality in both public and government facilities.	**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 can be categorized as vulnerable due to their reduced energy levels to fight for their rights in health facilities.	**Interpersonal Communication:** community dialogues on human rights and other safeguarding themes. **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.

Stakeholder group	Key characteristics	Preferred notification Means
Persons with underlying health conditions, 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 stigma and discrimination.	**Interpersonal Communication:** community dialogues on human rights and other safeguarding themes awareness. **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.
General population.	They may have less belief in the interventions of the emergency operation due to the current status quo.	**Interpersonal Communication:** Community dialogues on the accepted standards in the essential health care service delivery mechanism to boost community demand for quality health care service. **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.
GBV Survivors	Gender-based violence (GBV) increases during every type of emergency, including disease outbreaks and shortages of medical supplies. Care and support for GBV survivors may be	**Interpersonal Communication:** Victim support materials (integrated with service charter, and code of conduct provisions of the MoH)

Stakeholder group	Key characteristics	Preferred notification Means
	disrupted, including safety, security and justice services.	**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 human rights, transparency and responsibilities in safeguarding quality health care service delivery in Malawi **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).

Additionally, as part of commitment to inclusive and community-centered development, stakeholder consultations will be conducted at all health facilities undergoing infrastructure refurbishments and construction. These consultations will directly engage affected individuals in one-on-one discussions, providing them with a platform to voice their concerns, provide feedback, and express their needs.

To ensure continuous communication and responsiveness, stakeholder consultations will be held every quarter throughout the duration of the project. This proactive approach not only fosters transparency but also enables us to address any emerging issues promptly, adapting our plans to best meet the needs of the community.

By prioritizing direct engagement and dialogue with affected persons, we aim to build trust, enhance transparency, and ultimately deliver infrastructure projects that align with the aspirations and priorities of the communities.

The project will adapt to different requirements. 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 Plan Infection Control and Waste Management Plan Stakeholder consultations	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	Quarterly	MoH 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	Quarterly	Moh 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	Quarterly	MOH and PIU

3.5 Stakeholder engagement process

The project includes significant resources allocated for implementing stakeholder engagement activities. Various methods for consultations will be utilized as part of the project's ongoing interaction with stakeholders. Stakeholders will be continuously informed as the project progresses and evolves, including reporting on the project's environmental and social performance, and the implementation of the Social and Environmental Performance (SEP) plan and grievance redress mechanisms (GRM). This will be crucial for the wider public.

Stakeholders engaged in the process included Ministry of Health officials, District Environmental Health Officers, Directors of Health and Social Services, Health Centre Management Committees, and Civil Society Organizations (CSOs). The engagement process commenced with stakeholders being briefed on the proposed projects, outlining their roles in planning and responding, and sharing their experiences with previous projects involving their participation in health emergency responses.

Virtual consultations were conducted with minimal representation, engaging heads of public health and district environmental health officers who also serve as incident managers during health emergencies. This took place on April 3, 2024, with meaningful interactions. Stakeholders commended the initiative to engage them prior to project commencement, emphasizing the importance of proactive planning for emergencies to enable councils to establish structures and build capacities for effective preparedness and response.

Additionally, one-on-one engagements were held with Ministry of Health officials and CSOs in Blantyre, taking advantage of a meeting where these stakeholders were present from April 2 to April 5, 2024. During these engagements, there was a suggestion to collaborate with other departments such as education and national security. Capacity building for teachers and security personnel on One Health principles emerged as important issues. This collaboration aims to integrate One Health concepts into education curricula and equip security personnel with the knowledge to respond effectively to health emergencies, thereby strengthening overall preparedness and response efforts.

Virtual consultations were also held with community members and Directors of Health Services, focusing on capacity building for staff and Village Health Committees and the provision of resources for emergency preparedness. Community members eagerly anticipate the project, recognizing its potential to empower them in addressing emergencies effectively. Discussions emphasized the need for tailored training programs and resource allocation to support community-level emergency response efforts. Directors of Health Services emphasized the importance of collaboration between healthcare facilities and communities, highlighting the crucial role of Village Health Committees in community-based preparedness and response. See annex 6 for the list of stakeholders consulted.

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 Care 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 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	General population, including Vulnerable households Government agencies, media, private sector etc.	MoH

Project stage	Topic of consultation / message	Method used	Target stakeholders	Responsibilities
		print and electronic)		
	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 Directorate of Health Education Services within the MoH. 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 RCCE Committee that works in collaboration with the various clusters within the District Council.

- 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 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 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 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 for implementing the SEP is $340,000 (refer to Annex 5).

- ***Media Interface***
    - Conduct Regional Press Briefings;
    - Conduct Regional Media Tours;
    - Media press releases on various matters of national interest with regards to essential health services.
- ***Community Engagement***
    - Briefing of local and religious leaders;
    - Semi-annual reviews with key stakeholders
- ***Monitoring of Communication interventions with district task teams***

  An estimated USD 40,000.00 will be used for the monitoring the engagement strategies.

- ***Training of GRM coordinating committees and personnel***

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 will 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 Grievance Redress Mechanism (GRM)

In order to resolve all grievances effectively, the Project will utilize the existing 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.

Furthermore, all consultants and contractors involved in our infrastructure projects will undergo comprehensive training on Grievance Report mechanisms. This training will ensure that all stakeholders are equipped with the knowledge and tools necessary to address and resolve any grievances that may arise throughout the project lifecycle. The training will include gender-based violence (GBV) and prevention of sexual exploitation and assault. This comprehensive training will also include a survivor-centered perspective, emphasizing the importance of empathy, sensitivity, and

support for survivors. By equipping our workforce with the knowledge and skills to recognize and respond to these critical issues, we reaffirm our commitment to creating safe and inclusive environments for all individuals involved in our projects.

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

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

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; ● Health Facility Incharge (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
Workers grievance Committee	• Two worker representatives per site (including female workers). Number can increase if site has many workers. • Health facility section head • Consultant representative • Contractor representative (e.g Environmental and Social Specialist

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

All committee members at national, district and community levels as well as staff/consultants in the PIU, Contractors, and Supervision Consultants will be oriented on their roles and responsibilities in GRM process, gender-based violence, sexual exploitation and abuse, sexual harassment, as well as on environmental and social safeguards requirements.

5.2 GRM Stages

The GRM is 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 includes 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;
- Ensures that those providing services (healthcare workers, uniformed services providers, ambulance workers, etc.) can lodge complaints securely and confidentially;
- 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, 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) Investigation, Assessment, analysis and response (iii) Resolution and closure (iv) Registry and monitoring (v) GRM Monitoring and Evaluation (vi) Appeals process

Step 1: Complaint or grievance uptake

Multiple channels will be availed to the public for channelling complaints on the project. Grievances can be submitted via the following channels:

· The PHIM toll free hotline of 929 , Short Message Service (SMS) line

· E-mail:ombudsman@ombudsmanmalawi.org

· Letter to Grievance focal points at local facilities

· Complaint form to be lodged via any of the above channels

Walk-ins may register a complaint in a grievance logbook at a facility or suggestion box. Any complaint received is forwarded to GRC secretary of the facility where the grievance originated from, the secretary will log in and categorized according to the following complaint types: GBV related, health workers related, patient/guardian related, contractors' workers related and other.

The project will utilize the 24-hour toll free hotline which was established for the Emergency Operations Centre (EOC) within the PHIM. The grievance hotline is handled by trained grievance handlers (the number of handlers will be increased depending on demand) who speak Chichewa and English, which are the official national languages.

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 through the office of Hospital Ombudsman 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: Investigation, 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 and monitoring:

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 Monitoring and 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 GBV, SEA, SH 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.

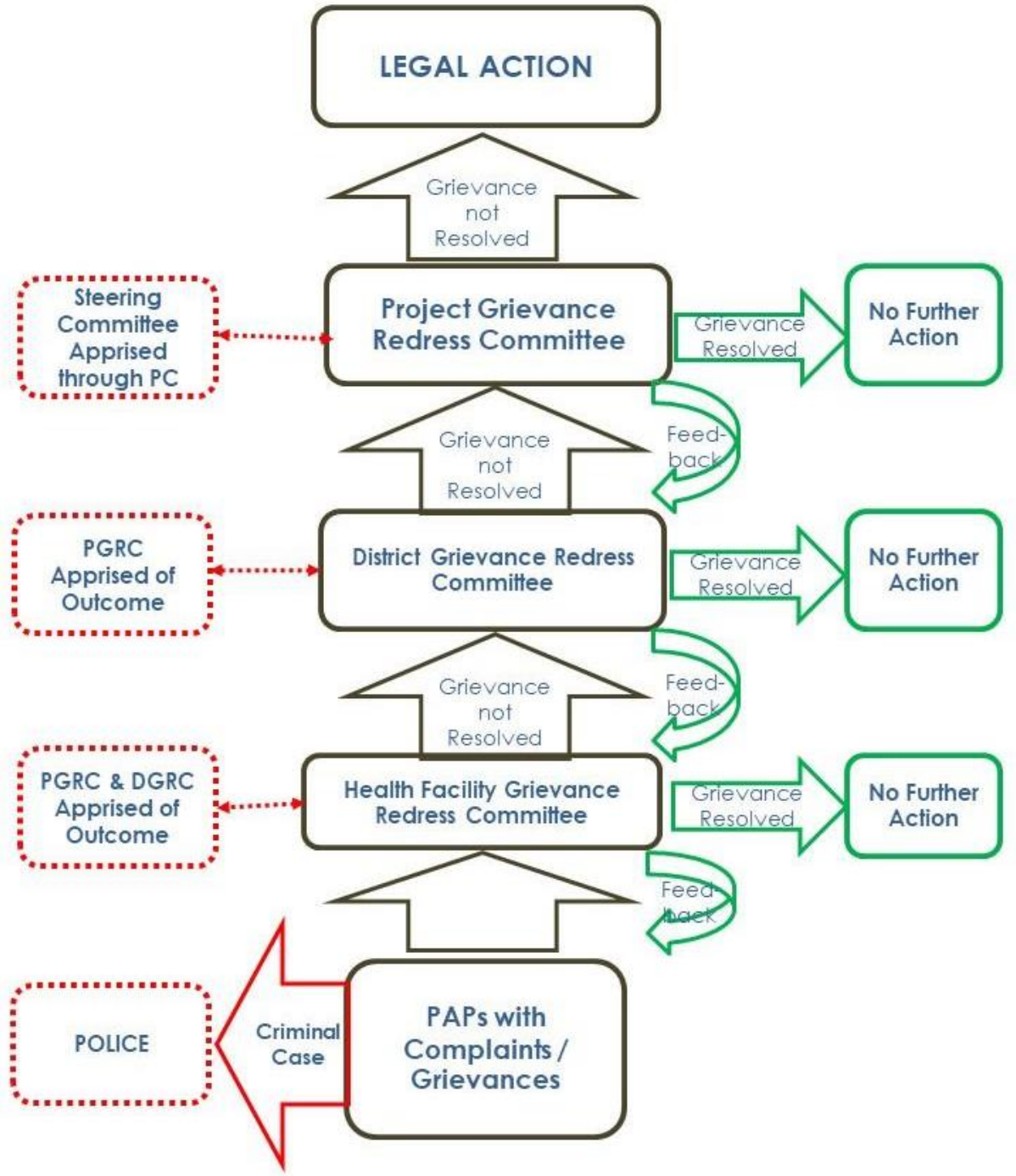

Figure 5-1: Processes and Institutional arrangements for the GRM

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. The LMP will contain more details on the labour Grievance Mechanism

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 Emergency Operation 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 essential health services in the public health sector.; 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:	E-mail:
			Contact Tel.	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 HEPRR Project caused or is likely to cause to you?				
(b) Why do you believe that the alleged harm results directly from the HEPRR ?				
(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 EHS COMMUNICATION PLAN

ITEM/ACTIVITY	STAKEHOLDERS	COST ($)
Bi-Annual National stakeholder meeting.	CSOs, MDAs, NGOs, Development Partners	120,000
Training of GRM coordinating committees and personnel	Hospital Ombudsman, GRCs, consultant, contractors	60,000
District consultations	The general public and staff	120,000
District Monitoring and communication strategy	General public/CSOs	40,000
Total Cost		**340,000**

ANNEX 6: LIST OF PEOPLE CONSULTED

	Gender	Position	Institution	
	F	Deputy Director-Health Financing	Ministry of Health HQ	
	M	Deputy Director-PHIM	Ministry of Health	
	F	Director of Health and Social Services	Chikwawa DHO	
	F	Director of Health and Social Services	Zomba Central Hospital	
	M	Director of Health and Social Services	Nkhatabay DHO	
	M	Director of Health and Social Services	Mulanje DHO	
	M	Director of Health and Social Services	Mangochi DHO	
	M	CPHO	Zomba DHO	
	F	CPHO	Thyolo DHO	
	M	DEHO	Ntchisi DHO	
	M	DEHO	Nsanje DHO	
	M	DEHO	Kasungu DHO	
	M	DEHO	Mzimba North DHO	
	M	DEHO	Likoma DHO	
	M	DEHO	Mangochi DHO	
	M	DEHO	Mchinji DHO	
	M	DEHO	Ntcheu DHO	
	M	Executive Director	Health Rights and Education Program	
	M	Executive Director	Network of Jounalists living with HIV(JONEHA)	
	F	Compass Coordinator	PANGEA	
	F	Senior Advisor Global Policy	AVAC	
	F	Executive Director	Coalition of women living with HIV	
	M	HCMC Chair	Rumphi DHO	
	M	HCMC Chair	Mwazisi Health Centre	
	M	HCMC Chair	Mpala Health Centre (Mulanje)	
	M	HCMC Chair	Katuli Health Centre (Mangochi)	
	M	HCMC Treasurer	Mkumba Health Centre (Mangochi)	
	M	HCMC Chair	Monkeybay Rural Hospital (Mangochi)	
	M	HCMC Member	Chimwankango Health Centre (Mchinji)	
	M	VHC Member	Chang'ambika Health Centre (Chikwawa)	

	F	VHC Chair	Changoima (Chikwawa)	
	M	ADC Member	Changoima (Chikwawa)	