FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA

MINISTRY OF HEALTH

HEALTH EMERGENCY PREPAREDNESS, RESPONSE AND RESILIENCE PROJECT

Stakeholder Engagement Plan (SEP)

Final

July 2023

Table of Contents

List of Tables

List of Acronyms

AHRI	Armauer Hansen Research Institute
CBMP	Cross-Border Mobile Populations
CBO	Community Based Organization
CDC	Centre for Disease Prevention and Control
CPF	Country Partnership Framework
CSO	Civil Society Organization
CERC	Contingent Emergency Response Component
EFDA	Ethiopian Food and Drug Administration
EPHI	Ethiopian Public Health Institute
EPSA	Ethiopian Pharmaceutical Supply Agency
ESF	Environmental and Social Framework
ESMF	Environmental and Social Management Framework
ESS	Environmental and Social Standard
GBV	Gender-Based Violence
GMU	Grant management Unit
GRM	Grievance Redress Mechanism
HCW	Health Care Worker
HEPRR	Health Emergency Preparedness, Response and Resilience
HEW	Health Extension Worker
HSTP II	Second Health Sector Strategic Plan
IDP	Internally Displaced Persons
IPC	Infection Prevention and Control
SSHUTLC	Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities
MoA	Ministry of Agriculture

MoH	Ministry of Health
NITAG	National Immunization Technical Advisory Group
NMA	National Meteorology Agency
NPHEOC	National Public Health Emergency Operations Center
PPE	Personal Protection Equipment
RCCE	Risk Communication And Community Engagement
RHB	Regional Health Bureau
SEP	Stakeholder Engagement Plan
SEA/SH	Sexual Exploitation and Abuse/Sexual Harassment

1 Introduction

1.1 Background

The demand for equitable access and quality healthcare services is increasing in Ethiopia because of a rapidly growing population, epidemiological transition of diseases, rapid urbanisation, and broader social and economic changes occurring in the country. The COVID-19 pandemic, civil conflict and climate shocks including drought have severely impacted the wellbeing of Ethiopia's people. Ethiopia has had the second largest number of COVID-19 cases and fatalities in Sub-Saharan Africa with almost half a million cases and 8,000 deaths since March 2020.[1] The pandemic contributed to a three percent decrease of Gross Domestic Product (GDP) and foreign direct investment declined by 20 percent. The shocks have exposed the continuous weaknesses of the health system to adjust itself in responding to the shock while continuing the delivery of essential health services.

In the past few decades, the government of Ethiopia (GoE) has made remarkable cross sectoral and cross-border investments to strengthen animal and human health services. However, the institutions are set up in such a way that they function independently with limited functional coordination. Since 2009, WHO and IGAD supported efforts to reinforce the cross-sectoral and cross-border coordination and collaboration with the bordering countries including South Sudan, Djibouti, Kenya, Eritrea and Sudan to improve the prevention of cross-border spread of diseases, harmonizing disease surveillance and early warning systems, and initiating a joint response to trans-boundary health threats and sustainable cross-border disease control mechanisms in the context of International Health regulations (IHR 2005). Cross-border mobile populations (CBMPs) make up a significant proportion of the population of the border localities of the three countries, including mobile pastoralists, refugees, seasonal cross-border labor, persons engaged in cross-border economic activity, undocumented migrants, internally displaced persons (IDPs), and communities that host refugees and IDPs.

In the last two decades, the efforts for health sector development were complicated by high population growth, urbanization, and changes in land use that drive increased contact between people and animal hosts. People and cattle movement across the porous borders is increasing, making cross-border spread of infectious diseases more likely. Infectious and non-infectious diseases disproportionately affecting communities living in poverty and very rural areas as access, cost, knowledge and cultural factors are barriers in reaching and protecting vulnerable populations with affordable quality services and key health information. Furthermore, Ethiopia is currently enduring a "triple burden of disease" as the prevalence of non-communicable

[1] Ministry of Health (MOH), "COVID-19 report," April 26, 2022.

diseases (NCDs), mental health illnesses and injuries have considerably increased, adding to the already high morbidity and mortality from endemic communicable diseases. Conflict and fragility further compound this reality and heighten the threat of infectious diseases, access to essential health services, and food insecurity, as well as impact the mental health of affected communities and humanitarian responders. Climate change induced drought is causing outbreaks in eastern and southern parts of the country while altering geographic and seasonal range of disease transmission in the country, along with increasing the intensity of climate sensitive disease transmission including malaria, diarrheal diseases, Acute Respiratory Infections (ARIs), meningitis and increasing the risk of Ebola virus disease within Ethiopia.

The government of Ethiopia have developed multiple five-year strategies for national public health capacity building, emergency response, strengthening one health and health security system in the country. In addition to country public health emergency response plans and strategies, Ethiopia aligns the country level effort with global standards including the WHO guidelines and frameworks for public health emergency response and resilient health systems building. The MoH is committed to implementing the WHO's international health regulation (IHR) Monitoring and Evaluation Framework. This includes the voluntary Joint External Evaluation (JEE) of IHR core capacities that should be followed with a national action plan revisions which is underway currently to achieve and sustain core capacities. The 2016 JEE assessment indicated that the need to build resilient health system through strengthening public health surveillance, multi-sectoral coordination including cross border collaboration, health workforce development and laboratory systems strengthening.

While the government and development partners, including the WBG, have invested in health systems strengthening (HSS) for over two decades, the country's capacity in proactive emergency preparedness and response and resilience remains poor and needs further attention and investment. Despite the multiple, severe, and long-lasting impacts of health emergencies (HEs) in the country, institutions, systems, and policies are largely designed to react to these events, rather than prevent or prepare for them. Therefore, moving from a reactive response to HEs to a proactive approach is critical. The responsibility for HE preparedness and resilience must be shared by governments, partners, sectors, and communities, which must collaborate effectively across the prevention-detection-response continuum, both within and across national borders, implementing actions that are proactive and sustainable, and possibly far upstream from the HE events themselves.

In recognition of these facts, the Federal Government of Ethiopia, in collaboration with the World Bank (WB), is developing the Health Emergency Preparedness, Response and Resilience (HEPRR) Project, with the aim of ensuring a sustained, comprehensive, and transformational impact on both health emergency preparedness/response and resilience, building on the many achievements of previous WBG supported projects.

The proposed project is fully aligned with government health sector strategies, such as the Health Sector Transformation Plan (2019/20-2024/25), National Action Plan for Health Security (2019-2023), National Public Health Emergency Preparedness and Response-Flagship Initiatives roadmap (2023), the National COVID-19 Response Plan and National Strategy and Plan of Action for Pharmaceutical Manufacturing Development in Ethiopia (2015-2025). These government country plans and strategies have identified building resilient health system, local capacity building for emergency preparedness and response, adequate and affordable access to pharmaceuticals, accelerating multi-sectoral action for proactive response to protect peoples from infectious and non-infectious and natural and manmade public health emergencies. The proposed HEPRR project is also aligned with the World Bank Group's (WBG) Country Partnership Framework (CPF FY18-22) for Ethiopia on improving the quality, equity, and utilization of health services, Focus Area 2.2 of Pillar 2 of the Ethiopia CPF. The HEPRR is in line with the World Bank's Fragility, Conflict and Violence (FCV) Strategy 2020 Pillar 2, which emphasizes the importance of maintaining engagement during conflict and crisis situations. It is also aligned with Pillar 4, which focuses on mitigating the consequences of FCV, given that the HEPRR will improve the capacity of health service provision and emergency response during conflicts and to peoples in refugee and internally displaced people (IDPs) camps and security constrained areas.

1.2 Description of the Project

1.2.1 Project Goal and Objective

The Health Emergency Preparedness, Response and Resilience (HEPRR) Project aims to strengthen the multi-sectoral preparedness, response, and resilience of the Ethiopian health system to public health emergencies. The project will support impactful interventions at national and sub-national levels that could strongly leads to enhanced coordination among sectors at different level of government for improved HEPRR capacity and supports cross-border collaboration with neighbouring countries such as Sudan, South Sudan, Djibouti, Kenya and Eritrea. The proposed interventions are mainly categorized in two technical components and several sub-components that focus on strengthening multi-sectorial and one-health approach to strengthening health system resilience and multi-sectoral preparedness and response to health emergencies in Ethiopia.

As stated in the Project Appraisal Document (PAD), the Program Development Objective (PrDO) of the HEPRR is to strengthen health system resilience and multi-sectoral preparedness and response to health emergencies in Ethiopia. HEPRR will strengthen two inter-connected pillars– Preparedness/Response and Resilience of health systems, enabling the rapid detection of and response to health emergencies while ensuring the availability of essential pharmaceuticals and health services continue to be delivered optimally even during emergencies.

1.2.2 Project Description

The proposed project will have four components, namely: (i) strengthening the preparedness and resilience of national and sub-national level health systems to manage public health emergencies; (ii) improving the detection and response to public health emergencies at national, sub-national and cross-border areas; (iii) program management; and (iv) Contingent Emergency Response Component (CERC).

Component 1: Strengthening the Preparedness and Resilience of the Health System to manage PHEs (US$ 80M)

This component would support institutional capacity building and resilience health systems strengthening across the health system building pillars to cope with public health emergencies while ensuring the continuity of essential health service delivery during public health emergencies. Effective emergency preparedness requires connecting and working together across all building blocks of the health system including health workforce, pharmaceutical supply and value chain, regulatory and governance capacity, and quality data and evidence informed decision making, adequate and sustainable financing, and integrated service delivery.

Subcomponent 1.1 Strengthen cross-sectoral and cross-border public health emergency preparedness and response and develop necessary legal frameworks and directives emphasizing essential public health functions – The support under this subcomponent goes beyond the conventional health sector and encompass both human and animal aspects of public health emergency while still focusing on the integration of such efforts within the wider health systems building pillars and reflecting the roles and contribution of other sectors. Specifically, this subcomponent supports: i) establishment of national public health security council to serve as a mechanism for collaboration among the relevant ministries; ii) enhance the linkage between the surveillance system, information communication, and diagnostic laboratory system within the public health sector and between the public and animal health sector; iii) under the umbrella of IGAD, establish/strengthen framework of agreement between neighboring countries to enhance cross-border collaboration and coordination mechanism with neighboring countries including human and animal health; iv) revise and codify the existing one-health and multi-sectorial public health emergency response legal frameworks and guidelines; v) expand the capacity of national Emergency Operating Center (EOC) in Ethiopia to be fit for non-traditional health sector related emergencies; and vi) establish a public health emergency response contingency and equity fund with matching from government, private sector, and other partners will be established.

Subcomponent 1.2 Support health workforce skill development and resilient engagement during public health emergency – Early detection, response, and recovery in times of public

health emergencies requires the availability of a multidisciplinary health workforce with the right knowledge, number and skill mix, clear risk compensation and incentive package. It is, therefore, important to strengthen PHEM leadership and the PHEs health workforce by rostering/preparing surge capacity, training public health cadres, and capacity building in PHEM staffs and stakeholders, as well as the development of emergency management, to strengthen, respond to, and lead public health emergencies. This subcomponent supports, specifically, i) strengthen the pre-service education and capacity to mainstream public health emergency detection and response in the existing health science training curriculums for both undergraduate and graduate studies; ii) training of additional field epidemiologists, genomics, data scientists, and health informatics, and laboratory professionals; and v) establish a Ethiopia Multi-sectoral Emergency Response Team at national, regional, and district levels and cross border areas.

Subcomponent 1.3 Support health systems readiness for continuity of essential health service delivery during public health emergencies – Another critical challenge in times of public health emergencies is to ensure continuity of essential health programs and services delivery. Hence, this component strengthens the ability of all actors and functions related to health to collectively mitigate, prepare, respond and recover from disruptive events with public health implications, while maintaining the provision of essential functions and services. Specifically, i) establishing regulatory, governance and management mechanisms to health facilities and health bureaus at different level to mobilize rapidly in times of crisis; ii) review the budgeting, public financial management and supply chain systems to reflect contingency resource commitments, fiscal flexibilities and autonomy to quickly respond to public health emergencies at all levels; iii) revise the essential health service package and medicines and equipment list to include supplies needed to deal with public health emergencies; iv) establish risk communication and community engagement strategies and mechanism for assessing and maintaining public trust in health services and public health measures to ensure routine health service utilization during public health emergencies; and v) develop capacities for quickly reorganizing and utilizing alternative service-delivery platforms to prevent service disruption during emergencies.

Subcomponent 1.4 Support digitalization of health sector processes and PHE information systems: – This subcomponent specifically supports, i) establish integrated and interoperable health information systems to monitor health risks, public health events and their impacts on health systems and services: (iii) establish/strengthen structures and resources for dissemination/communicating of information related to public health emergency and strengthen the platforms to engage with populations/communities; (iv) invest in cutting-edge, cost-effective technologies for risk registering and profiling at all levels of healthcare provision; (v) engage private health service providers (institutional and individual) in the integration and alignment of health information systems to build health systems resilience; (vi) develop functional information systems to improve the integration of critical public health, health care services, environment, port health, and veterinary surveillance data; and (viii) establish real-time monitoring systems to assess the disruptions to essential health services.

Component 2: Improving the detection of and response to public health emergencies (USD $145M)

This component will support the national detection and response pillars which aims to strengthen early warning system, revise the list of reportable diseases, strengthen risk screening at port of entries (PoEs) including border areas, enhance digital information management of multi-hazards (infectious disease outbreaks, biological, chemical, radiological and environmental), surveillance data analysis and interpretation, community level information collection and verification, provide feed-back to facilities and regions, finally, risk communication will be held alongside information management.

Subcomponent 2.1 Support collaborative surveillance and laboratory diagnostics (US$ 5M): – This sub-component focuses on the integration of surveillance information, laboratory investigation and feedback mechanisms and decision making at the cross-border areas considering the geopolitical situation of Ethiopia which are characterized by frequent conflict and fragile health systems, high number of refugees and internally displaced peoples (IDPs), unregulated movement of peoples and cattle across border and commercial movements. Hence, this component also entails the need to strengthen the one health approach in cross-border area through a focus on multi-sectorial approach and enhanced engagement of regional institutions such as IGAD and HECSA. Specifically, the support will include: i) strengthening the capacity of selected points of entries for screening, isolation, and quarantine as well as expanding the capacities of those existing centers to integrate one-health approach; ii) strengthen the linkages between field level bio-safety level (BSL-2) laboratories constructed by the Africa CDC project; iii) develop the legal frameworks, institutional structures with clear accountability for multi-sectoral and cross-border engagement with neighboring countries and iv) engage with academic institutions and think-tank groups to develop a research priority list.

Subcomponent 2.2 Support the emergency management and coordination: Ethiopia has not reached its optimum capacity in terms of rapid and effective emergency management and disease outbreak controls. Improving human resource capacity/subject matter experts, coordination centers and platforms, conduct operational research/outbreak investigations and equipping the response team with necessary logistics are critically important. Specifically, this component involves i) strengthening readiness and response coordination mechanism at national and sub-national level and; ii) capacitate and strengthen the rapid response team through identifying, training, and rostering subject matter experts at national and sub-national levels.

Subcomponent 2.3 Support accelerated access to and deployment of R&D, legal, and regulatory countermeasures in a PHE, leveraging public and private sector resources. For Ethiopia, with a growing population, increasing disease burden and unmet needs for pharmaceutical supplies such as medicines, diagnostic supplies, and vaccines, investing in local production is very strategic and an issue of national security as demonstrated by the COVID19

pandemic. This component supports the local pharmaceutical manufacturing initiative of the government and other sector actors along the value chain of pharmaceutical manufacturing. Specifically, i) support to strengthen the national enabling environment including medicine regulatory system; ii) develop human resources through relevant education and training; iii) encourage cluster development and production of active pharmaceutical ingredients; iv) create a research and development platform.

Component 3: Program Management

Sub-component 3.1 will support monitoring and evaluation and engagement of academia and think tank groups. This component will provide financing for i) coaching and technical support for data analysis, interpretation and lesson sharing and support for decision-making; ii) third party implementation and monitoring to support implementation of the project activities in conflict and security constrained areas; and (iv) data-based cross-border learning initiatives.

Sub-component 3.2 will focus on all other aspects of program management. Implementing the proposed project will require administrative and human resources that exceed the current capacity of the implementing institutions. Specific activities include: i) support for procurement, FM, environmental and social safeguards, monitoring and evaluation, and reporting; ii) recruitment and training of Grants Management Unit and EPHI staff and technical consultants; iii) operating costs and iv) support for cross border related administrative activities.

Component 4: Contingent Emergency Response Component (CERC)

This Contingent Emergency Response Component (CERC) is included under the MPA in accordance with World Bank's Investment Project Financing Policy, paragraphs 12, for situations of urgent need of assistance. This will allow for rapid reallocation of Project proceeds in the event of a natural or man-made disaster or health outbreak or crisis that has caused or is likely to imminently cause a major adverse economic and/or social impact. To trigger this Component, the Government needs to declare an emergency or provide a statement of fact justifying the request for the activation of the use of emergency funding.

1.3 Summary of Project Risk and Impacts

The main E & S risks and impacts of the HEPRR project are likely to arise from subproject activities to be financed under Component 1 and 2. The anticipated sources of these potential environmental and social risks of the stated Components can be grouped mainly into three types of subproject activities listed below:

a) Subprojects focused on strengthening and expanding capacities of new and existing facilities including by conducting construction and equipment installation activities. These include expanding the capacity of the National Emergency Operation Centre which would involve constructing a new building (Subcomponent 1.1), expanding the capacities of selected HCF in PoEs to integrate one health approach (Subcomponent 2.1) which may

involve construction in the PoEs. Moreover subcomponent 2.3 focuses on procuring medical equipments, supplies and other inputs to furnish and make functional a pharmaceutical production plant in Kilinto industrial park which would involve civil construction and mechanical installations as well as production (vaccine & medical equipments) operations.

b) Subprojects focused on supporting collaborative surveillance and laboratory diagnostics (Subcomponent 2.1) which would involve collection and transport of samples from surveillance points and performing analysis in health laboratories which would result in release of hazardous and infectious wastes.
c) Subprojects focused on digitalization of the health sector processes and PHE information systems (Subcomponent 1.2), enhancing linkages between surveillance systems with information communication (Subcomponent 1.1) strengthen linkages between BSL-2 laboratories and cross border detection and response activities using state of the art digital health technologies (Subcomponent 2.1). This group of subprojects is likely to cause environmental and social risks through the IT facility installation, distribution and release of e-waste.

In consideration of the above stated group of subproject activity types of the HEPRR which will be the main drivers for the occurrence of potential E & S risks on the one hand and the overall environmental and social baseline setting of the project areas where most activities are likely to be implemented in existing sites, the environmental and social risk assessment carried out as part of the present ESMF preparation has rated the environmental and social risk of the project to be "Substantial".

***Beneficial Impacts of the HEPRR Project*:** The following are among the main positive impacts of the HEPRR project. The project can:

- Help protect public health during emergencies by ensuring that appropriate medical resources are available, and communities are informed and prepared to respond to emergencies.
- Increase the resilience of communities by improving their ability to cope with emergencies and adapt to changing circumstance.
- Promote cohesion by encouraging community members to work together towards a common goal, such as protecting their health during an emergency.
- Reduce the economic disruption caused by emergencies, by ensuring that essential services continue to function, and that businesses are able to resume operations quickly.
- Increase trust in authorities and government institutions, as they demonstrate their ability to manage emergencies and protect the health and safety of citizens.

1.4 Summary of previous stakeholder engagement done during project preparation

Consultation during the project identification stage showed that there is strong demand and Government ownership to engage further on the preparedness and resilience agenda. Consultation on project preparation for HEPRR builds on previous consultations conducted by The Ministry of Health on projects that are relevant. The Ministry has made use of consultations conducted as part of the Africa CDC project and the Ethiopia Health SDG Project During the

SEP update for the Ethiopia COVID-19 Emergency Response Project, first Additional Financing, and during implementation, the project conducted several consultations including briefings, live chats on face book by the Minister, and virtual consultations with several stakeholders including: UNICEF, WHO, International Red Cross (IRC), Ethiopia Red Cross Society, Federal Police, Defense, Sector Ministries and Agencies, Regional Risk Communication and Community Engagement Departments, Prisons, Industry Parks, Iddir Associations, cross country driver associations; and quarantine facilities as well as community members at cluster or hot spot areas. In all discussion sessions, stakeholders expressed their interest to support the project implementation through their full cooperation. The current project will continue engaging all stakeholders and there will be continuous consultation and awareness creation activities as per the SEP and the RCCE strategy. In addition, stakeholder consultations done as part of the Africa CDC Support Program (9178633) focused on key issues such as: (i) review the initial design of the project; and (ii) understand the priorities of the national public health institutions in terms of their capacity building needs to inform prioritization of regional and sub-regional activities under the proposed operation. The recommendation of that particular engagement was that 'Africa CDC should take into account regional needs to inform the design of the program' and its outcomes include: (i) the prioritization of subcomponent 2.2, in particular the financing of the Kofi Annan Program and the FETP and the AES programming; (ii) informed prioritization of RCC activities under the project. The above consultations are particularly relevant because of inter-relatedness between the current program and the COVID-19 Emergency response project, even though the HEPRR project has a wider scope.

1.5 Summary of Stakeholder Consultation for the preparation of SEP

Stakeholders Consultations at the Federal MoH level

At the federal level, based on their relevance to the project and the proposed subproject activities, discussions were held with representatives/key personnel of the relevant stakeholders involved in project design and implementation, notably the MoH and EPHI. These personnel are six in number (the Senior Advisor to the Minister, Environment and Social Safeguard Specialists, Representative of the Pharmaceuticals and Medical Devices (PMD) Lead Executive Office, Grant Team Leader, Project Team Leader, and Representative of the Strategic Office Executive Committee).

Issues raised during federal level discussions included:

- *Relevance of the initiative*: alignment of the proposed project with current developmental priorities in general;
- *Grievance redress, including for GBV-SEA/SH*: legal provisions, what and how, mechanisms and procedures/processes;
- *ESMF implementation arrangements, monitoring procedures and capacity*: Experience and current status with handling ESMF monitoring, existing institutional arrangements

and practices (experience, challenges, capacity gaps, etc.).

- *Land acquisition and entitlements*: the rights of people over land territories and access to land and resources as encompassed in national laws;

Summary of outcomes from the consultations with federal level stakeholders are as follows:

Issues of Concern

1. Limited Capacity of ESMF Monitoring and Evaluation

Based on the experiences in previous World Bank supported projects, It was highlighted during the stakeholders' consultations that the inadequate attention given to the monitoring and evaluation of safeguard instruments was a serious drawback. In these respects, the level of awareness, knowledge and commitment required to monitor and evaluate the proper implementation of safeguard instruments is much lower than expected. Experience shows that such kinds of gaps make difficult the process of ensuring full compliance with the policy standards of the government and the World Bank. In connection with this, the Environment and Social Management Framework (ESMF) will have to encompass guidelines, procedures and standards to direct the monitoring and evaluation of safeguard issues at operational level.

In addition, stakeholder consultation participants noted that external consultants deployed on competitive basis should carry out an assessment of compliance with safeguard issues as part of project impact evaluation. Besides, unannounced random field monitoring visits are important to carry out an objective follow-up and observation of project implementation status. Such type of field monitoring can inform all those concerned about the facts on the ground that they may not always obtain in regular reporting formats that are normally filled in and submitted as reporting requirements.

2. Limited Capacity and the Need for Capacity Building

With a view to creating an enabling environment for result-based implementation of the project, HEPRR encompasses as one of its four components: 'Program Management (Component 3). This component aims encompasses the development of the human and institutional capacitates of the main implementing sector organizations under the MoH. In the capacity and support component, attention must also be given to enhancing the capacities of project management units at all levels towards the management of safeguard issues and ensuring compliance.

In this regard, stakeholder consultation participants underscore that there are serious capacity limitations in the MoH, particularly in the implementing partner agencies in respect to the management of safeguard issues, assigning safeguard specialists/focal persons and consistently monitoring strict compliance with the safeguard policies/standards of the government and the World Bank. Hence, as a mitigating measure, it was suggested that funds be earmark for the

recruitment and training of safeguard officers/focal persons.

As part of the capacity building component, HEPRR will need to organize staff trainings in wide ranging aspect of environmental and social safeguards, the development of the required instruments, implementation and monitoring of compliance, and reporting. In order to fill the gap in the human resource development in general, and project-related safeguards in particular, there is a plan by the HEPRR Program to engage selected federal universities hosting public health program as major stakeholders and assist by way of providing training in selected topics of health emergencies and project management work. With the provision of such capacity building support, the PCU and the safeguard specialists will be better placed to maintain quality standards of the technical advice they provide, the vetting/screening of proposals, as well as in the execution and monitoring of approved subprojects. Besides, in relation to the description of budget allocations and sources, it is necessary to clearly define in the appropriate project expenditures for safeguard-related costs for trainings, supervision, and technical assistance, the conduct of subproject specific environment and social assessments, and mitigation measures.

3. Land Acquisition/Loss of Assets

In relation to land acquisition and restriction of access to land, the consultation participants reiterate that the project is to finance only limited physical infrastructure, mainly the rehabilitation and expansion of existing ICU and Emergency facilities at the entry points in the border areas. Most of the activities are expected to be carried out on public land in existing medical facilities owned by Government. In this case the ESMF will provide a screening tool to determine any impact on land. One of the envisaged subproject activities which would have entailed a degree of land acquisition/loss of assets by individuals, households or communities is the vaccine manufacturing plant. However, this project investment venture will be carried out on 20,000 hectares of land already earmarked and secured for the purpose well ahead of the design of the project. The plant, which is located at the Kilinto neighborhood on the outskirts of Addis Ababa, does not involve major civil work and construction, but mainly installation of machinery in the already existing structures.

4. Elite Capture

The consultation participants tacitly mentioned about the risk of elite capture and/or different interest groups including traditional authority structures in relation to the risk communication, event-based surveillance, and community/citizen engagement, influencing community's prioritization and manipulation of subprojects. To reduce this risk, consultation participants stressed for the need for careful design of consultations with grassroots community members present in project targeted areas.

5. Newly Added Stakeholders to the Project

The consultation participants also stated that, in addition to the main stakeholders involved in the implementation of the COVID-19 Emergency Response Project, the HEPRR Program envisages to engage more stakeholders, including the Armauer Hansen Research Institute (AHRI), National Metrological Agency (NMA), Ministry of Agriculture (MoA), and universities having training programs in public health and related disciplines.

6. Coordination and Outreach Challenges

The HEPRR project is a multisector project. As such, it is likely to pose a coordination challenge. These include sub-national (regional, zonal and district level) coordination challenges and lack of capacities to implement Environmental and Social standards including SEP. There is also a potential challenge to reach historically underserved and vulnerable populations in emerging regions, IDPs, refugees, as well as pastoralists in borderland areas because of linguistic, cultural, accessibility, infrastructure barriers.

1.6 Program Location and Implementing Agency

This is a national project covering all eleven regional governments and two city administrations, but the bulk of the project interventions will likely be carried out in "high-potential" climate crisis prone lowland areas and border areas due to the cross-border nature of the project. The project will undertake interventions focusing on creating the public health preparedness, response, and resilient health system capacity at the district level. Due to the multi-sectoral nature of the project, the project will engage with regional governments within Ethiopia to ensure their buy-in, support coordination with sectors other than health and able to reflect their unique context in the design of the project interventions.

In addition to working on broader public health emergency preparedness, response and resilient health system building at the and sub-national level, the project will work with regional integration institutions such as Intergovernmental agency for Development (IGAD) and Africa Center of Disease Control (Africa CDC).

The Ethiopia MoH will be the implementing agency for the project and oversee the overall implementation of the project. The State Minister for Programs will be responsible for the execution of project activities and oversee the overall implementation of the project. The Grant Management Unit (GMU) of the Ethiopia MoH's Partnership and Cooperation Directorate (PCD) will be responsible for the day-to-day management of activities supported under the project as well as the preparation of a consolidated annual work plan and a consolidated activity and financial report for the above-mentioned project components. The Ethiopia MoH will also deploy the staff needed for proper implementation of the environmental and social management plan as specified in the project's Environmental and Social Impact Assessment (ESIA).

The Ethiopian Public Health Institute (EPHI) will serve as the key technical entity for the

implementation of the project activities. It will both support the PCD and directly implement certain technical activities. The EPHI will report directly to the State Minister, and it will share the project's technical and financial updates with the grant management unit. In addition to MoH and the Ethiopia Public Health Institute (EPHI), the Ethiopia Pharmaceutical Supply Agency (EPSA), Ethiopian Food and Drug Administration (EFDA), Regional Health Bureaus, technical directorates at the MoH and other key agencies will be involved in project activities based on their functional capacities and institutional mandates.

2 Legal frameworks for Stakeholder Engagement

2.1 National legal frameworks

The Constitution of Ethiopia (1995) guarantees citizens' the right to consultation in development projects that affect them[2]. Furthermore, it also states the right to sustainable development where citizens have the right to be consulted on policies and projects that affect their environment. The government of Ethiopia has put in place structures and processes to promote participation, consultation and grievance redress at local levels. The country's laws and regulations recognize the rights of most vulnerable in society that require special attention. The social protection policy (2014) recognizes vulnerable people to include children, older people, people with disabilities and chronically ill[3]. Similarly, the policy for women and children recognize their right for participation and consultation. Ethiopia has also ratified international conventions related to disability, women and children's rights. In addition, one of the strategic directions of the second Health Sector Strategic Plan (HSTP II) is ensuring community engagement, empowerment, and ownership. Engagement of all stakeholders is the mainstay of this strategic direction.

Health facilities and government offices supported under this project will be required to observe the legal frameworks (proclamation, regulation, directives) to ensure continuity of routine sexual and reproductive health services for women and their families. Particularly, the Gender Directorate of the Ministry of Health and Ministry of Women, Children and Youth Affairs have a mandate and will play a regulation role that recommends a zero-tolerance policy for sexual harassment, and to deliver periodic training for target health care workers on preventing and responding to GBV and associated physical, psychosocial and mental health conditions. A standard reporting mechanism that includes referral and feed-back and complaint mechanism will be established and properly implemented.

[2] Government of Ethiopia (1995). The Constitution of the Federal Democratic Republic of Ethiopia. Berahena Selam Printing: Addis Ababa, Ethiopia

[3] Ministry of Labour and Social Affairs (2014). National Social Protection Policy of Ethiopia. Addis Ababa, Ethiopia

2.2 World Bank Environment and Social Framework

The Project is prepared under the World Bank's Environment and Social Framework (ESF): As per the Environmental and Social Standard (ESS) and 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 **World Bank Environmental and Social Framework** sets out the World Bank's commitment to sustainable development, through a Bank Policy and a set of Environmental and Social Standards that are designed to support Borrowers' projects, with the aim of ending extreme poverty and promoting shared prosperity.

The respective ten **Environmental and Social Standards (ESS 1- 10)** set out the requirements for Borrowers relating to the identification and assessment of environmental and social risks and impacts associated with projects supported by the Bank through Investment Project Financing

ESS10 on "Stakeholder Engagement and Information Disclosure" notes "the importance of open and transparent engagement between the Borrower and project stakeholders as an essential element of good international practice". ESS10 emphasizes that effective stakeholder engagement can significantly improve the environmental and social sustainability of projects, enhance project acceptance, and make a significant contribution to successful project design and implementation. Stakeholders have to be identified and the SEP has to be disclosed for public review and comment as early as possible, before the project is appraised by the World Bank. ESS10 also requires the development and implementation of a grievance redress mechanism that allows project-affected parties and others to raise concerns and provide feedback related to the environmental and social performance of the project and to have those concerns addressed in a timely manner.

ESS10 applies to all projects supported by the Bank through Investment Project Financing. For the purpose of this ESS, "stakeholder" refers to individuals or groups who: (a) are affected or likely to be affected by the project (project affected parties); and (b) may have an interest in the project (other interested parties). Requirements. The Bank standard on Stakeholder Engagement and Information Disclosure requires that the project implementing agency engages with stakeholders throughout the project life cycle, commencing such engagement as early as possible in the project development process and in a timeframe that enables meaningful consultations with stakeholders on project design. The nature, scope and frequency of stakeholder engagement will be proportionate to the nature and scale of the project and its potential risks and impacts. The project will engage in meaningful consultations with all stakeholders. It will provide stakeholders with timely, relevant, understandable and accessible information, and consult with them in a culturally appropriate manner, free of manipulation,

interference, coercion, discrimination and intimidation. The project implementing agency will maintain and disclose as part of the environmental and social assessment, a documented record of stakeholder engagement, including a description of the stakeholders consulted, a summary of the feedback received and a brief explanation of how the feedback was taken into account, or the reasons why it was not. This SEP is prepared taking into account these requirements.

3 Stakeholder identification and analysis

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

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

3.1 Key Stakeholders

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[4], 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

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:

Directly Affected Parties:

- Institutions and staff involved in the project as PIUs (MoH, AHRI, EPHI, EPSA, EFDA)
- VMGs and IP/SSHUTLCs, including pastoralist and communities in borderland areas
- Beneficiaries and local communities hosting the projects rehabilitating hospitals and near vaccine production centers, laboratories, isolation units, and medical warehouses.
- Workers at construction sites of vaccine production centers, laboratories, isolation units, and medical warehouses, transport and logistic workers.
- Training institutions/universities and students within these.

Indirectly Affected Parties

- General public (through improved health)
- Health professionals (capacity built)
- Other Government agencies and development partners collaborating on the project
- Disadvantaged or persecuted groups, low-income groups, and hard to reach population groups

3.3 Other Interested Parties

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

- Mainstream media, including newspapers, radio, and television networks
- Politicians
- Other national and international health organizations, NGOs, CBOs

[4] 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.

- Businesses with international links

3.4 Disadvantaged and Vulnerable Groups and Individuals.

Historically Underserved 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 concerns and cultural sensitivities, and to ensure a full understanding of project activities and benefits. The vulnerability may stem from person's language, gender, age, health condition, economic status and financial insecurity, disadvantaged status in the community (e.g., minorities or marginal groups), dependence on other individuals or natural resources, etc. Involving 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:

- Vulnerable groups including elderly population, refugees and IDPs, children, people with pre-existing medical conditions, people living with HIV, pregnant women, lactating mothers and girls, illiterate people, people with disabilities, female headed households.
- Historically underserved communities in the emerging regions as well as pastoralists
- Disadvantaged or persecuted ethnic, racial, gender, and religious groups, and sexual minorities and people living with disabilities.
- IDPs, refugees, and migrant workers: ow-income migrant workers, refugees, internally displaced persons, populations in conflict setting or those affected by humanitarian emergencies, vulnerable migrants in irregular situations, pastoralist communities.
- Hard to reach population groups.

Vulnerable groups within the communities affected by the project will be further confirmed and consulted through dedicated means, as appropriate. The project ensures that targeted, culturally appropriate and meaningful consultations for disadvantaged and vulnerable groups before any vaccination efforts begin is provided. Description of the methods of engagement that will be undertaken by the project is provided in the following sections.

Table 1: Summary of Project Stakeholder Needs

Stakeholder	Key Characteristics/needs	Language Needs	Preferred notification means	Specific needs of the stakeholder
MoH, AHRI, EPHI, EPSA, EFDA	Limited resources for capacity building	Official FDRE working language	Written information - email, phone, letter	Technical knowhow, accessibility, & availability
Other government agencies and development partners collaborating on the project	Supporting the project within their mandate	Official FDRE working language; regional working languages as necessary	Meetings, formal letter, email, phone	Technical knowhow, accessibility, & availability
Educational institutions	Limited resources for capacity building	Official FDRE working language	Written information - email, phone, letter	Technical knowhow,
Pastoralists, communities in border areas, other affected communities	Low awareness Limited access	National and regional working languages	Meetings, local media, local community leaders, local government, CSOs, NGOs, CBOs	Meetings, local languages, accessibility, and affordability. Gender and culturally appropriate consultations
Vulnerable groups	Low awareness Limited access	National and regional working languages	Meetings, local media, local community leaders, local government, CSOs, NGOs, CBOs	Meetings, local languages, accessibility, and affordability. Gender and culturally appropriate consultations
General Public and media	Information on health emergencies	National and regional working languages	Print, local and digital media	Local languages, timely simple and clear messages
Civil societies and organizations	Advocacy and holding governments to account	National and regional working languages	Meetings, formal letter, print media	Accessibility, timing, participation by stakeholders.

4 Stakeholder Engagement Plan

4.1 Principles for stakeholder engagement:

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

- *Openness and life-cycle approach*: public consultations for the project(s) will be arranged during the whole lifecycle, 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; that is accessible and understandable, taking into account cultural sensitivities, languages or dialects of their choice, preferred means of communication, literacy levels of stakeholders, and special needs of stakeholders with disabilities and stakeholders that are members of other vulnerable groups opportunities are provided for communicating stakeholders' ongoing 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 will be encouraged to be involved in the consultation process. The project will provide equal access to information to all stakeholders taking into consideration cultural sensitivities and literacy levels. Sensitivity to stakeholders' needs is the key principle underlying the selection of engagement methods. Special attention is given to vulnerable groups, in particular women, children, people with disabilities and preexisting medical condition, elderly, , those with underlying health issues, refugees & IDPS and the cultural sensitivities of diverse ethnic groups.
- *Flexibility*: if social distancing inhibits traditional forms of engagement, the methodology should adapt to other forms of engagement, including various forms of internet communication

4.2 Purpose and timing of stakeholder engagement program

The main goal of stakeholder's engagement program is to create awareness of the key deliverables of the project, keep stakeholders updated on key activities, and provide avenues for affected people/community to voice their concerns and grievances. The stakeholder consultation for the project aims to create awareness and increase understanding, improve project decision making, mobilize support and forge collaboration and clarify roles and responsibilities. The stakeholder consultation for the project aims to create awareness and increase understanding, improve project decision making, mobilize support and forge collaboration and clarify roles and responsibilities. Stakeholder consultations will serve as a platform for the dissemination of project information and feedback. Stakeholder engagement that started at the project design stage will continue throughout the project cycle and will be updated on regular basis to promptly

include new developments and issues that may arise.

The project will ensure that the ESMF, SEP, RAF, SA and ESCP are adequately consulted with the community. Further, the project will ensure that the relevant parts of the ESCP are shared for general orientation on the Government's commitments.

4.3 Proposed strategy to incorporate the view of vulnerable groups

Incorporating the views of disadvantaged and vulnerable groups at various stages in project implementation should be done using appropriate communication methods. Information on consultation should be provided in advance and appropriate venues and times (taking into account mobility calendars) should be selected in consultation with local community leaders who have local knowledge. The use of local language and translation is critical. Focus group discussions, interviews and other participatory methods should be used. Meeting places should consider mobility and other physical constraints for participants and person to person interviews at convenient locations should be considered. Local institutions including schools, NGOs, community-based and faith-based organizations and community leaders should be approached to facilitate consultations.

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. Special arrangements should be made for child-care, transportation, interpretation as needed. Demonstrations and visual aids should be used where necessary and separate meetings could be held with women and girls depending on local norms.

Community consultations should be well documented and kept for reference. Where consultations are done through local administrations, basic guidelines and reporting formats should be provided by implementing agencies. Where possible, community facilitators from local NGOs could be called to assist the consultation process.

The project will ensure there is wide representation from all identified disadvantaged and marginalized groups in all stakeholder consultations throughout the project lifetime. This includes preparation, implementation, and handover phases of the project. The consultations will provide information to marginalized communities and other interested persons or groups as well as the project team to understand the project expectations and levels of involvement and provide feedback on the results of the project. The PIU team will ensure any committees are trained on information disclosure without discrimination and in an effective timely manner. Relevant and specific approaches to engaging vulnerable groups will be used to further ensure inclusion such as focus group discussions (based on age, gender and occupation, dialect preferences), interviews, and key informants.

Table 2: Vulnerable groups Feedback incorporation strategy

No	Vulnerable Group	Proposed strategy for consultation
1	Vulnerable Groups	Through representative bodies and organizations and other community members ensuring effective participation and culturally appropriate engagement, sharing key and specific information in local dialects/languages, providing relevant timelines for internal-decision making process amongst groups.
2	Persons with disabilities (deaf)	Use of sign language and other appropriate assistive tools as required, providing translations where necessary including local dialects, facilitate transport where necessary, engage through representative organizations and/or persons, provide relevant timelines for internal-decision making process amongst groups.
3	Women	Engage through representative organizations and/or persons, provide focused and relevant meetings in culturally appropriate settings for comfort and safety in asking questions or raising concerns, meeting schedules that are time appropriate to ensure participation and sufficient interaction, ensuring meeting venues are located in close proximity to resident area, translation into local dialects and meetings with female facilitators.
4	Persons with disabilities	Engage through representative organizations and/or persons, provide focused and relevant meetings in culturally appropriate settings for comfort and safety in asking questions or raising concerns, provide relevant timelines for internal decision-making process amongst groups.
5	Elderly	Host one to one meetings where necessary, provide transportation to meeting venues, consult on meeting settings and timelines with participants, provide language or dialect translator and/or facilitators, ensure meeting settings are culturally appropriate.
6	Children	Engage through representative organizations where possible, obtain consent from parent/caregivers, meeting locations familiar to the child e.g., local school venues or community meeting centers where possible, use child friendly means and language to communicate.

The Inclusion Plan will be achieved to the extent in which disadvantaged and marginalized groups participate and engage with the project activities from design to implementation. PIU will undertake consultations with the various groups on local development issues and concerns

if it is likely there may be adverse impacts of project activities. The objective of the consultations will focus on understating project operational structures, receiving input/feedback to avoid and/or reduce adverse effects associated with project activities and agree on relevant and effective mitigation measures.

4.4 Methods, tools and techniques for stakeholder engagement

It is critical to communicate to the public what is known about health emergencies, 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 way that are informed and continually optimized according to community feedback to detect and respond to concerns, rumors 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.

Risk Communication and Community Engagement will be a major part of the Project's stakeholder engagement. The project will build on the risk communication and community engagement (RCCE) strategy already implemented during the Covid-19 emergency.[5]

In addition, the project will undertake interventions recommended by the World Health Organization to ensure vaccine acceptance and uptake (demand). The project will make a deliberate effort to address new communication challenges the stakeholders and beneficiaries may face during emergency response. Given that RCCE is essential for epidemic surveillance, case reporting, contract tracing, and case management, the project stakeholders implement the following action points:

- Acknowledge the fact that the perception of risk among affected populations often differs from that of experts and authorities.
- Proactively communicate what is known, what is unknown, and what is being done to get more information with the objective of saving lives and minimizing adverse consequences.
- Generate behavioral and social data on the drivers of uptake and design targeted strategies to respond to and act on these drivers.
- Ensure communication and outreach to provide to the public at large, and the risk groups in specific, all information necessary to make an informed decision on the benefits and risks of

[5]World Health Organization. Risk communication and community engagement readiness and initial response for novel coronaviruses (nCoV). Interim guidance v1 January 2020 WHO/2019-nCoV/RCCE/v2020.1

the vaccination campaign, the prioritization of different population groups, and the procedure to attain available vaccines.

- Prepares to respond to any reports of any adverse effects following immunizations (AEFI) and have planning in place to mitigate any resulting crises of confidence.
- Prevent confusion, misunderstanding and the spread of misinformation and build trust in the response and increases the probability that health advice is adhered to.
- Observe the rights of beneficiaries and wider public in receiving health information and outputs of this project and communicate using traditional and through culturally sensitive community-based networks.
- Build capacity of MOH and EPHI GMU and surge staff to enhance risk assessment, communication, and documentation skills through continuous updates on RCCE resources and training.

Table 3: Stakeholders Consultation Matrix

Consultation Stages	Consultations Responsible within Project	Consultations Beneficiaries including disadvantaged individuals and groups	Method of engagement	Purpose
Verification of project locations/sites, conducting site visits	Project consultants (social specialists), PIU and other stakeholders	Affected parties, vulnerable groups, community leaders and elders	Face-to-face consultation meetings, official communications, mobile phones, email.	Create project awareness, understand benefits and any potential challenges, keep informed on progress
Assessing proposed intervention in project areas	Project consultants (social specialists), PIU and other stakeholders CBOs	Affected parties, vulnerable groups, CBOs, community leaders and elders	Face-to-face consultation meetings, official communications, mobile phones, email.	Keep informed on project objectives, create awareness, identify and address concerns on project impacts, feedback from would-be affected persons
Detailed analysis of project impact and assessments	PIU, Project consultants (social specialists), and other	Key project informants, focus groups, Affected parties, community	Both formal and informal interviews, Focus group discussions on specific risks and mitigation	Identification of key issues and concerns, agreement and development of early mitigation measures

Consultation Stages	Consultations Responsible within Project	Consultations Beneficiaries including disadvantaged individuals and groups	Method of engagement	Purpose
	stakeholders	leaders	measures	
Operations and implementation	PIU, Consultants, implementing partners	Affected parties, vulnerable groups, community leaders/elders and other stakeholders	Implementation, monitoring and evaluation, steering committees (formal or informal)	Address issues, effective implementation, inclusion plan,
Monitoring and Evaluation	PIU, Consultants,	Affected parties and vulnerable groups	Formal participation in review and monitoring	Identify solutions to issues and effectively implement in inclusion plan

4.5 Strategy on Information Disclosure

The HEPRR project will use various channels to publish the current SEP and other project related activities the amended documents are approved by the World Bank. These include: (i) disclosure of all relevant documents in the relevant sites and through the World Bank website. (ii) publication of posters and public notification in the targeted areas accessible to local communities including quarantine, isolation and treatment centers.(iii) Free printed copies of the ESMF and the SEP will be made accessible for the general public at Ministry of Health, Ethiopia Public Health Institute, Regional Health Bureaus, Woreda Health offices; quarantine, isolation and treatment centers; and other designated public locations to ensure public dissemination of the project materials; and(iv) Electronic copies of the ESMF, and SEP will be placed on the MoH, EPHI websites as well as the Regional Bureaus websites.

Social media platforms will be widely utilized to disseminate information regarding the project activities and facilitate basic and automated communication with citizens. Further, the project will disseminate information via chatbots on WhatsApp and other platforms.

Table 4: Disclosure of project information at different stages of the project cycle

Information to be disclosed	Method used	Target stakeholders	Responsibilities
Before appraisal			
Disclosure of project documents (PAD, SEP, ESCP)	• Websites – MoH and WBG • Brief summaries of the main features of the project SEP	All key stakeholders	• PIU
After appraisal			
Publicity on project approval and roll-out plans	• Audio-visual messages on project information (radio, TV) • Newspaper stories/supplements • Printed materials on project information • Social Media (Twitter, Facebook, Instagram, WhatsApp) • Emails • Press releases • Websites (MoH, WBG)	All key project stakeholders	• PIU • Communication expert • Social specialists
Disclosure of the project documents SMPs, updated SEP, LMP, GBV Action Plan, among others	• Websites - MoH and WBG • Brief summaries of the main features of the project SEP • Audio-visual messages on the project (radio, TV) • Newspaper stories/supplement • Social Media (twitter, Facebook, Instagram WhatsApp) • Emails • Press releases	• MoH, EPHI, and all partners involved in the project • Open access to all interested parties • Distribution of printed flyers to schools and other institutions	• PIU • WBG Team
During implementation			
Highlights on project activities, achievements and lessons learned	• TV/Radio spots/activations and announcements • Print materials (newsletters and flyers) • Town hall meetings • Newspaper stories/supplement • Social Media (twitter, Facebook, Instagram WhatsApp) • Emails • Press releases • Mobile phone block message	-Project beneficiaries -Other interested parties	• Social specialists
Update on project process	• Print materials (newsletter, flyers, etc.) • Project progress reports • Town hall meetings	All stakeholders	• Social specialists • PIU
Complaints/ compliments about the project implementation	• Logs and reports from the GRM focal persons	• Receivers of information and services • Information or Data managers	• PIU and social specialists
Monitoring and reporting			
Quarterly and Bi-annual reports	• Progress report including summaries of complaints and resolution	Regional Health Bureaus, MoH, EPHI offices	PIU

Outreach to IP/SSHUTLCs and VMGs

It is important to recognize that there is a challenge to reach IP/SSHUTLCs or VMGs (e.g. refugees, IDPs) in emerging regions, as well as pastoralists in borderland areas because of linguistic, cultural, accessibility, infrastructure barriers. Hence, it is important to identify specific engagement methods for this groups. The flowing are the suggested engagement methods for these groups:

1. IP/SSHUTLCs: communication through clan leaders, mobile health workers, HEWs, community volunteers, religious leaders, mobile vans, radio, available community networks, water points, grazing sites. This will be done in collaboration with the Health System Support Directorate – the directorate responsible to strengthen health systems and services in pastoralist regions – at the Ministry of Health and Ministry of Peace.
2. IDPs/refugees: Mobile audio van, megaphone, text messages, radio, HEWs, volunteers, banners, food ration package, stickers etc

4.6 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. Communicating the purpose and outputs of the project will be communicated to the wider public using relevant communication channels.

5 Resources and Responsibilities for Implementing Stakeholder Engagement Activities

5.1 Resources

The Ministry of Health will be in charge of stakeholder engagement activities. The estimated budget for the SEP is nearly 5 million USD, including Subcomponent 2.3: support risk communication and community engagement, empowerment, and social protection for all health emergencies.

5.2 Overall project management functions and responsibilities

The project implementation and monitoring arrangements are as follows:

- The Ministry of Health (MOH) will be the implementing agency for the proposed project in Ethiopia and oversee the overall implementation of the project. The State Minister for Programs will be responsible for the execution of project activities and oversee the overall implementation of the proposed project.
- **The Grant Management Unit (GMU)** of the Ethiopian MoH's Partnership and Cooperation Directorate (PCD) will be responsible for the day-to-day management of project

activities, as well as the preparation of consolidated annual workplans and consolidated activity and financial reports for the various project components.

- The Ethiopian Public Health Institute (EPHI) and the Armauer Hansen Research Institute (AHRI) will serve as the key technical entities for the implementation of the project activities. It will both support the PCD and directly implement selected technical activities. EPHI will report directly to the state minister and will share the project's technical and financial updates with the GMU. If necessary, EPHI will also reinforce the GMU with additional staff, including accountants and procurement officers, to manage the project activities under its purview. The Ethiopian MOH will also deploy the staff needed for proper implementation of the environmental and social management plan, as specified in the project's Environmental and Social Impact Assessment (ESIA).
- In addition to the MoH and EPHI, the Ethiopian Pharmaceutical Supply Agency (EPSA), Ethiopian Food and Drug Administration (EFDA), Regional Health Bureaus, technical directorates at the MOH, and other key agencies will be involved in project activities based on their capacities and institutional mandates.
- The National Public Health Emergency Operations Center (NPHEOC) is one of the leaderships and coordination platforms activated for health emergency preparedness and response coordination platforms in Ethiopia. The Center coordinates and executes all emergency preparedness and response activities under the auspice of the Ethiopian Public Health Institute (EPHI).

5.3 Budgetary Resources

Component 3: Program Management will be the source of the required budget for the activities related to SEP, including grievance management. Sub-component 3.2 reads "Implementing the proposed project will require administrative and human resources that exceed the current capacity of the implementing institutions, in addition to those mobilized through the other bank projects including COVID19 emergency response project and Africa CDC Project. Specific activities include: i) support for procurement, FM, environmental and social safeguards, monitoring and evaluation, and reporting; ii) recruitment and Training of Grants Management Unit and EPHI staff and technical consultants; iii) operating costs and iv) support for cross border related administrative activities and collaboration with IGAD."

6 Grievance Redress Mechanism

The main objective of a Grievance Redress Mechanism (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.

A Grievance Redress Mechanism (GRM) can be used as a tool to stay engaged with communities and receive information from them when other direct measures for stakeholder engagement and consultations are more limited during the outbreak of health emergencies. The existence of the grievance mechanism will be communicated to all stakeholder groups via the channels used to reach these groups for stakeholder consultations, including advertising it in local radios, newspapers and/or local noticeboards. The Project will provide a summary of the implementation of the grievance mechanism to the public on a regular basis, after removing identifying information on individuals to protect their identities.

6.1 Description of GRM

The GRM will be developed and applied to meet the needs of affected people, be cost-effective, accessible, designed to take into account culturally appropriate ways to handle community concerns, and work based on a well-defined time schedule.

Recognizing that formal legal mechanisms for grievance redress could be lengthy and cumbersome, the HEPRR Project will establish a grievance redress mechanism under the oversight of the GRM/PCU. For HEPRR Project to incorporate an in-built GRM, the GMU/PCU of the Ministry of Health (MoH) will put in place the structure in collaboration with regional project coordination bodies. The grievance investigation and resolution process operate in multi-tiered structure that extends from grassroots level to *Woreda* Appeal Committee, as described in the next section. All PAPs would be informed about how to register grievances, their specific concerns or complaints.

The Social Development Specialist in the GMU/PCU will be the focal person in the GRM Committee that will be established at national level. The GM committee with representatives from the EPHI. AHRI, and EPSA, will follow up grievances, and the grievances will be received through a multi-channel grievance uptake including through telephone, e-mails, and social media as well as in person or in writing.

The GM will provide for anonymous reporting in ways that will ensure confidentiality and anonymity of complainants. This will largely create an enabling environment to allow for

grievances to be raised by project affected persons without fear of retribution and reprisal. The GM will ensure transparency and accountability in the handling of grievances.

The social development specialist at GMU/PCU should work closely with the grievance redress committees at various levels to redress grievances. Where the complainant is not satisfied with the decision of the *Woreda* Appeal Committee, he/she could submit complaints to the GMU/PCU which will designate a committee to review and make decisions. The decision of the designated grievance committee of the GMU/PCU will be final.

The grievance mechanism established for the Program should also be culturally appropriate and accessible to affected historically underserved communities and takes into account the availability of judicial recourse and customary dispute settlement mechanisms among such local communities.

The MoH/HEPRR National PCU, in collaboration with concerned regional and *woreda* (Bureau of Health, and *Woreda* Health Office) will make the public aware of the GRM through awareness creation forums, training and capacity building. Any person who has complaints regarding the activities of the HEPRR Project subprojects during preparation/designing, implementation and operation phases shall have access to the Mechanism. Multiple channels including phone, e-mail, WhatsApp, Telegram, and other social media, in writing and in person will be used to file complaints. Contact details on the Mechanism will be publicly disclosed and posted in the offices of concerned *woreda* offices, and *Kebele* administration, as well as website and implementing partners.

The GRM will include the following steps:

Step 1 : Grievance discussed with *kebele* level grievance committees

Step 2: Grievance raised with the Woreda Grievance Office

Step3: Appeals woreda appeals committee.

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. In the instance of the health emergencies, existing grievance procedures should be used to encourage reporting of co-workers if they show outward symptoms.

The MoH Partnership and Cooperation Directorate reviews public feedback and grievances shared on social media and use the social media analysis to inform content messaging. MOH

facilitates that every health facility conducts a patient satisfaction surveys and clinical audits to identify limitation and best practices and incorporate the feedback from patients and clinical audit findings to improve quality of care processes and protocols.

With the introduction of the vaccines, there should be a mechanism to monitor the safety of the vaccine. As this is a new vaccine developed using technologies that were not tested in the past against a novel virus, a real-time monitoring of monitoring, knowledge sharing and communication mechanisms to warrant that any safety concern can be identified early and investigated in a timely manner, safeguarding the health of target populations and, ultimately, maintain trust in the immunization programs and the health systems.

Any adverse event following immunization (AEFI) detected will be urgently notified, reported, investigated and analyzed.

6.2 GRM on Addressing GBV/SEA/SH

The established GRM will also receive GBV/sexual exploitation, abuse, and harassment (GBV/SEA/SH) related complaints of the project, communicate through referral systems as necessary with stakeholders and authorities who are working on the cases and work on provision of response and follow up on the outcome. Special attention will be given to SEA/SH grievances (marked as confidential) to ensure confidentiality and the survivor will be given the options to seek legal redress, health care or psycho-social support as per their preference.

MoH will develop and implement GRM guideline based on the **GBV-SEA/SH Prevention and Response Action Plan that is part of the ESMF.** The guidelines will included detail information about the procedure, timing, referral system. The guideline will establish a clear and safe SEA/SH reporting protocol and referral system that facilitates safe access & referrals, handles data confidentially and defines accountability mechanism to handle SEA/SH allegations properly. MoH will use a simple, anonymous, and confidential tracking system that GRM can use to document when they observe/support and refer GBV incidents.

6.2.1 GRM Process for GBV/SEA/SH

Step 1: Grievance Uptake: Given the sensitive nature of GBV complaints, the GRM provides different ways to submit grievances. All grievance uptake channels can be used to report on SEA/SH-related grievances. No grievance uptake mechanism can reject such grievances, and all personnel directly receiving grievances will be trained in the handling and processing of SEA/SH-related grievances. Information on relevant legislation will be delivered to survivors prior to any disclosure of case details, for example through initial awareness raising sessions on the GRM. This will allow protect the survivor-centered approach from mandatory reporting.

The GBV survivor has the freedom and right to report an incident to anyone: community member, project staff, GBV case manager, local authorities. All recipients of the report should – with the survivor's informed consent – report the case to one of the Project's formal GRM. Furthermore, a survivor can ask someone else to act as a survivor advocate and report on her/his behalf.

The grievance recipient will be responsible for the recording and registration of the complaint. A GRM operator cannot reject a SEA/SH complaint. At the same time, however, the project can only respond to a SEA/SH complaint if it is directed into the designated GRM channels.

Confidentiality: All grievance recipients and anyone handling the SEA/SH-related grievances must maintain absolute confidentiality in regard to the case. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. There are exceptions under distinct circumstances, for example a) if the survivor is an adult who threatens his or her own life or who is directly threatening the safety of others, in which case referrals to lifesaving services should be sought; b) if the survivor is a child and there are concerns for the child's health and safety. The survivors need to be informed about these exceptions.

Informed Consent: The survivor can only give approval to the processing of a case when he or she has been fully informed about all relevant facts. The survivor must fully understand the consequences of actions when providing informed consent for a case to be taken up. Asking for consent means asking the permission of the survivor to share information about him/her with others (for instance, with referral services and/or IPs or PIU), and/or to undertake any action (for instance investigation of the case). Under no circumstances should the survivor be pressured to consent to any conversation, assessment, investigation or other intervention with which she does not feel comfortable. A survivor can also at any time decide to stop consent. If a survivor does not consent to sharing information, then only non-identifying information can be released or reported on. In the case of children, informed consent is normally requested from a parent or legal guardian and the children

Incident reporting

Severe incidents (defined as an incident *that caused significant adverse effect on the environment, the affected communities, the public or workers*, for example: serious injuries, fatality, GBV, forced or child labor, damage on Project infrastructure, as well as organized large scale robbery, looting etc., abuse and cases of mistreatment of communities and/ or workers by security forces (including GBV/SEA/SH, spread of communicable diseases among workforce, kidnapping, etc.), will be reported within 48 hours to the PIU and onwards to the World Bank.

At all times, the PIU will provide feedback promptly to the aggrieved party, for example through the phone. Feedback is also communicated through stakeholder meetings and beneficiary meetings

during project activities. For sensitive issues, feedback is given to the concerned persons bilaterally.

Records of all feedback and grievances reported will be established by the PIU. All feedback is documented and categorized for reporting and/ or follow-up if necessary. For all mechanisms, data will be captured in an excel spreadsheet. The information collected, where possible, should include the name of the person providing feedback as well as the county, (where applicable), the project activity and the nature of feedback or complaint.

Step 2: Sort and Process: All reporting will limit information in accordance with the survivor's wishes regarding confidentiality and in case the survivor agrees on further reporting, information will be shared only on a need-to-know-base, avoiding all information which may lead to the identification of the survivor and any potential risk of retribution.

Data on GBV cases recorded will only include the nature of the complaint (what the complainant says in her/his own words), whether the complainant believes the perpetrator was related to the project and additional demographic data, such as age and gender, will be collected and reported, with informed consent from the survivor. If the survivor does not wish to file a formal complaint, referral to available services will still be offered even if the complaint is not related to the project, that referrals will be made, the preference of the survivor will be recorded and the case will be considered closed.

If the survivor provides informed consent, the grievance recipient should inform the GRM Specialist. The GRM Specialist at the PIU will inform the World Bank. The report will be on the anonymized incident as soon as it becomes known to the PIU. Data shared will include the nature of the allegation; if the alleged perpetrator is associated with the Project; the survivor's age and sex' and whether the survivor was referred to other services. The Project's SEA/SH Action Plan has mapped all referral services in the different counties designated for interventions. The project team will keep an updated list available of these services.

Step 3: Acknowledgement and Follow-Up: Referrals are a process through which the survivor gets in touch with professionals and institutions regarding her case. Services can include health, psycho-social, security and protection, legal/justice, and economic reintegration support. The grievance recipient will instantly provide the survivor with contacts of the available referral services in the respective area. If the survivor wishes for any assistance with transport or payment for services, the grievance recipient will provide allowances. Referral services are provided even in cases where the survivor opts to not pursue the case through the GRM or through legal channels.

The grievance recipient explains to the survivor his or her right to control whether and how information about the case is shared with other entities as well as any implications of sharing information. The survivor will be informed about his or her right to place limitations on the type of information they want shared. The survivor's consent must be documented.

Step 4: Verify, Investigate and Act: The PIU GRM Specialist will be the key focal point for management of such grievances and concerns and will work closely with respective GBV Specialist counterparts at the Ministry of Gender and Social Welfare. Once a case has been taken in by a GRM recipient, and informed consent of the survivor is obtained to proceed with the case, the case file will be submitted to the GRM Specialist. The GRM Specialist will first ensure that the survivor has been provided with all necessary GBV referral services, and will ensure that the survivor is in safety.

Where the SEA/SH grievance was allegedly committed by a project worker, the grievance will be reported to the respective employer. The GRM Specialist will follow up and determine the likelihood that the allegation is related to the project. The GRM Specialist will follow up and ensure that the violation of the Code of Conduct is handled appropriately, e.g., the worker is removed from his or her position and employment is ended. The responsibility to implement any disciplinary action lies with the employer of the alleged perpetrator, in accordance with local labor legislation, the employment contract, and the code of conduct. The GRM Specialist will report back to the survivor on any step undertaken and the results.

Where the survivor has opted to take a formal legal route, the GRM Specialist will ensure that the survivor has all the support required to file a case at court. The GRM process will still proceed with the survivors' consent. Ensuring due process is a matter of the formal justice system and not the grievance handlers. Unlike other types of issues, it is not part of the GRM's remit to conduct investigations, to make any announcements, or to judge the veracity of an allegation. The GRM should refer the case to the domestic regulatory framework to process the case if the consent of the survivor is received.

Since this project assumes a fully survivor-centered approach, no information can be passed on without the consent of the survivor. If the survivor does not wish for the case to be pursued, the survivor shall be offered access to referral services and the GRM Officer should note that the survivor did not wish for the case to be pursued, and the case is considered solved.

Case closure requires a) the case has been referred to GBV service providers (if the survivor consented) for support and appropriate actions; and appropriate actions have been taken against the perpetrator; b) the service provider has initiated accountability proceedings with the survivor's consent.

If the survivor does not want to launch a complaint with the employer, the case is closed. If the complaint proceeds, the case is reviewed by the GRM Specialist and a course of action is agreed on with the respective employer. The alleged perpetrator's employer takes agreed-on disciplinary action. Once the action is deemed appropriate by the GRM Specialist, the case is recorded as closed.

7 Monitoring and Reporting

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. 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. The quarterly summaries will provide a mechanism for assessing both the number and the nature of complaints and requests for information, along with the Program's ability to address those in a timely and effective manner.

The programme will establish and maintain a database and activity file detailing public consultation, disclosure information and grievances collected throughout the program, which will be available for public review on request. Stakeholder engagement shall be periodically evaluated by the PIU.

Table 5: Monitoring Plan

Key components	Timeline	Methods	Responsible entity
Stakeholders access to project information and consultations.	Project preparation stage and throughout implementation	Surveys, interviews and observation	PIU
Awareness for beneficiaries on activities and their entitlements and responsibilities.	Project preparation stage and throughout implementation on monthly/quarterly basis	Surveys, interviews and observation	PIU
Relevance and appropriateness of consultation and engagement approaches	Monthly/quarterly and through implementation of project	Surveys, interviews and observation/review of project progress reports	PIU

Key components	Timeline	Methods	Responsible entity
Awareness of GRM platforms and their relevance	Monthly/quarterly and through implementation of project	Surveys, interviews and observation/review of project progress reports	PIU
Engagement of facilitators with stakeholder target beneficiaries.	Monthly/quarterly and through implementation of project	Surveys, interviews and observation/review of project progress reports	PIU
Status of reported grievances	Monthly/quarterly and through implementation of project	Interviews and review of project progress reports and GRM records	PIU

The following indicators will be used for evaluation:

1) Bi-annual grievances received by type of grievance, speed of resolution and how they have been addressed;
2) Level of involvement and participation of stakeholders including project affected people (disaggregated by gender and vulnerable groups); and
3) Incidents and accidents.

7.1 Reporting and dissemination plan

The Project will generate data-driven information and report periodically on quarterly, biannual and annual basis. The roles and responsibilities of stakeholders will be elaborated using an activity planning and reporting matrix developed for the purpose of this project.

Information on public engagement activities undertaken by the Project during the year may be conveyed to the stakeholders as outlined above and in addition via the publication of a standalone annual report on project's interaction with the stakeholders or best practices.

8 Budget

The total budget estimated for the SEP is estimated at **USD 2.5 Million**. The budget category breakdown is shown below.

Table 6: Estimated SEP Budget

No.	Activities planned	Total cost (ETB)	Total cost (USD)
1	Human resources (safeguard experts at PIUs)	1,512,000.00	28,000.00
2	Production of communication materials for mainstream media, social media, video documentation, call/hot line centers and stationery and mobile visualization boards, at national level;	18,900,000.00	350,000.00
3	Orientation on health emergencies Prevention & control, including vaccination through virtual trainings and meetings, and local media,	40,500,000.00	750,000.00
4	Financial support for all regions to train and deploy volunteers per region,	21,600,000.00	400,000.00
5	Financial support to all RHBs in supporting to incentivize HEWS in financial stipends and non-monetary forms and to provide technical support to selected Woreda (hotspots) or facilities; four RHBs	32,211,000.00	596,500.00
6	Financial support to all RHBs for printing and distribution of IEC/BCC materials (posters & banners), four RHBs	14,512,500.00	268,750.00
7	Intensified and targeted social mobilization using standard messages in hotspots (200 Woreda in four region) volunteers per region	2,524,500.00	46,750.00
8	Behavioral and sociocultural risk factors assessments; to be conducted at four woredas	3,240,000.00	60,000.00
	Grand Total Cost	**135,000,000.00**	**2,500,000.00**