# THE REPUBLIC OF KENYA

# MINISTRY OF HEALTH

# KENYA COVID-19 EMERGENCY RESPONSE PROJECT (P173820)

# STAKEHOLDER ENGAGEMENT PLAN (SEP)

## MAY 2020

## Table of Contents

## ABBREVIATIONS AND ACRONYMS

| | | |
|---|---|---|
| CAJ | - | Commission for the Administration of Justice |
| CAS | - | Cabinet Assistant Secretary |
| CERC | - | Contingent Emergency Response Component |
| CHV | - | Community health volunteer |
| CoC | - | Code of conduct |
| CoK | - | Constitution of Kenya |
| COVID-19 | - | Corona virus disease – 2019 |
| CS | - | Cabinet Secretary |
| EACC | - | Ethics and Anti-Corruption Commission |
| ESF | - | Environment and Social Framework |
| ESS | - | Environmental and Social Standard |
| FAQs | - | Frequently Asked Questions |
| GBV | - | Gender-Based violence |
| GEM | - | Geo-enabling Initiative for Monitoring and Surveillance |
| GRM | - | Grievance Redress Mechanism |
| HUTLCs | - | Historically Underserved Traditional Local Communities |
| ICT | - | Information Communication Technology |
| ICU | - | Intensive Care Unit |
| IDSR | - | Integrated Disease Surveillance and Response |
| IEC | - | Information Education and Communication |
| ILO | - | International Labor Organization |
| IPC | - | Infection prevention and control |
| KEMSA | - | Kenya Medical Supplies Authority |
| KMPDC | - | Kenya Medical Practitioners and Dentists Council |
| KNBTS | - | Kenya National Blood Transfusion Service |
| MOH | - | Ministry of Health |
| NERC | - | National Emergency Response Committee |
| NPHI | - | National Public Health Institutes |
| NYS | - | National Youth Service |
| OHS | - | Occupational Health and Safety |
| PAI | - | Project Area of Influence |
| PAS | - | Public Address System |
| PMT | - | Project Management Team |
| POEs | - | Ports of Entry |
| PPEs | - | Personal Protective Equipment |
| PS | - | Principal Secretary |
| PWDs | - | Persons with Disabilities |
| SEA | - | Sexual exploitation and abuse |
| THS-UCP | - | Transforming Health Systems for Universal Health Care Project |
| TTIs | - | Transfusion Transmissible Infections |
| VMG | - | Vulnerable and marginalized groups |
| WHO | - | World Health Organization |

## 1. INTRODUCTION

1. An outbreak of coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019, from Wuhan, Hubei Province, China to 212 countries and territories. As of May 07, 2020, the outbreak has already resulted in over 3.8 million cases and over 266,000 deaths. Over the coming months, the outbreak has the potential for greater loss of life, significant disruptions in global supply chains, lower commodity prices, economic losses and social disruption in both developed and developing countries.

2. The COVID-19 outbreak is affecting supply chains and disrupting manufacturing operations around the world. Economic activity has fallen in the past four months, especially in China, and is expected to remain depressed for many months. The outbreak is taking place at a time when global economic activity is facing uncertainty and governments have limited policy space to act. The length and severity of impacts of the COVID-19 outbreak will depend on the projected length and location(s) of the outbreak, as well as on whether there are is a concerted, fast track response to support developing countries, where health systems are often weaker. With proactive containment measures, the loss of life and economic impact of the outbreak could be arrested. It is hence critical for the international community to work together on the underlying factors that are enabling the outbreak, on supporting policy responses, and on strengthening response capacity in developing countries – where health systems are weakest, hence populations are most vulnerable.

## 2. PROJECT DESCRIPTION

3. The Kenya COVID-19 Emergency Response 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 of the seven components summarized below.

4. **Component 1. Medical Supplies and Equipment** [US$ 8,472,519]: This component aims to improve the availability of supplies and equipment needed to respond to COVID-19 and other public health emergencies and strengthen the capacity of the MoH to provide timely medical diagnosis for COVID-19 patients. Support under this component will include but is not limited to the following areas: strengthening capacity of seven laboratories (including two zoonotic laboratories) to manage large scale testing for COVID-19 cases and other infectious diseases. Support will include procurement of specialized equipment (i.e. PCR machines, sequencer etc.) to allow screening of multiple pathogens:

a. providing sample collection and packaging supplies, reagents and transport media, including shipment of samples to the National Public Health Reference Laboratories and other referral laboratories, providing sample collection and packaging supplies, reagents and transport media, including shipment of samples to the National Public Health Reference Laboratories and other referral laboratories;

b. procurement of personal protective equipment (PPE), pharmaceuticals and non-pharmaceutical commodities and supplies required for infection prevention control; and

c. strengthening clinical care capacity in selected hospitals to provide critical care for patients with severe illnesses. According to the WHO, while most patients with COVID-

19 develop mild or uncomplicated illness, approximately 14% develop severe disease requiring hospitalization and oxygen support while 5%[1] require admission to an Intensive Care Unit (ICU). This support will, therefore, increase the capacity of the MoH and County Governments to manage severe cases through the procurement of ICU sets and dialysis beds.

5. **Component 2. Response, Capacity Building and Training** [US$ 8,759,720]: This component aims to strengthen response capacity and build capacity of key stakeholders including health workers and communities. Support under this component will include but not limited to the following areas:

a. coordination of activities at national and county level, including support towards National COVID-19 Steering Committee and the National COVID-19 Task force;

b. training all health workers at all levels of the health system on relevant guidelines and protocols;

c. adaptation and roll out of the 3rd Edition of IDSR technical guidelines;

d. strengthening surveillance and screening at all points of entry; and at the community level including development and adaptation of an electronic community-based reporting system, and equipping all points of entry (POEs) with the necessities to function effectively;

e. strengthening operational capacity of the PHEOC, Rapid Response and Contact Tracing Teams;

f. cross hospital expert teleconferencing facilities in selected hospitals to enable clinicians share their knowledge and experiences in management of the diseases;

g. establishment and operationalization of the NPHI; and

h. increasing the number of health workers required to meet the additional demands for surveillance, rapid response and case management.

6. **Component 3. Quarantine, isolation and treatment centers** [US$ 12,676,400]. This component will strengthen the health systems capacity to effectively provide infection prevention and control (IPC) and case management of COVID-19 cases. Key areas of support include construction/renovations and equipping the following facilities:

a. Isolation rooms in all POEs;

b. Isolation rooms in level 4 health facilities in the 14 high risk counties;[2] and

c. strengthening capacity of Kenyatta National Hospital Infectious Disease Unit Mbagathi, Kenyatta University Teaching and Referral Hospital and Moi Teaching and Referral Hospital to manage infectious diseases – including structural changes to improve negative pressure airflow, floor and air quality, etc.

[1] Team NCPERE. Vital surveillances: the epidemiological characteristics of an outbreak of 2019 novel coronavirus diseases (COVID-19) – China. Chin CDC Weekly. 2020;2(8):113-22.

[2] High risk counties include Busia, Garissa, Kajiado, Kiambu, Kilifi, Kisumu, Machakos, Migori, Mombasa, Nairobi, Nakuru, Turkana, Uasin Gishu, Wajir.

7. **Component 4. Medical waste management** [US$ 3,387,600]: This component will ensure the safe disposal of waste generated by laboratory and medical activities. It will include:

a. procurement of specialized incinerators for three national-level referral hospitals and other referral laboratories, where these are not available; and

b. cost of construction of incinerator areas, licenses and training on incinerator use, and cost of medical waste packaging such as bags and safety boxes.

8. **Component 5. Community discussions and information outreach** [US$4,960,059]: Advocacy, communication and social mobilization is an integral component of strengthening surveillance and response to health emergencies. This component will ensure there is a two-way communication between the government and the population. Regular communication is essential in building trust and increasing community support and engagement on the response to enable compliance with public health recommendations. Supported activities include:

a. rapid community behavior assessment to gather information about different groups knowledge, attitudes, beliefs, and challenges related COVID-19 response;

b. continuous behavior assessment and community sensitization through mobile feedback (text messages, social media platforms) and dedicated radio call-in shows both mainstream and indigenous languages to ensure preventative community and individual health and hygiene practices in line with national public health containment recommendations;

c. design, production and distribution of Information Education and Communication (IEC) materials, and

d. publishing electronic IEC materials through all media outlets, including translation of messages into various vernacular languages.

9. **Component 6: Ensuring availability of safe blood and blood products for transfusion services** [US$ 10,000,000]: This support will go towards strengthening the capacity of the Kenya National Blood Transfusion Service (KNBTS) to provide safe blood and blood products. It will include the following.

a. Enhancing blood collection and supply services through strengthening the coordination of national, Regional Blood Transfusion Centers (RBTCs)[3] and satellite centers; procurement of consumables and supplies for blood collection; procurement of supplementary auxiliary equipment for the blood collection centres such blood mixers, blood bank refrigerators and blood donor coaches; and strengthening systems for blood mobilization, collection and retention.

b. Automating blood transfusion service systems to enhance efficiency and traceability of blood and blood products between collection sites, RBTCs, and transfusing health facilities. This will involve assessing the existing blood bank computerized system (BECS) and the extent to which it meets the country's needs. Depending on the outcome of the assessment, support will include expanding the BECs ICT system to satellite centres and facilities, or purchase and installation of a new software, procurement of ICT equipment and capacity building staff

[3] The KNBTS has six RBTCs in Nairobi, Embu, Nakuru, Mombasa, Eldoret and Kisumu and 25 satellite centres.

c. Enhancing screening for transfusion transmissible infections (TTIs). In order to ensure that blood for transfusion is safe and free from TTIs, the project will expand the KNBTS testing capacity. This will include procurement of auxiliary and multiplex laboratory equipment, and purchase of reagents for screening of TTI and pathogen inactivation.
d. Enhance efficiency and quality of blood and blood products. International blood transfusion standards recommend transfusion of blood products instead of whole blood apart from exceptional situations such exchange transfusion in new-borns or acute blood loss situation (trauma). The KNBTS is currently processing blood to blood components using manual system potentially compromising quality blood components and reduced efficiency[4] of the blood processing. Support will include: full automation of blood component processing systems; maintaining cold rooms for blood storage; procurement and maintenance generators to ensure limited loss of the blood and blood products; and establishing a preventive maintenance plan for all the laboratory equipment in collaboration with the National Public Health Laboratory Equipment Maintenance Centre of Excellence.
e. Strengthening quality assurance systems in line with international standards and best practices on blood safety. The KNBTS will pursue blood bank accreditation from the African Society for Blood Transfusion standards and further accredit two remaining testing centers to ISO 15189 standards. Support will also include trainings and mentorship of technical staff, enrollment of the testing centres into proficiency testing schemes and contract integrated courier services for blood transfusion.

10. **Component 7. Project Implementation and Monitoring** [US$ 1,743,702]: This support will finance activities for program implementation and monitoring by providing additional resources to strengthen coordination and management capacity of the project. Key areas of support include:

a. Operational costs and logistical services for day-to-day management of the project;
b. Monitoring and Evaluation (M&E) activities, including process evaluation to monitor implementation progress and address implementation challenges;
c. Environmental and safeguards related activities, including establishment of a call centre to handle complaints and feedback to the public, linked to the PHEOC;
d. Stakeholder engagement; and
e. Contracting of staff on short-term basis for any specialized skills not available in government.

11. The Kenya COVID-19 Emergency Response Project is 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.

12. The overall objective of this SEP is to define a program for stakeholder engagement, including public information disclosure and consultation, throughout the project cycle. The

[4] For example, with manual system, 6 units of blood (six donors) are required to make 1 therapeutic platelet dose compared to one unit using automated system. This not only reduces the cost of producing the blood products but also reduce the blood volume requirement.

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 the 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, stakeholders 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.

## 3. STAKEHOLDER IDENTIFICATION AND ANALYSIS

13. 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.

14. 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 for the groups' interests in the process of engagement with the Project. Community representatives may provide helpful insights into the local settings and act as main conduits for dissemination of Project-related information and as a primary communication link/liaison 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 sample of community members and heeding their views on who can represent their interests in the most effective way.

### 3.1 Methods

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

a. *Openness and lifecycle approach*: public consultations for the project will be arranged during the whole lifecycle, carried out in an open manner, free of external manipulation, interference, coercion or intimidation;
b. *Informed participation and feedback*: information will be provided to and widely distributed among all stakeholders in an appropriate format; opportunities will be provided for communicating stakeholders' feedback, for analyzing and addressing comments and concerns; and
c. *Inclusiveness and sensitivity*: stakeholder identification will be undertaken to support better communication and build effective relationships. The participation process for the project and sub-projects will be inclusive. All stakeholders at all times will be encouraged to get involved in the consultation process. Equal access to information will be provided to all stakeholders. Sensitivity to stakeholders' needs and the need to ensure that methods do not expose people to COVID-19 are the key principles underlying the selection of engagement methods. Special attention will be given to vulnerable groups, in particular women, youth, older persons, people living in informal settlements, urban poor, refugees and people living on the streets, persons with disabilities (PWDs), and people with existing chronic illness. Particular attention should be paid to historically underserved traditional local communities (HUTLCs) as

defined in ESS7[5], also known as traditional minorities or vulnerable and marginalized groups (VMGs) including hunter gatherers, forest dwellers and nomadic pastoralists to ensure that they are targeted with relevant information and services in local languages and in culturally appropriate ways.

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

a. **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;
b. **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
c. **Vulnerable Groups:** persons who may be disproportionately impacted or further disadvantaged by the project 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.

### 3.2 Affected parties

17. 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:

- COVID-19 infected people;
- People under COVID-19 quarantine;
- Relatives of COVID-19 infected people;
- Relatives of people under COVID-19 quarantine;
- Neighboring communities to laboratories, quarantine centers, and screening posts;
- Workers at construction sites of laboratories, quarantine centers and screening posts;
- People at COVID-19 infection risk (travelers, inhabitants of areas where cases have been identified, etc.);
- Healthcare workers;
- Municipal waste collection and disposal workers;
- MoH and the National COVID-19 Taskforce and the National Emergency Response Committee (NERC) on COVID-19;

[5]A distinct social and cultural group possessing the following characteristics in varying degrees: (a) Self-identification as members of a distinct indigenous social and cultural group and recognition of this identity by others; and (b) Collective attachment to geographically distinct habitats, ancestral territories, or areas of seasonal use or occupation, as well as to the natural resources in these areas; and (c) Customary cultural, economic, social, or political institutions that are distinct or separate from those of the mainstream society or culture; and (d) A distinct language or dialect, often different from the official language or languages of the country or region in which they reside

- County governments, especially the Council of Governors (CoG) and County Executives (CECs) for Health;
- Other public authorities including police and security services who may be required to enforce directives;
- Other public officers directly involved in COVID-19 response
- Airline and border control staff;
- Airlines and other international transport business; and
- Africa CDC, WHO and other key partners.

### 3.3 Other interested parties

18. The project stakeholders include parties other than these directly affected, including:

**i.** Mainstream media;
**ii.** Participants on social media;
**iii.** Politicians;
**iv.** Other national and international health organizations;
**v.** Other national and international NGOs;
**vi.** Businesses with international links; and
**vii.** The public at large.
**viii.** Other organizations involved in protection of human rights
**ix.** Health workers unions and associations

### 3.4 Disadvantaged/vulnerable individuals or groups

19. It is particularly important to understand whether the 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. Therefore, it is critical to ensure that awareness raising and stakeholder engagement with disadvantaged or vulnerable individuals or groups on infectious diseases and medical treatment in particular, is adapted to take into account such groups or individuals and to ensure a full understanding of project activities and benefits and protect them from spread through engagement. 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 facilitating them to participate in the project-related decision making so that their awareness of and input into the overall process are commensurate to those of the other stakeholders.

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

- Older persons;
- People with compromised immune systems or related pre-existing conditions;
- Illiterate people;
- Persons with disabilities (PWDs);
- Historically underserved traditional local communities (HUTLCs) are described as distinct social and cultural group possessing the following characteristics in varying

degrees: (a) self-identification as members of a distinct indigenous social and cultural group and recognition of this identity by others; (b) collective attachment to geographically distinct habitats, ancestral territories, or areas of seasonal use or occupation, as well as to the natural resources in these areas; (c) customary cultural, economic, social, or political institutions that are distinct or separate from those of the mainstream society or culture; and (d) distinct language or dialect, often different from the official language or languages of the country or region in which they reside. In Kenya these groups are also known as traditional minorities or VMGs and include hunter gatherers, forest dwellers and nomadic pastoralists.

- Female-headed households;
- Child-headed households
- Unemployed youth;
- People living in informal settlements;
- People living on the streets; and
- Urban poor.

21. 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 to adopted by the project is provided further below.

## 4. STAKEHOLDER ENGAGEMENT PROCESS

### 4.1 Summary of stakeholder engagement done during project preparation

22. Due to the emergency situation and the need to address issues related to COVID-19, consultations were held with public authorities and health experts, including Africa CDC. A number of surveys and innovations for community engagement have recently been carried out including by Geopoll, Infotrak, Africa Voices and the Population Council. However, most have targeted youth in the main urban centres thus emphasis should be placed on other groups including the vulnerable groups identified above. The MoH consultations were conducted as part of the Africa CDC project, 2019 and the Kenya Transforming Health Systems (THS) from 2016-2019 and East African Public Health Laboratory Projects from 2010-2019.

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

23. The WHO "*COVID-19 Strategic Preparedness and Response Plan:* Operational Planning Guidelines to Support Country Preparedness and Response" (2020) outlines the following approach in Pillar 2 on Risk Communication and Community Engagement, which will be the basis for the stakeholder engagement:

> *It is critical to communicate to the public what is known about COVID-19, what is unknown, what is being done, and actions to be taken on a regular basis. Preparedness and response activities should be conducted in a participatory, community-based approaches that are informed and continually optimized according to community feedback to detect and respond to concerns, rumours and misinformation. Changes in preparedness and response interventions should be announced and explained ahead of time and be developed based on community perspectives. Responsive, empathic, transparent and consistent messaging in local languages through trusted channels of*

*communication, using community-based networks and key influencers and building capacity of local entities, is essential to establish authority and trust.*

In addition to communication on COVID-19, it is also necessary to get feedback on the services provided under this project.

### 4.3 Proposed Strategy for information disclosure

24. 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 avoiding 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).

25. The project will adapt to different requirements. While country-wide awareness campaigns will be established, specific communication around Ports of Entry as well as quarantine/isolation centres and laboratories will have to be timed according to need and be adjusted to the specific local circumstances.

### 4.4 Stakeholder engagement process

26. The project includes considerable resources to implement the stakeholder engagement activities. The details on the approaches to be adopted are also covered in the Kenya Draft Health Sector Communication and Community Engagement Strategy which adopts the WHO guidelines and National Risk Communication Guidelines for Emergencies and Disaster Management. There would be a need for specific considerations for VMGs in particular areas and ensuring adequate feedback mechanisms to be funded under this project.

27. Stakeholders will be kept informed as the project develops and evolves, including reporting on project environmental and social performance and implementation of the SEP and grievance redress mechanisms (GRM). This will be important for the wider public, but equally and even more so for suspected and/or identified COVID-19 cases as well as their relatives. Table 1 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 1: Milestones for the SEP**

| Project stage | Topic of consultation / message | Method used | Target stakeholders | Responsibilities |
|---|---|---|---|---|
| After appraisal | Risk communication and community engagement strategy | Key informant discussions and FGDs | Communication expert, media experts and information users including VMGs | MoH communication expert and social safeguards officer |

| | | | | |
|---|---|---|---|---|
| Implementation | Complaints about service provision | County focal point logs and reports and national hotline | Receivers of information and services. Information or data managers | MoH PMT |
| Quarterly evaluation and feedback survey | Feedback of effectiveness of different channels of communication | Survey and Direct observation of the project subjects | Different stakeholders and VMG groups | MoH Communications |

## 5. COMMUNICATION

28. Part of managing stakeholder relationships is keeping track of who is speaking on the Project's behalf and what is being said on third parties' behalf, and what is being said by third parties. The formulation of communication messages and decisions on the channels to be used will be guided by the following key considerations:

a. The involvement of the affected parties in the Project Area of Influence and community members in the design and dissemination of information;
b. Use of multiple channels of communication including radio, newsletters, social media, fact sheets, frequently asked questions (FAQs), etc. based on the needs and access requirements of the target audience. All documents will be presented in English, Kiswahili and other local languages as appropriate and will include visual depictions for non-literates;
c. Ability to communicate to a broad range of people, which will be ensured through the use of media that is easily understood, such as local radio stations that use local languages and reach the particular groups of interest;
d. Sensitivity to GoK policies and regulations, the financiers (WB and others) and other communication requirements to safeguard the integrity of the process and the authenticity of the messages; and
e. Evidence-based media engagement: The Communication officer in the PMT will be required to monitor and evaluate the effectiveness of the information shared and the channels used, and adjust as necessary.

### 5.1 When to communicate

29. Project communication will be structured and offered regularly but with the flexibility of responding to issues as they emerge. It is envisaged that there will be more engagement at the MoH level, and due to the nature of the pandemic most actions will be driven by the National Taskforce. Given that the Project is currently under way, the stakeholders need to be informed on all planned activities with potential impact on them. It is important that the following information be provided regularly and on need-basis:

a. Number of people infected, recovered and deceased;
b. Extent of the disease in Kenya (with a focus on counties);
c. Changes in guidelines in managing the pandemic;
d. Changes in the patterns of the pandemic, e.g. new areas being affected, etc.;
e. Grievance redress mechanisms (GRM) and processes; and
f. The list of project related complaints received and resolved – this would ensure that the communities are not relying on rumors as their main source of Project information.

### 5.2 Targets, messages and communication channels

30. Table 2 presents a list of key stakeholders who will receive information on the Project, the regularity of engagement and the level of interaction. It is notable that the communication specified here is over and above the use of media during press briefings that are aired to all citizens. This list will be reviewed and adjusted from time to time based on the prevailing contexts and emerging communication needs.

**Table 2: Communication Matrix**

| **Stakeholder** | **Specific org / agency** | **Message** | **Communicator** | **Delivery method** | **Schedule** |
|---|---|---|---|---|---|
| *Who will you communicate to?* | *Who exactly will be targeted at this level?* | *What is the purpose of communication?* | *Who will the communication be from?* | *How will the communication be delivered?* | *When will it happen and how often* |
| People directly affected by COVID-19 | COVID-19 infected people | Update on their status and psychosocial support | Health personnel responsible | In person | Daily |
| | Relatives of COVID-19 infected people | Update on the progress of the patients and psychosocial support | Health personnel responsible | -Phone<br>-Text | Daily |
| | People under COVID-19 quarantine | Update on their status and psychosocial support | Health personnel responsible | In-person | Daily |
| | Relatives of people under COVID-19 quarantine | Update on the progress of the those in isolation and psychosocial support | Health personnel responsible | -Phone<br>-Text | Daily |
| | All of the above | Grievance mechanism and patient/relative feedback questionnaires | Health personnel responsible | Posters at facilities<br>Patient feedback questionnaire | At discharge |
| People at risk of infection | Neighboring communities to laboratories, quarantine centers and screening posts | -Progress of the construction<br>-Safety measures in place | -Facility in charge<br>-Health promotion team | -Fact sheets<br>-Radio<br>-TV<br>-Public Address System (PAS) | Weekly and on-need basis |
| | Workers at construction sites of laboratories, quarantine centers and screening posts | -Safety measures<br>-Infection prevention and control (IPC) management<br>-Referral pathways | -Facility in-charge<br>-Contractors<br>-Health promotion team | -Fact sheets<br>-Radio<br>-TV<br>-Posters/flyers, -PAS | Weekly and on-need basis |
| | Municipal waste collection and disposal workers | -Safety measures<br>-Referral pathways | -CEC for Health<br>-Health promotion team<br>-Occupational health team | -Fact sheets<br>-Radio<br>-TV<br>-Posters/flyers, PAS | Weekly and on-need basis |
| People at risk of COVID-19 | Travellers | -Quarantine measures<br>-COVID-19 Protocols | -KMPDC<br>-MoH team | -Fact sheets<br>-Protocols<br>-SMS, PAS | Before and after arrival |
| | Inhabitants of areas where cases | -Safety measures<br>-Progress on the patients/ those in quarantine | -CEC for health<br>-Community leaders (CHWs) | -Fact sheets<br>-Radio<br>-TV | Weekly and on-need basis |

| Table 2: Communication Matrix | | | | | |
|---|---|---|---|---|---|
| **Stakeholder** | **Specific org / agency** | **Message** | **Communicator** | **Delivery method** | **Schedule** |
| | have been identified | -Sensitization on stigma | -Health promotion team | -Posters/flyers<br>-SMS, PAS | |
| Vulnerable groups | -VMGs<br>-People with pre-existing conditions<br>-Informal settlements<br>-Refugees camps<br>-VMGs/HUTLCs | -Information on COVID-19<br>-Safety measures<br>-Availability of health services<br>-Sensitization on stigma<br>-Updates on COVID-19 | -Health<br>-Promotion team<br>-CEC for health<br>-Implementing partners (with local networks)<br>-CHWs | -Fact sheets<br>-Radio<br>-TV<br>-Posters/flyers*<br>-PAS | On-need basis |
| Healthcare workers | All cadres including CHWs | -Personal safety<br>-IPC<br>-Roles & responsibilities for observation of protocols & to patients and communities, GRM<br>-Institutional safety<br>-Update on protocols<br>-Status of infection in the country | -Acting Director of Health<br>-Chair KMPDC<br>-Chair of the relevant councils, unions and associations<br>-County teams | -Update reports on WhatsApp<br>-Webex/zoom meetings<br>-In-person briefings | Daily and on-need basis |
| People at risk of COVID-19, VMGs and healthcare workers | | Grievance mechanism<br>Community feedback survey | Health promotion team<br>PMT | Leaflet, poster in health offices and health facilities<br>Telephone or in person survey | Throughout the project<br>Mid-point and ¾ point |
| MoH | The entire health system | -Update on protocols<br>-The status of infection in the country | CS, CAS, PS and Acting Director of Health | -Update reports on WhatsApp<br>-Webex/zoom meetings<br>-In-person briefings | Weekly and on-need basis |
| National coordination teams | National COVID-19 Taskforce<br>National Emergency Response Committee (NERC) on COVID-19 | -Country needs/ emerging challenges<br>-Citizens perceptions and complaints<br>-Country progress<br>-Updates on protocols<br>-Global trends | CS, CAS, PS and<br>-Acting Director of Health | -Update reports on WhatsApp<br>-Webex/zoom meetings<br>-In-person briefings | Daily and on-need basis (e.g. during a crisis) |
| County Governments | County Governors and CECs for Health | -County status<br>-County preparedness<br>-Challenges<br>-Complaints and grievances<br>- Community concerns | - NERC<br>-CoG | -Update reports on WhatsApp<br>-Webex/zoom meetings<br>-Virtual monitoring tools e.g. GEMS | Daily and on-need basis |
| Public Authorities | NYS and security officers | -Update on protocols<br>-Safety measures<br>-Referral pathways | -NERC<br>-MoH | -Update reports<br>-Protocols<br>-Webex/zoom meetings | Weekly and on-need basis |
| Ports of Entry | Airports and land borders | -Update on protocols<br>-Safety measures<br>-Referral pathways | -MoH<br>-NERC | -Update reports<br>-Protocols<br>-FAQs | Weekly and on-need basis |

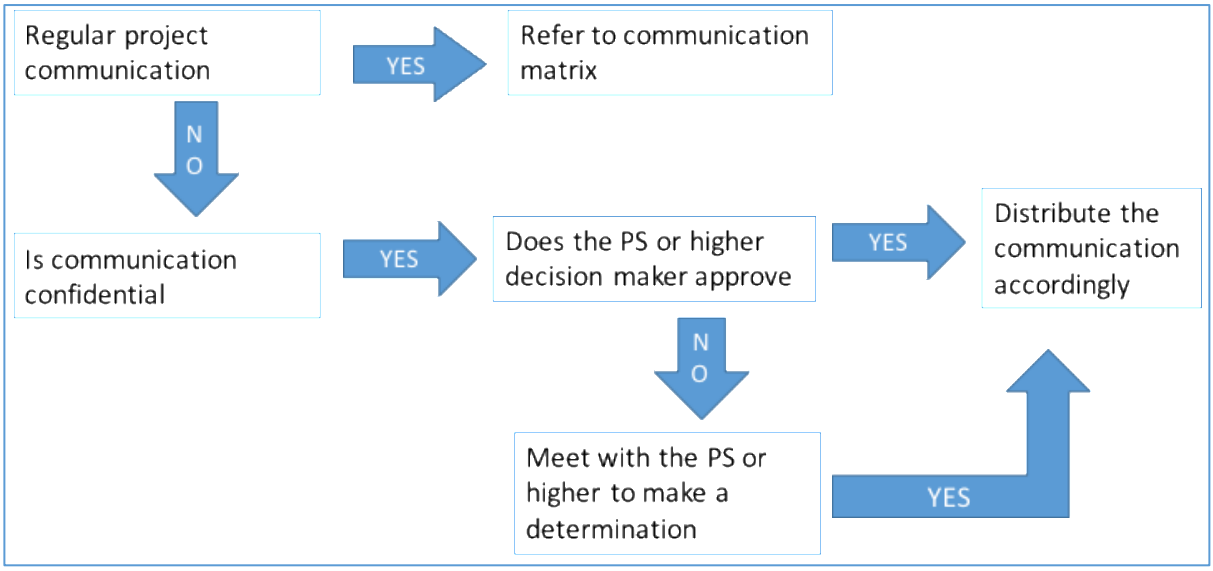
| Table 2: Communication Matrix | | | | | |
|---|---|---|---|---|---|
| **Stakeholder** | **Specific org / agency** | **Message** | **Communicator** | **Delivery method** | **Schedule** |
| | | - Grievance mechanism<br>- Traveller feedback surveys | | -Fact sheets<br>-Posters/flyers<br>-Survey forms | Ongoing |
| Health community – local and global | Africa CDC, WHO and other key partners | -Country progress<br>-Country needs/ emerging challenges<br>-Global trends | -National Taskforce on COVID-19 | Update reports | Weekly/ monthly. On need basis |

*The information should be presented in language and formats that are understandable by the target groups.

### 5.3 Communication escalation process

31. Communication can be an extremely complex process depending on the size and scope of the project and the number of stakeholders. The flowchart presented in Figure 1 provides the key stakeholders with a better understanding of the steps involved in sharing Project information. It is notable that there may be occasions or situations which fall outside of the communication flowchart where additional clarification is necessary. In such situations, the Principal Secretary (PS) will be responsible for discussing the issues with the PMT to decide on how to proceed, as illustrated in Figure 1.

**Figure 1: Project communication flow chart**




32. The communication team will review and refine the communication plans regularly. The monitoring tools for the SEP will include indicators such as preferred source of information, most effective channels of communication and people's perceptions on the SEP.

## 6. GRIEVANCE REDRESS MECHANISM

33. 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[6]. Specifically, the GRM:

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

### 6.1 Description of the project GRM

34. Multiple channels will be availed to the public for channeling complaints on the project, including:

a) telephone and texts (a dedicated line will be purchased for this purpose);
b) in person visits to the MoH offices, health facilities across the country, and county offices etc.;
c) letter writing to the Ministry's postal office box;
d) email – a dedicated email address will be shared for public use;
e) blog – to be developed and dedicated to the project; and
f) a toll free 24-hour hotline.

35. The MoH will acquire a 24-hour toll free hotline which will be established as part of the Transforming Health Systems project Contingency Emergency Response Component (CERC). The hotline will be staffed with trained grievance handlers (the number of handlers will be increased depending on demand) who speak Kiswahili, English and if possible other languages from those communities that may have limited Kiswahili knowledge. Efforts will be made to seek handlers who are empathetic and can communicate to vulnerable people as well as those in hard to reach counties. A protocol for handing complaints, including staff complaints and confidential information e.g. GBV/SEA complaints will be developed and disseminated.

36. County specific issues will be handled by the County Grievance Office and MoH grievance focal points. These will also be trained on the GRM protocol, initially in the 14 high risk counties (the 1st phase of the project[7]) and then nationally. They will submit the log of complaints and resolution to the national complaints coordinator once a month and refer any urgent complaints immediately. The health facility grievance focal points will also be strengthened, especially for facilities receiving and treating COVID-19 patients.

[6] Adapted from: http://documents.worldbank.org/curated/en/342911468337294460/pdf/639100v10BRI0F00Box0361531B0PUBLIC0.pdf

[7] It is notable that the patterns of the COVID-19 infection may influence a shift in the list of priority counties. For instance, although Mandera County was not in the original list, it is now a hotspot that requires support.

37. The GRM will include the following steps:

a. 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;
b. Ensure those providing services (healthcare workers, uniformed services providers, ambulance workers, etc.) can lodge complaints securely and confidentially;
c. Ensure that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants; and
d. Avoid the need to resort to judicial proceedings, unless the complainant decides that the process provided has failed.

### 6.2 Description of the project GRM

38. The project complaints handling mechanism does not replace the functional legal and country mechanisms, but provides a system for managing project level complaints to ensure that they are identified early, mitigated and addressed where legal action is not yet warranted, and enables project improvements to prevent further complaints. All staff are responsible for the functioning of the GRM in order to improve project outcomes, and should forward complaints whenever they come across them. Complaints may be raised formally or informally and all should be acknowledged by the person receiving them, referred to the appropriate focal points for logging (county and national levels), follow up and resolution. The following actions will be used for managing complaints for this project.

a. Complaints should be sent to the GRM focal point or National /County Grievance Redress Officer by email, text, phone, letter or in person. The complaints should be collated onto a complaints form and logged into the register (Annex 1 and 2). The complaints handling email grievance@cherproject.com, telephone contacts (07696995546) and Toll free number should be disseminated widely to all stakeholders as well as sent formally to counties together with an overview of the complaints mechanism for further dissemination and should be displayed on the MOH website.
b. Complaints should be reviewed by the PMT (or a sub-committee) within 2 weeks of receipt.[8] The grievance committee, made up of the following PMT members: social safeguards officer, or National/County Grievances redress officer, communication officer, FM, procurement, M&E, inter-governmental, legal, internal audit from the Ministry, with the Project Manager as the chair and the GRM Officer[9] as the secretary, will review the complaints and provides guidance on the course of action and ensure follow-up on previous complaints and feedback on resolution to the complainant. The grievance committee can co-opt members involved in the COVID-19 response based on the nature of the complaints. Minutes of the meetings will be kept and action points summarized for ease of follow-up. Recommendations are likely to include: internal audit, multi-agency monitoring visits including health practitioners, etc. Any preliminary investigation should take place within one month of the committee

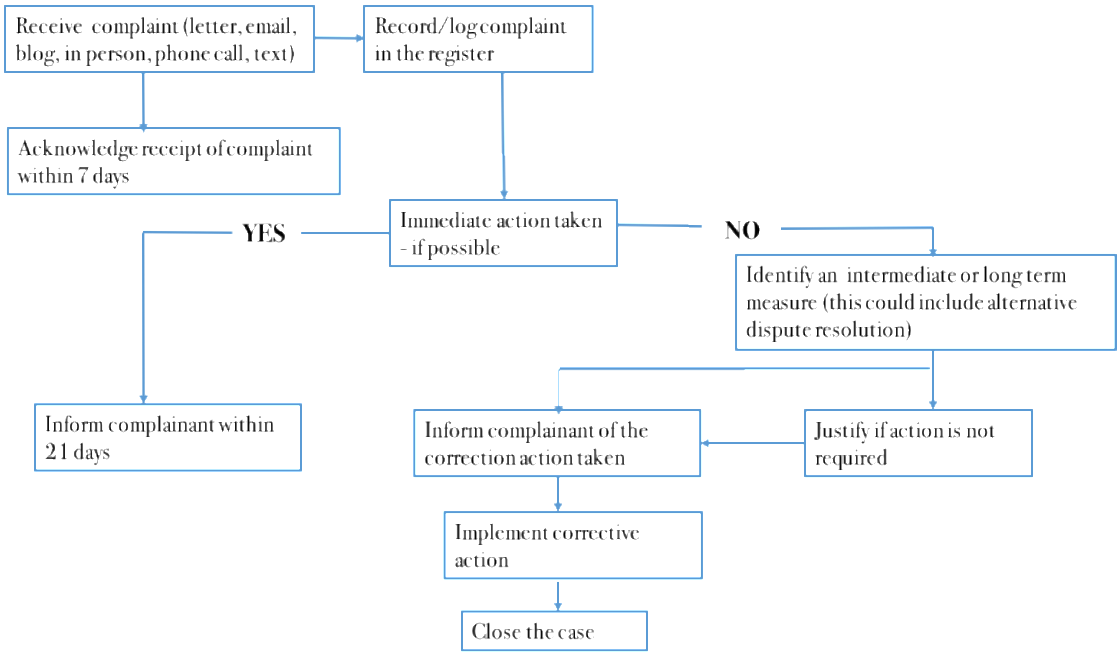
[8] The team should consider whether to form a new committee or to expand the existing Ministerial Standing Committee for complaints.
[9] This could be the social safeguards officer or communication officer or other designated person initially.

meeting. All formally raised complaints require feedback to the complainants within 3 weeks (21 days) of a decision being made.

c. For informal complaints i.e. those raised through social media, print media or not formally lodged, the committee should be deliberate upon them to decide whether to investigate based on the substance and potential impact/reputational risk.
d. If the complaint is referred to the government's legal complaints structures (e.g. EACC, CAJ, etc.), the World Bank should be notified.
e. Complaints regarding SEA should be kept confidential, the name of the complainant should not be recorded, only the age and gender of the complainant, and whether a project worker was involved and should be sent directly to the PM who should immediately inform the World Bank.
f. No disciplinary or legal action will be taken against anyone raising a complaint in good faith.
g. A quarterly report of complaints resolution should be provided to the World Bank (as per the reporting format in Annex 3).

39. The practical steps to be used in addressing grievances for this project are presented in Figure 2.

**Figure 2: Steps to be followed in addressing complaints**




40. A toll free line will be acquired to receive complaints on the project including for workers, and confidential complaints such as incidences of GBV/SEA. This will be guided by a complaints protocol (to be prepared) which all the operators will be trained on. Features for recording may be considered to ensure that people can call in at any time of day or night. Once the county grievance focal persons have been trained on the COVID-19 complaints protocol, county selection options may also be included, particularly for affected communities.

41. The Project team will explore the possibility of operating an online platform for the GRM. There are operational examples including the Regional Pastoral Livelihoods Resilience Project (RPLRP) that the team could learn from. The online platform will allow for an expedited review and response process for the complaints and grievances. This activity will be closely linked to the National ICT Response Team currently based at the Ministry of ICT, Innovation and Youth.

42. Grievance registers should be issued to all supported hospitals through this project including the laboratories, blood transfusion centers, isolation/quarantine centers and hospitals. An orientation should be provided to the complaints focal person within the hospital and the staff of the public relation desks. The complaints mechanism should be clearly described on posters displayed next to each public relation desk and COVID-19 testing and treatment facilities.

43. Each county should identify a health grievance redress focal person who should be oriented on the GRM and should have a devoted email (mohpandemicproject.county@gmail.com) and telephone contact that should be disseminated to all health staff and facilities. They should maintain a grievance log and send it to the GRM focal person in the PMT every month. The GRM focal points within the PMT

will ensure that counties have grievance focal persons who are adequately oriented on the COVID-19 project, it's GRM and referral pathways and have a system of resolving grievances at the county level. The Geo-enabling Initiative for Monitoring and Surveillance (GEMS) monitoring tool used by THS could be adapted to monitor the county project progress including concerns and grievances by stakeholders.

## 7. RESOURCES AND RESPONSIBILITIES FOR IMPLEMENTING STAKEHOLDER ENGAGEMENT ACTIVITIES

### 7.1 Resources

44. The MoH will be the main implementing agency for the project and will lead the execution of project activities, including this SEP. The budget contains adequate budgets for the SEP and GRM and should be referenced when developing the detailed workplan. The Kenya Medical Supplies Agency (KEMSA) will be responsible for procurement and distribution of medical supplies and equipment. The institutional and implementation arrangements for the project are contained in Annex 4.

45. The NERC on COVID-19, chaired by the Cabinet Secretary for Health, will provide stewardship and oversight of the project. The NERC was established by the President through an executive order to address various aspects related to COVID-19 preparedness and response including: (i) coordinate Kenya's preparedness and response to COVID-19; (ii) coordinate capacity building of medical personnel and other professionals; (iii) enhance surveillance at all points of entry; (iv) coordinate the preparation of national, county and private isolation and treatment facilities; (v) coordinate the supply of testing kits, critical medical supplies and equipment; (vi); conduct a risk capacity vulnerability assessment for the health sector and develop a system recovery strategy (vii) coordinate both local and international technical, financial and human resources support efforts with development partners and key stakeholders; and (viii) formulate, enforce and review of processes and requirements for entry into Kenya for people travelling from COVID-19 affected countries, among others.

46. The National COVID-19 Taskforce will provide technical guidance throughout the project implementation. The Taskforce draws membership from the MoH, other relevant Government agencies, development partners, non-governmental and civil society organizations. The mandate of the Taskforce is to review the evolving threat from the COVID-19 outbreak and regularly offer technical advice to the MoH and other line ministries on appropriate measures. The Taskforce has 6 sub-committees responsible for: resource mobilization; public health emergency operations center; media, communications and call center; case management and capacity building for health workers; laboratories of samples handling and testing; and facility preparedness.

47. The project will be managed by the newly established PMT. The MoH will be required to (a) designate staff with appropriate skills set and recruit on exceptional basis to fill skills gaps; (b) build staff capacity; and (c) make resources available to conduct day-to-day functions. The Ministry may also get staff from other Ministries on secondment to augment the capacity of the PMT. Staff for cross-cutting functions (for example, procurement officers, project accountants, safeguards officers, M&E) will be shared between the THS-UCP, with additional staff with the appropriate skills set being designated as necessary. The MoH and

the other ministries will release those staff assigned to the PMT of any other duties and responsibilities so that they can fully dedicate themselves to the project. The PMT will be responsible for coordinating and managing the timely and effective implementation of the Project. It will have a dedicated Project Manager with overall responsibility for effective implementation of the activities. The PMT will prepare quarterly financial and technical reports and submit these to the World Bank within the stipulated timelines. They will work closely with the PMT for the THS-UCP.

## 8. MONITORING AND REPORTING

48. The SEP will be periodically revised and updated as necessary in order to ensure that the information and the methods of engagement remain appropriate and effective in relation to the project context and spread of the pandemic. Any major changes to the project related activities and to its schedule will be duly reflected in the updated SEP. Quarterly 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.

49. The quarterly 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; and
- A number of Key Performance Indicators (KPIs) will also be monitored by the project on a regular basis.

50. The project team will conduct surveys on World Bank supported components at mid-point and three-quarter point. The results from these surveys will be used to inform the World Bank on the necessary steps to take towards meeting the project goals. In addition, the World Bank supported GEMS tool will be used by county health focal points (all county focal points have been trained and are currently using the tool) to provide feedback on the project and the situation of particular groups. The County focal points will encourage the CHWs to feed in concerns, if necessary anonymously, in case communities may be reluctant to do so.

51. The ESMF, ESIAs/ESMPs, LMP and updated SEP will be disclosed on the MoH website. Table 3 shows the list of documents to be disclosed.

**Table 3: Disclosure of project documents**

| Project stage | Target stakeholders | List of information to be disclosed | Methods and timing proposed |
|---|---|---|---|
| Before appraisal | Health stakeholders and the general public | PAD, SEP, ESCP | *WB and MOH website* |
| Within one month of effectiveness | All stakeholders identified above | Updated SEP, LMP, ESMF | *WB and MOH website* |

| | | | |
|---|---|---|---|
| Quarterly | Implementing partners | Progress report including summaries of complaints and resolution | *WB and MOH website* |
| Before key activities | Key stakeholders for specific activities | ESIA or ESMP | *WB and MOH website* |
| Annual | General public | Annual report on progress and lessons learnt | *WB and MOH website* |

## ANNEXES

### Annex 1:[10] Complaints form

1. Complainant's Details:

Name (Dr / Mr / Mrs / Ms) _____
ID Number _____
Postal address _____
Mobile _____
Email _____
County _____
Age (in years): _____

2. Which institution or officer/person are you complaining about? Ministry/department/agency/company/group/person

_____
_____
_____

3. Have you reported this matter to any other public institution/ public official?

☐ Yes ☐ No

4. If yes, which one?

_____
_____

5. Has this matter been the subject of court proceedings?

☐ Yes ☐ No

6. Please give a brief summary of your complaint and attach all supporting documents [Note to indicate all the particulars of *what* happened, *where* it happened, *when* it happened and by *whom*]

_____
_____
_____
_____
_____
_____
_____

7.. What action would you want to be taken?

_____
_____
_____
_____

Signature _____
Date _____

[10] Based on the Kenya Public sector complaints handling guide, CAJ.

## Annex 2: 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 3: Complaints reporting template

| No. of complaints received | Main mode complaint lodged | No. of complaints resolved | No. of complaints pending | Duration taken to resolve, e.g. spot resolution, 1 day, 7 days, 14 days, 1 month, quarterly, annual | Recommendations for system improvement |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Note that this form could be replaced with the use of the GEMS system on which THS and VMG focal points have been trained on.

## Annex 4: National actions on COVID-19

| Step | Actions to be taken |
|---|---|
| 1 | ☐ Implement national risk-communication and community engagement plan for COVID-19, including details of anticipated public health measures (use the existing procedures for pandemic influenza if available) |
| | ☐ Conduct rapid behaviour assessment to understand key target audience, perceptions, concerns, influencers and preferred communication channels |
| | ☐ Prepare local messages and pre-test through a participatory process, specifically targeting key stakeholders and at-risk groups |
| | ☐ Identify trusted community groups (local influencers such as community leaders, religious leaders, health workers, community volunteers) and local networks (women's groups, youth groups, business groups, traditional healers, etc.) |
| 2 | ☐ Establish and utilize clearance processes for timely dissemination of messages and materials in local languages and adopt relevant communication channels |
| | ☐ Engage with existing public health and community-based networks, media, local NGOs, schools, local governments and other sectors such as healthcare service providers, education sector, business, travel and food/agriculture sectors using a consistent mechanism of communication |
| | ☐ Utilize two-way 'channels' for community and public information sharing such as hotlines (text and talk), responsive social media such as U-Report where available, and radio shows, with systems to detect and rapidly respond to and counter misinformation |
| | ☐ Establish large scale community engagement for social and behaviour change approaches to ensure preventive community and individual health and hygiene practices in line with the national public health containment recommendations |
| 3 | ☐ Systematically establish community information and feedback mechanisms including through: social media monitoring; community perceptions, knowledge, attitude and practice surveys; and direct dialogues and consultations |
| | ☐ Ensure changes to community engagement approaches are based on evidence and needs, and ensure all engagement is culturally appropriate and empathetic. |
| | ☐ Document lessons learned to inform future preparedness and response activities |