Republic of the Union of Myanmar

Ministry of Health and Sports

Department of Medical Services

MYANMAR COVID-19 EMERGENCY RESPONSE PROJECT (P173902)

and the Additional Financing (P174386)

STAKEHOLDER ENGAGEMENT PLAN

31 July 2020

1. Introduction/Project Description

An outbreak of the coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019, following the diagnosis of the initial cases in Wuhan, Hubei Province, China. Since the beginning of March 2020, the number of cases outside China has increased thirteenfold and the number of affected countries has tripled. On March 11, 2020, the World Health Organization (WHO) declared a global pandemic as the coronavirus rapidly spreads across the world. As of March 26, 2020, the outbreak has resulted in 514,018 confirmed cases and 23,383 deaths in 200 countries.

Myanmar was one of the first countries to conduct the Joint External Evaluation (JEE), a process developed by WHO to assess a country's capacities to prevent, detect and rapidly respond to public health risks. It helps to identify the most critical gaps within the human and animal health systems. Myanmar had an average score of 2.2 out of 5, compared to the global average of 2.8. On the Global Health Security Index (GHSI), Myanmar ranked 72 out of 195 countries with an overall score of 43.4 out of 100; however, in the category of "sufficient & robust health system to treat the sick & protect health workers," Myanmar score was considerably lower, 19.5 out of 100. As of 20 March 2020, Myanmar has total of 230 Intensive Care Unit (ICU) beds at the Central level, 146 across the 44 Region and State Hospitals, and 17 at the Waibagi infectious disease specialist hospital. At present, the capacity is one ICU bed per 141,000 population and one ventilator per 217,000 population.

After the WHO declaration of COVID-19 as the global pandemic on March 11, 2020, Myanmar had its first confirmed case only on March 23 and seven days later on March 30, fourteen cases have been confirmed. As of July 12, 2020, Myanmar has registered a total of 331 confirmed cases of COVID-19 of which there have been 6 deaths. . With the support from WHO, United States Center for Disease Control (USCDC) Thailand and Japan, Myanmar's National Health Laboratory (NHL) began testing on Feb 20, 2020 and priority to this capacity, Ministry of Health and Sports (MOHS) relied on the testing to be carried out in Thailand. Presently, The GOM has recently developed a strategy to expand COVID-19 diagnostic capacities and testing in Myanmar which presents a framework for strategic decisions on how to expand the eligibility criteria for testing at the same time ensuring expanding through test. The operational plan for expanding diagnostic testing in Myanmar outlines a phased approach for ramping up testing volume at central/reference, subnational and frontline/point of care laboratory testing sites to optimize clinical and surveillance objectives, while maintaining quality assurance and adequate laboratory and clinical healthcare worker safety standards. The strategy outlines expansion of testing capacity in the following three areas: (1) diagnostic: to expand the capacity to quickly confirm cases; (2) containment: to ensure early identification of cases to cut transmission, which may mean start considering also asymptomatic contacts; and (3) public health surveillance: to estimate the virus circulation amongst communities, thus inform decision-makers on public health measures. In line with this new strategy to expand the number of testing sites, MOHS requested that the AF support strengthening of laboratory capacity mainly at State/Region levels. The government has added as part of the strategy the introduction of Immunoassay

serology for the qualitative detection of antibodies against SARS-CoV-2, through use of automated immunoanalyser. This is aimed to help boost the means of testing, especially among population living in the states/regions, in complementary to the existing PCR technology in a few central laboratories and expansion of GeneXperts platforms under National TB Control Program to test for COVID cases

Despite the apparent low number of confirmed cases in the country, the government and development partners recognize and acknowledge the high risk of a national outbreak and rapid spread, given long and porous borders and vibrant trade and migration with China and Thailand.

The Myanmar COVID-19 Emergency Response Project and its additional financing (the Project) aims to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness. The project comprises the following components:

1. Component 1 will be revised to have two subcomponents:

   (a) **Subcomponent 1.1: Strengthening hospital capacity at central and State/Region level across the country (US$48.5 million, Original Credit). Strengthening hospital capacity at central and State/Region level across the country (US$48.5 million, Original Credit).** This subcomponent will include all activities outlined under Component 1 of the parent Project, i.e., supporting the key activities related to clinical management and health care services and infection prevention and control identified and prioritized in the Contingency Plan; enhancing hospital preparedness and surge capacity through increasing the availability of well-equipped ICU beds with trained health staff to operate them; increasing the number of State/Region level hospitals with an ICU facility to improve access to intensive clinical care services; and refurbishing and equipping these ICUs.

   (b) **Subcomponent 1.2: Strengthening hospital capacity at township level in conflict-affected areas (US$5.67 million, AF).** This subcomponent will be supported through the PEF AF, to further strengthen hospital readiness and surge capacity of a selected number of hospitals in conflict-affected states with hard to reach areas. This will be done through two main activities. First, the subcomponent will finance provision of medical equipment and consumables in three township level hospitals in Rakhine, Kachin and Shan North states[1]. Support to these hospitals will include procurement of equipment and supplies to upgrade the emergency departments (triage area) and isolation wards as well as high dependency units. In addition, it will finance supplies needed for waste management, as well as other basic requirements including water tank, water filtration system and oxygen plant. As with Subcomponent 1.1, this activity will continue to be under the responsibility of Medical Care Division under the DMS.

[1] If further resource and time permit within the timeframe, two to three more hospitals in Kayin and Kayah states may be added for support.

Second, this subcomponent under AF will support strengthening of laboratory capacity at State/Region level hospitals in hard to reach and conflict affected areas. Through provision of fully automated immunology analyzers (planned in 16 sites), immunoassay reagents (18 sites) and biochemistry analyzers and reagents (3 sites), the subcomponent aims to expand the testing capacity of subnational level hospitals in a total of 18 sites in line with the GOM's laboratory capacity expansion plan. Quality control, safety of health workers in these laboratories and maintenance will also be of priority and the AF will support costs related to these. The National Health Laboratory will be responsible for the implementation of this activity, while procurement will be conducted by DMS as departmental responsibility. A tentative list of sites to be supported is included in Annex.

To ensure safety of health workers unless provided through other resources, the AF will also finance PPE, masks and other consumables in the target hospitals. To ensure activities financed under PEF will be fully completed within the PEF closing deadline, procurement of goods will be strictly limited to those whose procurement and distribution can be completed within this timeframe, and no civil works is foreseen under the AF. As with Subcomponent 1.1, procurement of this subcomponent will be carried out by UNOPS

2. **The increase in scope of Component 1 as outlined below will be reflected in an increase in indicative component allocation from US$48.5 million to US$54.17 million.** The allocation to Subcomponent 1.2 (US$5.67 million) reflects the AF through PEF funding that will be complement Subcomponent 1.1 of the parent Project but with a clear focus on hospitals and laboratories in hard to reach and conflict affected areas, for improvement in their ICU and laboratory capacity.

3. **Increase in scope and cost of Component 2.**

4. Component 2 focused on reinforcing the clinical care capacity at the hospitals supported under Component 1 of the parent project, with its activities focusing on capacity building for clinical management, IPC and HCWM, system development for COVID referrals, regular and inclusive health sector coordination at union and S/R level, leveraging ICT platforms for information sharing and community engagement. The original component will be expanded to set more focus on strengthening capacity on risk communication and community engagement, targeting a broader audience through frequent and enhanced collaboration with partner organizations including EHPs. Collaboration with EHPs is important for adapting and extending risk communication and community engagement activities to populations not easily reached by government public health service delivery in non-government controlled and conflict-affected areas. Inter-sectoral collaboration efforts on the pandemic response will also be strengthened under this expanded component, emphasizing stronger collaboration at S/R levels with engagement of non-government stakeholders such as NGOs, CSOs, EHPs.

5. **The increase in scope of Component 2 will be reflected in an increase in indicative component total allocation from US$1.0 million to US$3.0 million**. The allocation to Subcomponent 2.2 and 2.3 reflects the PEF funding that will be added to complement the effort made under Subcomponent 2.1 which was originally envisaged as Component 2 of the parent project.

6. **Subcomponent 2.1 Enhancing Capacity, Coordination and Engagement on Clinical Care (US$1.0 million, Original Credit)** will finance activities initially foreseen under Component 2 of the parent Project, namely: (1) developing national guidelines on clinical treatment, infection prevention and control, health care waste management, and tailored patient referral pathways at S/R and hospital level; (2) providing training for health workers from MOHS, private sector and ethnic health providers in clinical management, infection prevention and control, health care waste management and referrals; and (3) supporting regular information sharing and coordination of responses between public health and clinical teams within MOHS, as well as across the various public and private (profit and non-profit) agencies through ICT platforms and regular coordination meetings at union and region/state level. The subcomponent will also support information dissemination to the public and private health providers and the general public about the ICU and HDU facilities and hospital preparedness and provide information on how to notify and refer suspected cases to the designated hospitals.

7. **Subcomponent 2.2 Strengthening Risk Communication and Community Engagement (US$0.72 million, AF**) will complement the activities under Subcomponent 2.1 with a focus on training of health workers to communicate with and educate the general public about COVID-19. The AF will also support IEC material development/adaptation in local language, especially for EHPs and NGOS working in conflict-affected areas to ensure that the contents reflect the relevance of specific areas they are operating in. Some of these materials will focus on referral pathways, which are developed under the parent Project, to help promote awareness and collaboration on referral among the health actors and people living in conflict-affected areas. The materials developed will be pre-tested and translated for each ethnic group. In addition, this subcomponent will support rapid assessment to gather information on the behaviors, concerns and preferred communication channels and languages of people who are most vulnerable to COVID-19 and their networks. Community Engagement will also be an important aspect of this subcomponent, involving - ethnic, religious and community leaders and groups, as well as support to development of guidelines and training materials on community engagement. Media advocacy to deliver key risk communication messages, including in local ethnic media outlets, as well as panel discussions that include representatives from CSOs/EHPs will also be supported. Activities to be carried out under Subcomponent 2.2 will be under the responsibility of Health Literacy Promotion Unit (HLPU) of Department of Public Health (DPH).

8. **Subcomponent 2.3. Cross Sectoral Coordination and Capacity Strengthening on COVID-19 response (US$1.28 million, AF).** The subcomponent will support cross sectoral coordination at central and State/Region levels including Inter-Ministerial Committee Meetings as well as State/Region levels to coordinate national responses, including non-government stakeholders

such as NGOs, CSOs, EHPs. The subcomponent will also support after action review of COVID-19 involving sectors relevant to overseeing the national response and plan. Complementing subcomponent 2.1 whose training focus on clinical management, infection prevention and control, health care waste management and referrals all of which are aligned with the focus of the original project on strengthening hospital readiness, subcomponent 2.2 will focus its capacity building activities of health workers (both from MOHS & partner organizations including EHPs and CSOs) on COVID-19 response more broadly, including risks communication, disease surveillance, identification of contacts, case notification and reporting, etc.. In addition to delivering union level trainings for MOHS staff, Central Epidemiology Unit (CEU) will collaborate with State/Region Health Departments to conduct training at subnational levels with participants from EHPs and CSOs and would focus on topics related to their immediate needs of COVID-19 response. Activities to be carried out under Subcomponent 2.3 will be under the responsibility of Central Epidemiology Unit of DPH.

9. In addition, the subcomponent will provide operational costs for central and State/Regions officials and Basic Health Staff – especially those working in conflict-affected states and in hard to reach areas, consumables such as protective kits and non-contact thermometers including distribution to areas operated by EHPs, and logistic support especially sanitation facility (mobile toilets) at Points of Entry (POEs) . The subcomponent will also support costs related to transportation of samples and supplies from hard to reach areas and POEs.

10. **In all the subcomponents under Component 2, the project would leverage the existing high penetration of mobile phone infrastructure in Myanmar and the tablets platform introduced by MOHS**, to explore ICT use in information dissemination, training, and any other use as described under the parent Project. Multiple channels/tools on ICT platform for effective and timely communication about the COVID-19 situation and seeking feedbacks and suggestions from the public will be used. Channels/tools that are most feasible to establish within the six-month implementation timeframe will be prioritized to complement other channels/tools that will be developed with support of the MCERP parent project and AF-EHSAP. The guidelines on data privacy as described under the parent project will be duly followed.

11. **Increase in scope and cost of Component 3.** Activities envisaged under Component 3 of the parent project will remain unchanged but with the following addition to support the expanded scope of the project:

12. **Component 3. Project Management and M&E (US$500,000, Original Credit).** Component 3 will remain unchanged as from the description under the parent Project and will not receive any additional budget under the AF. The Component will continue to support project-related management functions including planning, budgeting, reporting and coordination across the various levels and units within MOHS. The component will also continue to strengthen the capacity of the PMT to enable them to perform their day-to-day project management function, including procurement, contract management, work planning and budgeting.

Monitoring and Evaluation: The proposed project would support DMS and other MOHS departments with data collection, disease surveillance, and M&E activities related to COVID-19 response, and finance associated costs. They include collecting and analyzing the data from the central and region/state level hospitals, which would receive the proposed project's investment for surge capacity; monitoring the progress of implementation based on the results framework indicators; carrying out virtual and in-person supervision and oversight visits, quality checks for the compliance with the clinical guidelines and infection prevention and control and health care waste management procedures; and conducting baseline assessment and regular assessment of hospital readiness using standard checklists. ICT platform– i.e., videoconferencing/telecom-ferencing facility, tablets and mobile phones – will also be utilized to enhance data collection and monitoring efforts. A grievance redress mechanism (GRM), building on the lessons learned from the EHSAP and aligning with proposed GRM measures in the Additional Financing, will use an ICT platform (hotline, text messaging) and dedicated staff within the Project Management Team will be assigned for handling GRM. Information about the GRM will be disseminated together with project information to the public and private health providers, public and other stakeholders such as ethnic health organizations, civil society organizations, local authorities, etc.

The Myanmar CO*VID-19 Emergency Response Project and it's AF* are being prepared under the World Bank's Environment and Social Framework (ESF). As per the Environmental and Social Standard ESS 10 Stakeholders Engagement and Information Disclosure, the implementing agencies should provide stakeholders with timely, relevant, understandable and accessible information, and consult with them in a culturally appropriate manner, which is free of manipulation, interference, coercion, discrimination and intimidation.
The overall objective of this SEP is to define a program for stakeholder engagement, including public information disclosure and consultation, throughout the entire project cycle. The SEP outlines the ways in which the project team will communicate with stakeholders and includes a mechanism by which people can raise concerns, provide feedback, or make complaints about project and any activities related to the project. The involvement of the local population is essential to the success of the project in order to ensure smooth collaboration between project staff and local communities and to minimize and mitigate environmental and social risks related to the proposed project activities. In the context of infectious diseases, broad, culturally appropriate, and adapted awareness raising activities are particularly important to properly sensitize the communities to the risks related to infectious diseases.

2. Stakeholder identification and analysis

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

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

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

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

2.1 Methodology

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

- **Openness and life-cycle approach:** public consultations for the project(s) will be arranged during the whole life-cycle, carried out in an open manner, free of external manipulation, interference, coercion or intimidation;
- **Informed participation and feedback:** information will be provided to and widely distributed among all stakeholders in an appropriate format; opportunities are provided for communicating stakeholders' feedback, for analyzing and addressing comments and concerns;
- **Inclusiveness and sensitivity**: stakeholder identification is undertaken to support better communications and build effective relationships. The participation process for the projects is inclusive. All stakeholders at all times encouraged to be involved in the consultation process. Equal access to information is provided to all stakeholders. Sensitivity to stakeholders' needs is the key principle underlying the selection of engagement methods. Special attention is given to vulnerable groups, in particular women, youth, elderly 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[2,] 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:

- Individuals, family members and communities infected by coronavirus and those who have developed serious COVID-19 disease symptoms.
- Individual, household and communities that are identified as vulnerable to COVID 19, including those individuals, households or communities which may be considered disadvantaged or vulnerable due to social or economic status
- Health care providers (doctors, nurse, supporting staff) with front-line responsibilities for treating COVID-19 patients.
- Hospital personnel responsible for the collection and disposal of health case waste.
- Workers supporting the renovation and rehabilitation of health care facilities
- MOHS and other Government program administrators and those with direct line management responsibilities in MOHS.
- Hospital administrators and management responsible for implementing government strategic vision, procedures, and requirements to acceptable technical and quality standards.
- Individuals and communities living in close proximity to health care centers providing treatment for COVID-19 patients.
- Equipment suppliers supplying key goods and services.
- Local government entities where hospitals are located.
- EHPs and Ethnic Armed Organizations (EAOs).
- Ambulance personal transporting COVID-19 patients from EAOs) controlled territory to government condoled territory.
- Check point staff between EAO controlled territory to government-controlled territory.
- People crossing boarders at Point of Entry

[2] Vulnerable status may stem from an individual's or group's race, national, ethnic or social origin, color, gender, language, religion, political or other opinion, property, age, culture, literacy, sickness, physical or mental disability, poverty or economic disadvantage, and dependence on unique natural resources.

2.3. Other interested parties

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

- Donors and entities active in the health care space in Myanmar.
- Mass media including international, national and local media outlets covering coronavirus pandemic.
- Non-Government Organizations (NGOs) active in health care issues and/or social and environmental risk management, treatment of disadvantaged and vulnerable groups.
- Economic entities that could be affected by management strategies involving shut down of businesses affected coronavirus related.
- The general public and populations not currently infected by coronavirus who are interested in monitoring government response and status of the pandemic.

2.4. 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 and other high-risk individuals with pre-existing medical conditions such as pulmonary or heart conditions, cancer, diabetes, and other individuals with suppressed immunity.
- The poor with limited availability to pay for medical services.
- Internally Displaced Persons.
- Children, especially those who may be malnourished with low immunity.
- Individuals and communities in remote geographic locations with limited access to medical services.
- Persons with mental or physical disabilities.

- Ethnic minorities and indigenous communities.
- People living in active conflict zones.
- Returning migrants,

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.
The Project will carry out stakeholder engagement in line with requirements of ESS 10 as well as WHO guidance on risk communication and community engagement:
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/risk-communication-and-community-engagement

3. Stakeholder Engagement Program

3.1. Summary of stakeholder engagement done during project preparation

During preparation consultation meetings were conducted virtually and through email, over a period of several days from 24 to 27 March 2020. Participants were representatives from MOHS, WHO, Global Fund, ACCESS TO HEALTH FUND, United Nations Office for Project Services (UNOPS), The Vaccine Alliance (GAVI), Asian Development Bank and Japan International Cooperation Agency (JICA). These consultations were primarily to inform project design. Consultations were undertaken in Burmese and English

The Environmental and Social Commitment Plan (ESCP) and this SEP instruments were disclosed through the website of MOHS: www.mohs.gov.mm. Updated versions of the SEP and the final ESMF will be disclosed on the same website and on the World Bank Group website during project implementation.
Consultations with affected and interested stakeholder on the ESCP and SEP were conducted between May 29 and June 2 2020 and further information on the approach is provided in Section 3.4. This stakeholder engagement event was conducted for both the parent project and the Pandemic Emergency Financing Facility, funding this AFPEF, and as such, covered similar the activities and impact that are anticipated under this additional finance. Feedback from these are taken into account in the revision of the ESCP and SEP and development of ESMF.
Through consultation with ethnic groups and their representative and specifically Ethnic Health Providers, conducted on May 29, 2020, this revised SEP also reflects a strategy specific to engagement with ethnic groups including:

- identification of affected group and communities their representative bodies and organisations
- engagement approaches that are culturally appropriate engagement processes and that allow for sufficient time for decision making processes;
- measures to allow for their effective participation in the design of project activities or mitigation measures that could affect them either positively or negatively;

- how MOHS will plan and implement their collaboration with EHP and EAOs to achieve agreement on referral protocols. These referral protocols will be developed under Component 2.
- Inclusion of non-government stakeholders such as NGOs, CSOs, EHPs in cross sectoral coordination at central and State/Region levels including Inter-Ministerial Committee Meetings as well as State/Region levels to coordinate national responses
- Media advocacy to deliver key risk communication messages, including in local ethnic media outlets, as well as panel discussions that include representatives from CSOs/EHPs

A summary of the public consultations conducted between May 29 and June 2 2020 is included as Annex 8 in the ESMF.

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

Different engagement methods are proposed with virtual methods being proposed and taking into account social distancing for undertaking:

- Focus group meetings.
- Virtual consultations using interactive information campaigns, web-site Q&A, social media.
- Consultations with affected individuals where social distancing are feasible.
- One on one interviews.
- Site visits where protective equipment and worker safety can be maintained.

Targeted consultations with disadvantaged and vulnerable groups:

- Elderly.
- People with disabilities.
- Ethnic minorities.

An adaptive approach may be needed for outreach to individuals and communities in conflict affected areas of Myanmar as well as reach agreement on physical transfer of patients across lines of control to reach the referral hospitals. These include the states of:

- Rakhine
- Chin
- Mon
- Shan
- Kayah
- Kayin
- Tanintharyi

- Bago
- Kachin

Due to the high risks of infection, in person or face-to-face consultations will be limited. The Project will employ a mix of virtual communications techniques through readily available channels such as radio, television, social media, MOHS websites, dedicated telephone lines, published and other print materials brochures provided in hospitals and health centers, email listservs, among other possible means.

Feedback on stakeholder inputs should documented and made available in a transparent manner. This may include: publishing results on MOHS website; inclusion of feedback and suggestion in revised documentation with Annex indicating the ways in which feedback was taken into account.

3.3. Proposed strategy for information disclosure

Project stage	Target stakeholders	List of information to be disclosed	Methods and timing proposed
Preparation prior to effectiveness of both parent project and AF	*Government entities; local communities; vulnerable groups; indigenous groups; health workers; health agencies;*	*SEP with draft Grievance Redress procedures;* *Regular updates on Project development*	*MOHS website and Information Communication Technology platform for Focus Group Meetings/ Discussions conducted between May 29 and June 2 2020; One-on-one staff interviews* *Site visits where feasible*
Project Implementation of both parent project and AF	*Implementing entities* *Patients* *Affected households and communities* *Media*	*ESMF* *Final SEP* *Final Labor Management Procedures* *Project progress reports and periodic updates* *Brochures and educational materials* *Press releases*	*Combination of:* *Focus Group Meetings/ Discussions;* *Community consultations;* *Formal meetings with structured agendas* *Media campaigns, press releases, public service announcements* *Maintain website with up to date facts figures and progress reports*

Project stage	Target stakeholders	List of information to be disclosed	Methods and timing proposed

3.4. Stakeholder Engagement plan

Project stage	Topic of consultation / message	Method used	Target stakeholders	Responsibilities
Preparation prior to effectiveness of both parent project and AF	*The parent project and AF, its activities and potential E&S risks, impacts and mitigation measures* *Introduce ESF instruments* *Present the SEP and GRM*	*Virtual consultation* *Public meetings where social distancing can be maintained with no risks of exposure to virus conducted between May 29 and June 2 2020*	*All project affected people* *Other interested parties* *Relevant Ministries working in, or with an interest in health sector and COVID-19* *Vulnerable and disadvantaged*	*MOHS through the Project management team*
Project Implementation of both parent project and AF	*Updated ESF instruments* *Feedback from consultations* *Information about project activities in line with WHO guidance on risk communications and*	*For Government entities:* *Correspondence by phone/email; one-on-one interviews; formal meetings; roundtable discussions;* *For local communities/vulnerable groups:*	*All affected parties* *Other interested parties* *Disadvantaged and vulnerable EHP and EAO*	*MOHS through the Project management team* *Work through CSO and/or advocacy groups representing dis-advantaged*

Project stage	Topic of consultation / message	Method used	Target stakeholders	Responsibilities
	community engagement	*letters to village leaders; traditional notifications; disclosure of Project documentation in a culturally appropriate and accessible manner; community meetings; focus group discussions; outreach activities]*		*and vulnerable groups*

3.5 Future of the project

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

Subcomponent 2.3 will support cross sectoral coordination at central and State/Region levels including Inter-Ministerial Committee Meetings as well as State/Region levels to coordinate national responses, including non-government stakeholders such as NGOs, CSOs, EHPs. The subcomponent will also support after action review of COVID-19 involving sectors relevant to overseeing the national response and plan.

4. Resources and Responsibilities for implementing stakeholder engagement activities

4.1. Resources

The main implementing entity for the Project is the MOHS coordinated through its Department of Medical Services. The MOHS through the Project Management Team will be in charge of stakeholder engagement activities. The MOHS has designate at least one senior staff member to provide oversight and guidance to the implementation teams on project requirements for stakeholder engagement including information disclosure and GRM.

Since the AF will follow the same implementation arrangement for the parent project, the project management team already includes In addition to the Project Director and Project Manager, designated staff responsible for key areas including dedicated staff for environmental safeguards and social safeguards, in addition to fiduciary, M&E, etc. the same staff will in principle oversee the E&S aspects, but they will also add additional human resources as needed

in case the workload for both parent and AF cannot be managed by the current dedicated persons.

The budget for the SEP is included under Component 2 of the project. Component 2 has a combined budget of 3 million USD

4.2. Management functions and responsibilities

The project implementation arrangements including for carrying out stakeholder engagement activities will be the responsibility of the MOHS through the Project Management team. The stakeholder engagement activities will be documented by MOHS and included in ESF documents as well as through the MOHS project website and ICT platform.

5. Grievance Redress Mechanism

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

- Provides affected people with avenues for making a complaint or resolving any dispute that may arise during the course of the implementation of projects;
- Ensures that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants; and
- Avoids the need to resort to judicial proceedings.

5.1. Description of GRM

The MOHS, through the Project Management team, will establish a multi-tiered grievance mechanism where some responsibilities for addressing site-specific grievances will be allocated to local hospitals. Other grievances related to overall government strategy, timing and success of roll-out will be handled at the national level by MOHS. MOHS will designate at least one member of the Project management team to be responsible for GRM related activities.

The GRM will include the following steps:

- Submission of grievances either orally or in writing to designated focal point in each hospital and/or MOHS Project Management team.
- Recording of grievance and providing the initial response within 24 hours.
- Investigating the grievance and Communication of the Response within 7 days.
- Complainant Response: either grievance closure or taking further steps if the grievance remains open. If grievance remains open, complainant will be given opportunity to appeal to MOHS/Project Management Team.

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.

The GRM is in the process of being operationalized through the assignment of a GRM focal point from the parent project and the PMT is working to put in place prioritized GRM intake channels, a protocol and database. The MoHS has been using the MoHS Project Facebook page as the main in-take channel to date, since it is much easier to quickly and widely share information there than on the MoHS website. The Facebook page will continue to be one of the prioritized intake channels with dedicated officers reviewing feedback, compiling into a database and processing for action and response according to a defined protocol with PMT oversight. The GRM will also including provisions allowing anonymous grievances to be raised and addressed and how any complaints of gender-based violence will be handled, as well as detailed contact numbers and addresses.

Following engagement and feedback, the GRM and its operationalization takes into account the needs of various affected groups including from ethnic groups and their representatives to ensure on methods are culturally appropriate and accessible and take account their customary dispute settlement mechanisms.

6. Monitoring and Reporting

6.1. Involvement of stakeholders in monitoring activities

[Not applicable]

6.2. Reporting back to stakeholder groups

The SEP will be periodically revised and updated as necessary in the course of project implementation in order to ensure that the information presented herein is consistent and is the most recent, and that the identified methods of engagement remain appropriate and effective in relation to the project context and specific phases of the development. Any major changes to the project related activities and to its schedule will be duly reflected in the SEP.

Monthly summaries and internal reports on public grievances, enquiries and related incidents, together with the status of implementation of associated corrective/preventative actions will be collated by responsible staff and referred to the senior management of the project. The [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 ESF Key Performance Indicators (KPIs) will also be monitored by the project on a regular basis, including the following parameters:

    - *Frequency and type of public engagement activities;*
    - *Numbers of Grievances received within a reporting period (e.g. monthly, quarterly, or annually)*
    - *Number of grievance resolved within the prescribed timeline; number of press materials published/broadcasted in the local, regional, and national media*
    - *Potentially the number of referral patients crossing boundary of area of control between EAO and GOM to access referral hospital.*
    - *The distribution of the fever screening kits and the non-contact thermometers to EHP*